

 Drug Misuse Research Division
The Health Research Board



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Drug Misuse Research Division

The Health Research Board

National Report on Drug Issues Ireland 2000

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Foreword

This report is very much the result of collaborative work within and outside the Drug Misuse Research Division. We in the Drug Misuse Research Division, 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 -

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Voluntary and Community Groups and

Academic Researchers.

New material for this year's report is presented in italics except where [almost] all the material is new i.e. Chapter 2 and Key Issues, Sections 13 and 14. As a complete report was requested, each chapter was started anew and where relevant extracts were copied from last years report [1999].

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Rosalyn Moran
Head of Division

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SUMMARY

Main Trends and Developments : Rosalyn Moran

Some developments in policy and programmes of a general nature are overviewed, followed by a review of developments in specific sectors as follows

- - Treatment Policy and Programmes
 - Prevention Policy and Programmes
 - Criminal Justice / Law Enforcement and Supply Side

Recent Developments – General

- A **Review of the National Drugs Strategy** is nearing completion. The review had broad terms of reference and will address, inter alia, *demand and supply issues*.
- The delivery of the National Drugs Strategy will take place within the framework of the **National Development Plan 2000-2006**, which, inter alia, will involve greater devolution of power to regional structures, with which existing structures in the drugs area will co-operate. The intergrated inter-agency approach and the involvement of local communities in the delivery of policy will continue.
- A **National Advisory Committee on Drugs** has been established by the Cabinet Committee on Social Inclusion in recognition of the importance of having authoritative information and research findings available as a guide to policy. The Group will have continuing responsibility for research and information on drug misuse in Ireland and is implementing a prioritised three year programme of research and evaluation on the extent, nature, causes and effects of drug misuse in Ireland and identifying the contribution to be made by all the relevant interests.
- The **Integrated Services Process** [described in last year's report] has been put in place in four areas on a pilot basis. Priority themes for each of the four pilot areas are being implemented. The need for Departments and Agencies to heighten their engagement to ensure that the ISP is integrated into their budget planning, resource deployment and new programme design has been highlighted. It is hoped these initiatives will form a model of best practice that can be extended to other deprived urban areas.
- **Addiction Research Centre** – has been established in Trinity College, Dublin. It is a joint initiative involving the Department of Social Studies and the School of Pharmacy in TCD. The Centre will aim to provide a focus for independent and critical academic research into the prevention and management of alcohol and drug problems in Ireland.
- **Private Sector Involvement** in supporting initiatives, in the fight against social inclusion, is growing. A number of schemes are underway e.g. The Companies Caring for Children Initiative, Foundation for Investing in Communities¹ and Irish Financial Service Centre Trust. The latter, for example, provides financial support towards the development of a

¹ Annual Report of the Inter-Departmental Committee, 1998/99. Social Inclusion Strategy. Stationery Office, Dublin. P.33.

residential facility in Tullow, Co. Carlow where young drug offenders can avail of training and be educated to prepare for employment; the Trust also provides finance to St James' Resource Centre which operates as a rehabilitation centre for ex-prisoners and drug users.

- ***Cross border activity*** and co-operation in the drugs area is likely to increase.

Recent Developments in Treatment Policy and Programmes

- All health boards have continued to expand their prevention, treatment and rehabilitation programmes. This is particularly so in the three area Health Board in the East [ERHA], where the opiate problem is most acute.
- In 1999 & 2000 all Health Boards have been provided with additional funding to continue to develop all aspects of their drug prevention and treatment services.
- Increased resources have been allocated in 1999 by central Government to all health boards to develop databases and information systems to help characterise the drug problem in their areas.
- *The Kilkenny Drugs Initiative, a cross community body which includes representatives of the Garda and the South Eastern Health Board, conducted a six-month study of substance misuse in Co. Kilkenny. It found that cannabis is widely used in schools in Kilkenny and students are dealing in many other drugs. It also found that the use and misuse of substances was not confined to any age bracket, gender or socio-economic background.*
- The expansion of provision of drug treatment services by means of the primary health care system continues for stabilised users.
- The Misuse of Drugs [Supervision of Prescription and Supply of Methadone] Regulations 1998 came into force in July 1998, imposing strict control on the prescribing and dispensing of methadone, which aimed inter alia, to reduce the leakage of methadone onto the illicit market.
- In 1998 treatment cards were introduced for those receiving methadone.
- Five GP Co-ordinators have been recruited to facilitate GP involvement in community based drug treatment in the three area health boards in the East and to help lessen the waiting list. Liaison Persons have been appointed in other health boards.
- By end of July 2000, there were 4,851 people receiving methadone in Ireland [only 90 of these were from outside of the ERHA area]. In 1998 there were 3,600 receiving methadone in ERHA area.
- In August 2000, there were 158 GPs prescribing methadone, 131 of these in ERHA i.e. 27 in rest of country. In addition, there are 207 pharmacists dispensing methadone to clients who are either attending a GP-based substitution programme or attending satellite clinics. Of the 207 pharmacists dispensing methadone, 154 are located in the ERHA area.
- There is much media coverage and political concern as there are still 406 opiate addicts on the waiting list for treatment in clinics around Dublin [October, 2000].
- Public opposition to the opening of clinics in neighbourhoods continues. The Health Boards are adopting a partnership approach with local communities.

The ERHA Service Plan for the AIDS/Drugs Service included a commitment to 'Social Development'.

- Needle exchange has been available in the Dublin area since 1989. There were 6,000 people attending needle exchange programmes in the EHB in 1999 and these are not included in the treatment returns². The Drug Misuse Research Division is exploring the possibility of reporting on these statistics along with the regular drug treatment figures.
- Three liaison midwives are to be appointed in the ERHA to deal with pregnant misusers, one has already been appointed.
- The funding available to the EHB/ERHA to develop drug programmes and services has increased from IR£1million/Euro 1.27m in 1992 to IR£17 million/ in 1999 and IR£22m/Euro 27.95m in 2000.
- The EHB published an Inventory of Policies for the Board's AIDS/Drug Addiction Services in October 1998 which covers policy in all main areas under the headings *treatment, viral illnesses, general and administrative*.
- The ERHA has been reconceptualising its service provision and affording a greater role to prevention and rehabilitation along with the traditional focus on treatment.
- The EHB in 1999, developed a Rehabilitation Blueprint which involves realignment of treatment services to a rehabilitation focus. This new focus will commence at assessment stage.
- A rehabilitation co-ordinator will be appointed in each of the three regions of the ERHA.
- There is anecdotal evidence that benzodiazepines misuse has increased as has prescribing of same by a small number of GPs. A committee to examine the nature and extent of benzodiazepine prescribing in Ireland has been established by the Department of Health and Children. The committee will make recommendations on good prescribing practice in general and in particular in relation to the management of drug misusers.
- Homelessness amongst drug misusers and ex misusers is recognised as an increasing problem.
- Hepatitis C is becoming an increasing problem amongst injecting drug users.
- FAS has committed a significant number of Community Employment places towards rehabilitation programmes for recovering drug misusers. These programmes are being developed through the Local Drugs Task Forces.
- A review of the National AIDS Strategy has been carried out and AIDS Policy 2000 was published in June 2000.
- The Prison Service and the ERHA have put together a joint programme to ensure greater cohesion and continuity of care in the treatment available to drug misusers entering or leaving prison.

Recent Developments in Prevention Policy and Programmes

- The Department of Health and Children has provided funding to all health boards to collect information on drug prevention in their areas.

² Figures for 2000 not available.

- A number of initiatives in the prevention area are being funded through the Local Drug Task Forces and Young People's Facilities and Services Fund.
- 'Walk Tall' is a substance misuse prevention programme for primary schools piloted in 1998. This and a programme aimed at second level school pupils 'On My Own Two Feet' will continue to be implemented in schools during 2000.
- A National Youth Health Programme – a partnership between the Department of Health and Children and the Department of Education and Science and the National Youth Council of Ireland provided extensive training on drug prevention and policy development in 1998. Training with the pack 'Drug Questions Local Answers' (developed by the Department of Health and Children) continues to be used in several health board areas. This is a resource pack, which enables communities to provide a multi-disciplinary approach to the drugs issue.
- New information cards and other resource materials, designed to be user friendly and accessible, were developed for European Drug Prevention Week, 1998 and are still available free of charge to interested parties.
- The Irish element of the EDDRA database continues to be developed with the addition of evaluated projects. The promotion of the database has reinforced the need for evaluation in this context.

Recent Development in Criminal Justice / Law Enforcement and Supply Side

- Up to the mid 90s police activity focused mainly on supply reduction and law enforcement. Since 1995 however, the area of demand reduction has become a more important and prominent aspect of policing the drug problem. *The fostering of strong community links are seen as an important aspect of effective policing.*
- A **Garda National Drugs Unit** (GNDU) was established in September 1995, replacing the former Dublin based Drugs Squad. The establishment of the Unit was a marked departure in that it placed the responsibility for Drug Law Enforcement on a national level within the GNDU. It also introduced the concept of demand reduction.
- *The new five year **corporate strategy for the police force** – 'Policing In Ireland' was put in place on 1st January 2000. The enforcement of laws relating to drugs was one of the major priorities identified. Operationally this will involve each manager in each Garda Division/District and Station drawing up specific plans/targets, reviewing progress and adjusting strategy as needed [Sutton, 2000].*
- Each of the 27 Garda divisions in the country have a **specialised Drug Unit** with responsibility for enforcement of drugs legislation. In the cities of Dublin, Limerick and Cork, districts have specific drug operational units dealing with the drug problem at local level. For example, since January, 2000 there are *18 dedicated Drug Units in the Dublin Metropolitan Region who are in constant liaison with each other and with the GNDU [Sutton 2000].*
- *The Commissioner is represented on the **National Drug Strategy Team** by a Detective Superintendent from GNDU and each of the **Local Drug Task Forces** has a Garda representative at Inspector level.*

- **Interagency co-operation** has increased and is seen as vital in combating the international drug trade. Accordingly, there is growing co-operation between the Police, Customs and Navy. A Memorandum of Understanding and a working protocol has been drawn up between the police and the Customs service. Both agencies engaged in joint training programmes and exercises with the Naval Service. The interagency co-operation involved in the operation of the CAB – the Criminal Assets Bureau [i.e. police, social welfare, revenue] has been phenomenally successful in the freezing and forfeiture of the proceeds of criminal activity including drug-related crime.
- A **Coastal Watch Programme** has been established where local people assist in policing the 3,000 miles of coastal area in Ireland. Each coastal division was assigned an Inspector with specific responsibility for liaison with the local community so as to channel information and intelligence more effectively.
- *EU and International co-operation* has also increased greatly since 1995. **Drug Liaison Officers** have been established in The Hague, Europol and Madrid. In June 1988 a Liaison Officer was posted to Interpol, Lyons on a permanent basis.
- An EU funded initiative - the **Oisin Programme** was adopted by the Council of Ministers in 1996. The aim is to improve channels of communication, to identify international drug dealers, to share information and best practice in relation to demand reduction, training and intelligence gathering and to exchange insights in relation to the working methods of participating police forces. Police forces in Ireland, Finland, Northern Ireland, Portugal, Scotland and Wales are collaborating in an initiative which will examine the extent and effects of controlled drugs in rural areas, and to formulate programmes to counteract the threat posed. A new Oisin programme was started in 2000 [details not available].
- **Within the EU, an Garda Siochana is represented** at a Senior Management level in the following working groups – The Horizontal Drugs Working Group, The Police Co-operation Working Group, The Multi-disciplinary Group, The EU Working Party on Drug Trafficking and The Mixed Committee on Drug Trafficking.
- **Seizures** – there has been an increase in heroin seizures in recent years. Cannabis constitutes the highest proportion of seizures relatively.
- **Ireland has the strongest legislation in Europe** for countering drugs (e.g. the 1996 Criminal Justice [Drug Trafficking] Act - allows for 7 days detention of a suspect without charge, subject to judicial approval i.e. the suspect must be brought before the courts within this period however; 1996 Proceeds of Crime Act - onus is on criminal to prove assets were obtained legitimately).
- **Community Policing Forums** have been set up to allow the Gardai to work with local community groups and individuals in targeting drug pushers as well as improving overall relations between the Gardai and local communities. A number of these are being supported by Local Drug Task Forces [Flood 1999]. A 'policing forum' is being piloted in the South Inner City of Dublin.
- Complaints by communities, regarding open drug dealing on the streets led to the set up of **Operation Cleanstreet**- an undercover operation to identify small time drug dealers. Initially the Operation was focused on a few areas in Dublin where open dealing had become a major problem [December 1997]

but it is now a nation-wide initiative and has included operations in Kells, Navan, Trim and Drogheda. Five Operation Cleanstreet programmes have been put in place and over five hundred street dealers have been identified / prosecuted.

- The Garda presence at large music events e.g. Homelands in Mosney and Creamfields in Punchestown, has increased along with arrests of persons found in possession of controlled drugs or possession for the purposes of supply.
- **Operation Nightcap** – designed to target licensed premises who allow the consumption, sale and supply of controlled drugs from their premises has been implemented.
- **Operation Rectify** – designed to target individuals involved in the sale and supply of controlled drugs and prescription drugs in the vicinity of Treatment Centres is underway.
- **Operation Tap** – designed to target individuals in the sale and supply of controlled drugs to the homeless and prostitutes, particularly in Central Dublin has also been introduced.
- **Operation Dochas** – designed to make substantial inroads into the drug problem in Dublin through the identification of the critical areas requiring action and the deployment of Gardai solely to this operation in these communities.
- Garda sources estimate that **drug users are responsible for 66% of all detected crime in the Dublin Metropolitan Area** during 1996.
- **Drug Courts** are to be introduced on a pilot basis in Dublin in late 2000. Commentators stress however, that development of the necessary supportive infrastructure, is a prerequisite to the success of the initiative. An independent evaluation of the pilot is planned.
- The Department of Justice, Equality and Law Reform is involved in a number of **diversion type initiatives** at the moment. Intensive Probation Supervision is provided through a number of projects. These projects divert serious offenders from prison at the court stage and place them in a community-based programme with the ultimate aim of reintegrating them into employment. The EU INTEGRA programme funds the CONNECT project which is aimed at the reintegration of certain prisoners [in Mountjoy jail], some of whom may have had drug addiction problems, into society and the workforce. A further phase of the project was implemented in November 2000.
- **Garda Youth Diversion Projects** - The Garda Community Relations Section has established a number of crime prevention and intervention programmes throughout the country. These programmes are funded by the Department of Justice, Equality and Law Reform and are generally managed by either Foróige and/or the City of Dublin Youth Service Board. At present there are 39 projects throughout the country, ten of which were established as part of the first phase of the expansion of the Garda Youth Diversion Programme under the National Development Plan earlier this year. An additional IR£16 million has been provided over the life of the Plan to facilitate a significant expansion of this particular Programme. Provision for further phases of this expansion are well advanced.
- The Department of Justice, Equality and Law Reform's Discussion Paper 'Tackling Crime' stated that the link between crime and disadvantage is

real. In order to widen the debate on crime and its causes a **Crime Forum** was established which reported in 1998. Following publication of the Report of the National Crime Forum, the **National Crime Council** was established by the Minister in 1999. The Council was established on an initial two year non-statutory basis. The establishment of the Council will facilitate broadly-based and well-informed discussions on crime on an ongoing basis and will serve as an important aid to policy formulation. The key roles envisaged for the council are :1) to focus on crime prevention, with particular emphasis on the underlying causes of crime and the development of partnerships and practical approaches which will be effective at community level; 2) to focus directly on raising public knowledge and awareness of crime; 3) to examine the 'fear of crime' and to address the issues, including those relating to minorities, which arise as a consequence of this fear; and 4) to identify research priorities which could be commissioned by the Department of Justice, Equality and Law Reform.

- **A White Paper on Crime** will be prepared in 2001. This paper will focus on linkages between the various agencies within the system, and in the wider sense between the causes of crime and the Government's specific measures to target social inclusion.
- Legislation is being prepared to establish the **Prisons Service** as an independent, statutory service. The first Director General was appointed on 15 July, 1999 and given responsibility for day to day management of the prison system. Amongst the Director General's priorities is the provision of medical care to prisoners on a par with public health care in the community. To this end, two major initiatives have been taken. Firstly, the Prisons Service in July 2000 published the First Report of the Steering Group on Prison Based Drug Treatment Services which has identified the resources required at individual prison level, to put in place a systematic approach to treatment of prisoners with drug dependencies. The Report indicated that the Eastern Regional Health Authority will have substantial input in the delivery of drug treatment. On foot of this report, the Government on 18/10/2000 approved the new approach to drug treatment in prisons. It is estimated by the Director-General that full implementation of the programme will take at least 2 years involving as it will, recruitment and training of staff and key professionals, inter alia. Secondly, a Group has been established to conduct a comprehensive review of the structure and organisation of prison health care services. This Group's report is due for publication in the middle of 2001.

PART 1

NATIONAL STRATEGIES: INSTITUTIONAL & LEGAL FRAMEWORKS

1. Developments in Drug Policy and Responses

1.1 Political framework in the drug field : Rosalyn Moran

Introduction : Significant changes have occurred in Irish society over the last years. Foremost amongst these are dynamic economic growth, improvement in living standards, ending of large-scale emigration, improvement in employment opportunities, growth in young educated population etc. Amidst these positive developments however, there exists pockets of poverty, homelessness, drug addiction and disaffection, particularly amongst young people in certain urban areas [Annual Report of the Inter-Departmental Committee, 1998/99, p.56]. The Government recognising the inequitable distribution of societal resources has made social inclusion a policy priority and has allocated on foot of wide social partnership arrangements [e.g. National Development Plan - NDP, Programme for Prosperity and Fairness - PPF, National Anti-Poverty Strategy - NAPS etc.] much needed financial resources to combat poverty and exclusion.

The Government's approach to the drugs problem is embedded in a broad social inclusion framework [see Drug Misuse Research Division (1999), National Report on Drug Issues : Ireland 1999]. The effects of social exclusion are seen 'to contribute to the deep rooted and intractable problems of serious drug misuse' [Flood, 1999]. An integrated inter-agency approach to tackling these problems has been put in place and local community participation in the formulation and implementation of policy is being nurtured and resourced. Devolution of power to local and regional authorities to tackle social exclusion has begun and related structures are being developed.

National Drugs Strategy : *Since 1996, the Government's drugs strategy has been underpinned by the findings, recommendations and policies established by the two reports of the Ministerial Task Force on Measures to Reduce the Demand for Drugs. This strategy is being reviewed at the present time and it is anticipated that the review will be completed before end of year 2000 [see below].*

The overall aim of the Irish Government's Drug Strategy is to provide an effective, integrated response to the problems posed by drug abuse and to work in partnership with the communities most affected by the drugs problem in tackling the issues raised.

Arising from this, the key objectives of that policy are to :

- reduce the number of people turning to drugs in the first instance through comprehensive education and prevention programmes
- provide appropriate treatment and aftercare for those who are dependent on drugs
- have appropriate mechanisms at national and local level aimed at reducing the supply of illicit drugs and
- ensure that an appropriate level of accurate and timely information is available to inform the response to the problem.

In line with these overall aims and objectives, *four basic principles* underpin the Government's strategy –

- it is recognised that an effective strategy must encompass a range of responses which not only addresses its consequences, but also attacks its causes
- the response to the drug problem must take account of the different levels of drug misuse, which are being experienced around the country. While illicit drug use is a nation-wide phenomenon, [particularly the use of drugs such as cannabis and ecstasy], heroin abuse – in view of its public health implications and close association with crime – is currently seen as the most pressing aspect of the problem. A more targeted response is required, therefore, in the areas experiencing the highest levels of heroin abuse
- the need for all agencies which have a role in responding to the drug problem to work together so as to ensure that their individual contributions form part of an overall coherent approach. There is a need to ensure that all programmes and services which respond to the drug problem are delivered in a coherent, integrated manner
- the need to tap the depth of experience and knowledge which community groups and voluntary organisations can bring to a response to the drug problem. It is recognised that there is considerable knowledge and experience among communities in the areas experiencing the highest levels of use. These communities, therefore, must have an opportunity to participate in the design and delivery of the response to the problem in their areas [Flood, 1999].

An interesting aspect of the Irish Government's drugs strategy is a resourcing of the development of sporting and recreational activities for young people at risk with a view to promoting more healthy and productive behaviour.

At the micro level, the objective of drug policy in Ireland is to maintain people in and restore misusers to a drug free lifestyle. In practice, it is acknowledged that this is not an option for a number of citizens in the short-term. Accordingly, a pragmatic approach is taken and the importance of the minimisation of risk i.e. harm reduction is stressed in treatment and in a number of education and rehabilitation programmes. The emphasis on harm reduction has grown with the concern relating to the public health implications of the growth in AIDS/HIV and Hepatitis B and C infections.

The Government's strategy involves a range of responses, which addresses the causes and consequences of drug misuse. The Government's response can be characterised as supporting general initiatives to tackle social exclusion and specific initiatives within the social inclusion framework but more specifically targeted at drug related problems. The general initiatives are targeted at issues seen as contributing to the drugs problem [e.g. unemployment, social deprivation] [see Drug Misuse Research Division, National Report for EMCDDA 1999]. Such programmes provide scope for agencies and communities affected by the drugs problem, to avail of financial and other resources to tackle the broader problems associated with drug misuse in their communities.

The Government's specific response to tackling the drugs problem is focused around two major initiatives - the Local Drug Task Forces – LDTF, and Young People's Facilities and Services Fund - YPFSF. Both initiatives are largely focused on areas where the opiate problem is most acute [see Part 4, 12.2].

*In addition to these two major initiatives which are largely focused on urban areas where the drug problem is most acute, Government strategy has begun to address the drug problem on a nation-wide basis, in particular the use of so-called 'recreational drugs', such as cannabis and ecstasy, particularly among young people. **Regional Drugs Co-ordinators** have been appointed to assist the Regional Health Boards in developing appropriate programmes and services, mostly in relation to drugs awareness, education and prevention. On the request of the Department of Health and Children all health boards now have co-ordination structures in place which work with varying degrees of success and involvement from other agencies and groups [DofHC submission to National Drug Strategy Review, p.3, DofHC, internal document]. Thus, a number of the Health Boards have set up Regional Co-ordinating Committees in their areas, which work in partnership with other relevant agencies in developing a co-ordinated response to the drug problem, having regard to the needs of their particular regions.*

The Government's strategy involves a number of major initiatives to tackle the drug problem from the supply side [see 1.2 below]. Legislation has been introduced over the past few years to significantly increase the powers of the Gardai and other authorities to tackle organised crime and drug dealing. In a complimentary manner, there is an increasing recognition by agencies working on the supply side that demand reduction must accompany supply reduction measures and thus demand reduction has become an increasingly important aspect of the work of law enforcement agencies. Part 3 [9.3 and 9.6] describes some projects on demand reduction which address interventions in the criminal justice system.

*The institutional mechanisms involved in ensuring the implementation of the National Drug Strategy not surprisingly overlap with the mechanisms in place to combat social exclusion in general. Foremost here is the **Cabinet Committee on Social Inclusion** – which gives political direction to the Government's social inclusion policies. This Committee receives input from the **Inter-Departmental Group on the National Drugs Strategy** and the **National***

Drugs Strategy Team. The relevant Government Departments and agencies are represented in these groups. In addition, 2 representatives, one from each of the community and voluntary sectors are represented on the National Drugs Strategy Team which plays a central role in overseeing the implementation of the Government's Drug Strategy and at the operational level the work of the Local Drugs Task Force, *inter alia*. The Team was established on the principles outlined in the Strategic Management Initiative for addressing issues which cut across the remit of a number of Government Departments and Agencies. Finally the **Local Drugs Task Forces** – 12 in Dublin, 1 in Cork and 1 in Bray - provide a strategic locally-based response by the statutory, community and voluntary sectors to the drug problem in the areas worst effected. The **National Assessment Committee and Development Groups** established under the **YPFSF** are also involved at the implementation level [see Part 4, 12.2].

Preliminary arrangements have been put in place to give expression to the recent developments towards greater devolution to the regional level under the National Development Plan, *inter alia*. Accordingly, the LDTFs and Area Based Partnership Companies etc. are due to work with the Directors of Community and Enterprise and the City/County Development Boards –CDBs, when drawing up their integrated local action plans. Arrangements for co-ordination of planning and delivery of services are to be agreed with the CDBs.

International context : Ireland's drug strategy is framed within the context of various international and EU agreements e.g. Political Declaration on the Guiding Principles of Drugs Demand Reduction - United Nations Special Session on Drugs held in New York 1998 with its 2000-2008 targets; UN Conventions on Narcotic Drugs and Psychotropic Substances and EU Action Plan on Drugs 2000-2004.

1.2 Policy implementation, legal framework and prosecution : Mary O'Brien.

a) Law and regulations – drug-related issues

The body of legislation which forms the statutory framework for the control of drugs in Ireland, is drawn up on an inter-sectoral basis by the relevant Government Departments of Health & Children; Justice, Equality & Law Reform; and Environment. The law is implemented by the Garda Síochána (police), the Revenue Commissioners, and the Customs Service. A brief description of the Acts and listing of Regulations - Misuse of Drugs Act 1977 & 1984, can be found at Appendix 1. These 1977 and 1984 Acts provide for a wide range of controls over drugs, which are liable to be misused. They include controls relating to cultivation, licensing, administration, supply, record keeping, prescription writing, destruction and safe custody. These laws also include provisions designed to deal with the irresponsible prescribing of controlled drugs by medical practitioners. The Misuse of Drugs Acts 1977 and 1984 are the two central pieces of legislation under which the majority of prosecutions in relation to drug misusers are made.

In the past few years a number of changes have been made to the legislative framework surrounding drug issues. The Criminal Justice Act, 1999 makes amendments to the Misuse of Drugs Act, 1977 to provide for a new drug related offence. The new section (15A) creates a new offence related to the possession of drugs, with a value of IR£10,000/ Euro12,700 or more, for the purpose of sale or supply. A person found guilty of such an offence may be imprisoned for up to life and be subject to an unlimited fine. The Act also provides for a mandatory minimum sentence of ten years in prison. However, where it is found that addiction was a substantial factor leading to the commission of the offence, the sentence may be reviewed after half of the mandatory period, at which time the court may suspend the remainder of the sentence on any condition it sees fit.

The Housing (Traveller Accommodation) Act, 1998, which is the legislative framework within which housing authorities provide for the accommodation needs of Travellers, is a key element in the Government's efforts to promote social inclusion and equality and to counter discrimination. This law applies relevant sections of the Housing (Miscellaneous Provisions) Act, 1997 in respect of the control of anti-social behaviour, such as drug dealing, to halting sites provided by local authorities or by voluntary bodies.

New legislation in relation to mental health, which is currently being drawn up, proposes that addiction will be excluded from the scope of the definition of mental disorder in the legislation. Although in practice it is not invoked, under current legislation (Mental Treatment Act, 1945) addiction remains on the statute books as a criterion for non-voluntary committal to a psychiatric hospital. It is now considered unacceptable to detain by law, people whose primary problem is addiction.

New regulations introduced in 1999 (Misuse of Drugs (Amendment No. 1) Regulations, 1999) gave authority to certain officials of the Department of Agriculture to possess cannabis hemp, lawfully, in the course of their duties for monitoring and sampling in the production of hemp fibre.

- I In 2000 new regulations (Customs-free Airport (Extension of Laws Regulations, 2000) were introduced to extend drug controls under the Misuse of Drugs Acts, 1977 and 1984, and the Irish Medicines Board Act, 1995, to include the Customs free area at Shannon airport. This instrument covers a loophole in the legislation and allows the Irish Medicines Board to inspect any company within the customs free area at Shannon Airport.*

An order has been drafted (Misuse of Drugs Act, 1977 (Controlled Drugs) (Declaration) Order, 1999) to extend the list of substances controlled under the Misuse of Drugs Acts. The need to do this arose out of Ireland's obligations under the United Nations Conventions on Narcotic Drugs, Psychotropic Substances and Precursor Chemicals, but also because of concerns about the abuse of amphetamine-type substances, and the use of certain drugs in sport. The drugs to be controlled include substances associated with ecstasy misuse (4-MTA, ketamine, ephedrine and

pseudoephedrine), as well as a number of substances which are on the current International Olympics Committee list of prohibited substances in an effort to prevent doping in sport. This order will be brought into force shortly.

Social and health drug-related issues have arisen, particularly in relation to the implementation of two pieces of legislation. The first is a health issue in relation to the Criminal Law (Sexual Offences) Act, 1993. A study carried out by the Women's Health Project in Dublin (O'Neill and O'Connor 1999) found that the legislation dealing with prostitution is having a negative impact on the lives of prostitutes. The researchers comment that increasing complaints from local residents and the requirements of the legislation, that anyone 'loitering for the purposes of prostitution' be directed from the area, has resulted in sex workers going underground and working in increasingly unsafe environments. Consequently, it is becoming more difficult for health workers, with the aim of providing healthcare and preventing HIV, to reach the women. This has serious implications for public health policy. The authors of the study recommend that a review of the current legislation be undertaken as soon as possible.

The second is a social and health issue in relation to housing legislation (Housing (Miscellaneous Provisions) Act, 1997) and its effect on drug users. This law allows public housing authorities to initiate an excluding order procedure against occupants of local authority housing who are 'involved in anti-social behaviour'. A study of the impact of the legislation (Memery and Kerrins 2000) found that it gave local authorities the political go-ahead to evict tenants and to use indirect means, such as encouraging other family members to exclude the individual, to remove those considered to be involved in anti-social behaviour much of which was drug-related. People excluded from access to public housing can find themselves also discriminated against in seeking hostel accommodation because of their drug use. The exclusion of the individual involved in anti-social behaviour from the home, results in the loss of essential family supports, as well as removal from community based drug services. This report states that 'street homelessness resulting from exclusion leads to open drug taking and riskier drug taking practices' (p 33). Such behaviour will increase the risk of contracting infectious diseases. Outreach workers from one local drug project are experiencing difficulty in contacting intravenous drug users because they have gone 'underground' for fear of local anti-drug activists (personal communications with drug project workers). A study of out-of-home drug users (Cox and Lawless 1999) suggests that the housing legislation has contributed to the rise in homeless among drug users.

Other aspects of drug legislation were criticised at the public National Forum on Crime held in 1999. One such issue, is the provision under the Criminal Justice (Drug Trafficking) Act, 1996, which allows the police to detain a person accused of drug trafficking for a period of seven days. Some contributors to the Forum considered that this provision could prove to be counterproductive, resulting in more convictions of drug users and small-time dealers rather than curbing the activities of large-scale drug traffickers. Another was the then proposal (now law - Criminal Justice Act, 1999) to provide for a new drug

offence related to the possession of drugs, with a value of IR£10,000 or more, for the purpose of sale or supply, and for a mandatory minimum sentence of ten years in prison. It was criticised 'both on grounds of principle relating to mandatory sentences generally and because of the difficulty of establishing the actual value of a seizure' (National Crime Forum Report 1998: 72).

Barry (2000) [Reference: Irish Medical News June 2000] in a discussion paper writes that the supply of drugs and the legal framework in which drug policy is formulated in Ireland require examination. He poses the question as to what the benefits and disadvantages of current drug laws are to the health of the population. He suggests that posing such questions usually meets a blanket response of no softening of the laws on drugs. He also comments that there does not seem to be an acknowledgement of the fact that there is not necessarily a link between whether something is legal, and whether it is good or not good for one. He proposes that the time is right to have an honest debate on the current legislative basis of drug policy in Ireland; and though such a debate may not be welcomed, he posits that it is necessary.

b) Prosecution policy, priorities and objectives in relation to drug addicts, occasional users, drug-related crime

All criminal prosecutions are taken under the authority of the Director of Public Prosecutions (DPP). It is a function of the Garda Síochána (police) not alone to investigate crime but also to initiate prosecutions and in summary cases (where an offence is a minor one chargeable by way of a summons, tried before a judge) to prosecute offenders to verdict. Consequently most prosecutions are taken by the police, usually the Garda who investigated the matter, under the name of the DPP.

Sections 3 and 15 of the 1977 legislation are the sections most frequently used in drug prosecutions. Section 3 covers the possession of any controlled drug, and Section 15 concerns trafficking of controlled substances. The use per se of a drug, other than opium, is not a criminal offence.

In addition to custodial measures there is a range of non-custodial options available to sentence those who plead or are found guilty. The decision of the court in relation to sentencing may be influenced by a Pre-Sanction Report. This report is compiled by the Probation and Welfare Service and includes information on factors that may have contributed to the individual's offending, such as addiction to drugs. Non-custodial options include :

- Probation Order (Probation of Offenders Act, 1907) – this is to secure the rehabilitation of the offender, to protect the public and to prevent the offender from committing further offences. It is used, inter alia, for drug users where conditions may include attendance for treatment and the provision of urine for analysis. This is the preferred procedure in the District Court when dealing with drug users.*
- Order of Recognisance (Misuse of Drugs Act, 1977, Section 28 as amended by the Misuse of Drugs Act, 1984) – This is an order requiring an offender to undergo treatment for drug addiction in a residential centre or in the community. This is an important non-custodial option for drug users who offend in Ireland. However, in practice this Order is not generally used by the*

courts since the provision of a statutory place of treatment has always been problematic, *inter alia*.

It has been recommended that the necessary Courts' Rules and Regulations be updated by the various Court Rules Committees (Final Report of the Expert Group on the Probation and Welfare Services, 1999).

c) *Any other important project of law or other initiative with political relevance to drug related issues*

While the legislative framework requiring an individual to undergo treatment for drug addiction as a non-custodial option in sentencing exists, in practice it is rarely used by the courts. The establishment of a Drug Courts system, initially on a pilot basis in Dublin, under the jurisdiction of the District Court, is being planned. These courts are intended to be treatment oriented, where people with a drug problem and who are charged with non-violent offences, are diverted to treatment programmes rather than to prison. This development is likely to have major implications for treatment services and the success of the initiative will depend on the formulation and implementation of cohesive treatment and rehabilitation programmes.

The Medical Bureau of Road Safety at the Department of Forensic Medicine, National University of Ireland, Dublin, in collaboration with the Garda Siochana (police) has undertaken a study to examine the level and type of drug use among drivers and its contribution to accidents. All samples submitted between 1 July and 31 December 1999, which were under the legal limit for alcohol, were tested. Preliminary results from 338 samples showed that cannabis was most frequently found (34%), followed by benzodiazepines (25%). Cocaine was the drug least commonly found at 4% of the sample (Medicine Weekly) [Reference: Medicine Weekly, May 2000, Vol.4, No.19].

1.3 Developments in public attitudes and debates : Rosalyn Moran

The first national survey of Drug-Related Knowledge, Attitudes and Beliefs in Ireland was published by the Drug Misuse Research Division of the Health Research Board in September 2000 [Bryan et al 2000]. The questionnaire on which the research was based constituted a module of the 1998 Irish Social Omnibus Survey. A total of 1,000 adults 18 years and over, randomly selected from the 1997 Register of Electors for Ireland, took part in the study. Data was collected using face-to-face interviews between February and April 1998.

Key Findings and Recommendations

The Irish have a good general awareness of commonly used illegal drugs. However, their perception of the general harmfulness of these substances indicates a lack of accurate knowledge about the different effects associated with different types of drugs.

Recommendation: The provision of accurate information of a non-sensationalist type to all age groups, on the relative known risks associated with different types of drugs.

Societal attitudes towards drug users are mostly negative. Those with personal experience of someone 'with a drug problem' tend to have less negative attitudes, as do the younger adults surveyed and those with higher levels of education.

Recommendation: The promotion of more positive attitudes towards those who misuse drugs, particularly among older people and those with less education. A positive attitudinal climate is important to the social integration of problem drug users and to their willingness to avail of treatment.

The public generally perceives drug taking to be common among young people, and there is a high level of concern about the current drug situation in Ireland. Notwithstanding, alcohol abuse tends to be perceived as a more serious problem in society than drug abuse.

Recommendation: The continuation of efforts to address the problem of legal as well as illegal drugs.

While societal attitudes towards those who use drugs are negative, respondents attach high priority to providing help to drug users. This high level of support for drug treatment is likely to be related to the widespread perception that the drug problem is a very serious issue in Irish society.

Recommendation: The retention of the drugs issue high on the political and social agenda.

More Detailed Results include :

- ***members of the general public were generally aware of the kinds of illegal drugs most commonly used.*** Ninety-four per cent reported that they had heard of heroin, cocaine, ecstasy and cannabis, while 70 % had heard of LSD and amphetamines
- ***self-reported cannabis use*** (as measured by lifetime prevalence) ***stood at 12 % for the entire sample.*** The younger urban sector of society tended to have greater personal experience of cannabis and to know people who had taken cannabis or had 'a drug problem'. Males reported greater use of cannabis and knowledge of cannabis users than females
- the results indicated ***a high level of concern about the current drug situation*** among the general public
- a substantial proportion of ***respondents believed that experimentation with drugs was commonplace among young people.*** Over half of those who took part in the survey believed that it was 'normal' for young people to try drugs at least once, and at least 40 per cent believed that most young people experimented with cannabis and ecstasy
- ***respondents generally regarded illegal drug taking as a dangerous pursuit.*** Approximately three quarters (77%) believed all illegal drugs to be equally harmful to health, while over 40 % believed that one could become dependent on drugs after just one experience. Half the sample (54%) believed regular use of cannabis was just as dangerous to health as

regular use of heroin. This somewhat **exaggerated sense of the effects of illegal drugs was less common** among the younger members of the adult population surveyed

- **social avoidance and fear of drug users and those addicted to drugs were high among respondents.** Moreover, sympathy for drug addicted individuals was relatively low. Younger respondents and respondents with a higher level of education were less inclined to perceive drug addicts in a negative light. Moreover, those with personal knowledge of someone 'with a drug problem' typically held more positive attitudes towards those who were addicted to drugs
- consistent with the widespread concern about the severity of the current drug situation was **an overwhelmingly high level of support for drug prevention.** Over 90 % of respondents agreed that the allocation of financial resources for drug prevention was worthwhile. Almost 95 per cent supported the notion of providing drug education to primary school children
- current harm reduction initiatives, including **the provision of heroin substitutes such as methadone, and needle exchange facilities to heroin dependent clients, received support** from two thirds of respondents (63% and 66% respectively). Furthermore, while the provision of drug treatment on the basis of need received almost unanimous support, two thirds of respondents (65%) felt this should only be provided to those who had abstinence as their ultimate goal
- regarding alternative policy options, **76 per cent of respondents agreed that cannabis use should be against the law**, while over 70 per cent agreed that drug addicts convicted of petty offences should be given the option of receiving treatment instead of having a jail sentence for their crime.

The publication of this report based on empirical findings received some media attention. In general issues surrounding the misuse of drugs continue to receive a high level of attention in the media. Law enforcement issues receiving attention include policing initiatives, drug seizures, drug-related crime, criminal law cases and lifestyles of drug 'barons'. In addition, one of the issues frequently reported on is the opposition of local communities to the opening of drug treatment facilities in their neighbourhoods – the NIMBY phenomenon (Not In My Back Yard). In response to such opposition, health boards endeavour to involve local communities in the planning and management of services. More recently, the outbreak of illness and deaths among injecting drug users in Dublin received a lot of media coverage which, inter alia, reiterated the risks taken by drug users.

The methodological work carried out by Dr. C. Comiskey on prevalence of drug misuse in Dublin has been widely covered in the media. The fact that these are estimates is rarely mentioned and rarer still is the presentation of ranges and confidence intervals or a number of estimates, as recommended by the EMCDDA. As a consequence, in general the coverage has not been very balanced. An outcome of the EMCDDA- National Working Group on Prevalence was the adoption of a set of recommendations aimed to improve

standards in the conduct and reporting of prevalence data. These standards were broadly circulated.

Two issues – prescription of heroin and decriminalisation of cannabis have received some attention from the Irish parliament – Dail Eireann, on a motion to note the Report of the Joint Committee on European Affairs on European Aspects of Drug Issues, Thursday 18 May, 2000. In relation to cannabis, the Minister of State at the Department of Tourism, Sport and Recreation, Mr. Eoin Ryan T.D., referred to the sensitive issue of the decriminalisation of cannabis and noted that the Joint Committee's document did not come out with any specific recommendations but drew attention to the 'diversity of approaches in the European context' and recommended that 'an objective presentation of the facts relating to different strategies' must be part of any ongoing debate or policy formulation [Ryan 2000]. Thus, there is little evidence of a desire to decriminalise cannabis, as the KAB survey findings reported above also, would indicate.

The issue of heroin prescription was referred to in this Minister's speech also. The Report of the European Affairs Committee referred to a "heroin prescription" model which was being piloted in Switzerland. Minister Ryan observed 'Obviously, such a radical approach has aroused much debate, and indeed controversy, not only in Europe but also here in Ireland. I note that while the European Affairs Committee recommends that the Irish health authorities should consider the need for and be authorised to develop what it describes as "innovative drug treatment measures", the Committee stops short of specifically recommending the introduction of the Swiss model here in Ireland' [Ryan 2000].

In the course of debates amongst professionals regarding the need for a variety of treatment options, the desirability / feasibility of the provision of injecting rooms is beginning to be discussed. A proposal was made in a submission of the Merchants Quay project to the National Drug Strategy Review, in this regard. Recent statements from Government representatives have indicated that there are no plans to introduce heroin prescription projects in this country [DofHC, personal communication].

In summary, it would appear that along with political initiatives including the devolution of powers to more local and regional levels, the growing involvement of the community & voluntary sectors and the inter-agency and integrated approach to the drugs problem - that a more open climate for debate is developing.

1.4 Budget and funding arrangements : Rosalyn Moran

Given the positive state of the national finances and reflecting the priority the Government has given to the drugs issue, it is not surprising that allocations to address the drugs problem have increased greatly. Under the National Development Plan 2000-2006 most spending in the drugs area is accounted for under the broad Social Inclusion policy. Much of the money has been channelled to support local action and community groups in their efforts to tackle the drugs problem. To date the focus has been on areas where the drug

problem is most acute – Dublin, Cork and Bray, with smaller allocations to other regions. However, under the new NDP, a number of sub-programmes which address the drugs problem directly or indirectly [operating under the broader Social Inclusion Strategy] are more geographically dispersed.

Details of funding to support the Drugs Initiative and Social Inclusion measures are outlined below.

Funding in the drugs area is most appropriately viewed in the broader context of the Irish Government's National Development Plan - NDP 2000-2006 and, in particular, the Plan's commitment to tackle social exclusion as a policy priority. The Plan covers the seven year period 2000-2006 and will involve an investment of £40.588 billion Irish pounds/ Euro 51.55 billion [at 1999 prices] of public, European Union and private money. This Plan is one element of a nexus of social partnership agreements [e.g. National Anti-Poverty Strategy - NAPS, Programme for Prosperity and Fairness – the PPF] which embrace the major sectors and interest groups of civic society and all of which address the issue of social inclusion.

The Plan involves inter alia three National [or Inter-regional] Operational Programmes

- economic and Social Infrastructure
 - employment and Human Resources
 - productive Sector
- and 2 Regional Operational Programmes for the
- Border, Midlands and Western - BMW Region and
 - Southern & Eastern – S&E Region.

The following national objectives underpin the National Development Plan (NDP);

- continuing sustainable national economic and employment growth
- consolidating and improving Ireland's international competitiveness
- fostering Regional Development
- promoting Social Inclusion.

Spending on the **Inter-Regional or National Operational Programmes** will include financing of projects relating to social inclusion, which of course have important implications for all citizens including drug misusers, but at the more macro level [e.g.. development of rural transportation will increase access to resources including treatment]. This type of spending on social inclusion is complemented by spending on the S&E and BMW **Regional Operational Programmes** which are designed to promote, inter alia, balanced regional development.

The focus at these regional levels will be on **Sub-Programmes** such as Regional Infrastructural Investment, Social Inclusion and Productive Investment. Measures which will be taken under the Social Inclusion Sub-Programme in both Regions fall under headings such as - Childcare, Equality, Community Development/Family Support, Crime Prevention [many measures here address drugs area], Youth Services and Services for the Unemployed.

Table 1.1 shows expenditure on Social Inclusion in the NDP Operational Programmes.

Table 1.1 : Expenditure on Social Inclusion, NDP 2000-2006

Operational Programme	National € million	BMW Region € million	S&E Region € million
<i>Economic and Social Infrastructure</i>	10,157.9	2,451.9	7,706.0
<i>Employment and Human Resources</i>	7,576.7	2,154.7	5,422.0
<i>Regional Programmes</i>	1,343.1	280.1	1,063.0
Total	19,077.7	4,886.7	14,191.0
Expenditure Per Capita €	5,261	5,062	5,333

Source : Ireland, National Development Plan 2000-2006. p. 187. Stationery Office, Dublin.

Footnote to table : In addition to the Community Support Framework there will be four Community Initiative programmes – Interreg, Equal, Leader and Urban – each supporting some projects in the social inclusion arena.

Under the Regional Programmes, the allocations to combat drug abuse specifically, for this seven year period, will be IR£112 million/ Euro 142m for the SE Region and IR£10 million / Euro 12.7m, for the BMW Region. This totals IR£122 million/ Euro 155m [DofTSR, Internal Doc. 10]. These funds will be allocated to the LDTF areas and will address the drug problem under the themes education, prevention, treatment rehabilitation and supply reduction [DofTSR, Internal doc 10].

Funding for the LDTFs [and most likely for YPFSF in 2002] will be channeled through the new or adapted structures which are being or will be put in place to deliver the NDP. These structures will involve devolution of the implementation of these initiatives to the regional level and will involve continued integration of relevant agencies.

Thus the recently established County and City Development Boards – CDBs whose primary function will be to draw up a comprehensive Strategy for Economic, Social and Cultural Development [by Jan 2002] have a key role in co-ordinating local delivery of social inclusion measures. The CDBs will operate on the partnership principle with the Regional Assemblies and under the local government umbrella with membership drawn from local development organisations, social partners, local representation of State agencies and local government itself [NDP 2000 document]. A Director of Community and Enterprise has been appointed by each CDB. All the relevant programmes and projects, and their delivery mechanisms, covered by the NDP will be expected to accord with this framework.

Key underlining principles of the framework will be the use of common delivery areas (e.g. county/city and, where appropriate, local electoral areas for community development/social exclusion) and of a single agency designated for delivery of specific components (e.g. micro-enterprise) of local development in any one area so as to avoid overlap, confusion and competition between agencies [NDP 2000].

Preliminary arrangements have been put in place to coordinate existing structures for the implementation of actions in the drugs area [see implementation mechanisms described in 1.1 above] with these new local structures. Thus the LDTFs and Area Based Partnership Companies, ADM-Community Groups are due to work with the Directors of Community and Enterprise and the CDBs when drawing up their integrated local action plans. Arrangements for co-ordination of planning and delivery of services are to be agreed with CDBs by the mid-term review of the Regional Operational Programmes – i.e. 2003 [DofTSR, Internal Doc. No. 10].

No detailed breakdowns of national **expenditure relating to drugs in the requested areas** i.e. law enforcement; epidemiological, prevention and treatment; evaluation, quality and training is available. The Drug Misuse Research Division submission to the National Drug Strategy Review include a recommendation to start work on costing expenditure on drugs - this is in line with recent recommendations at EU level [see EU Action Plan].

As noted above, **geographical differences** in the nature and extent of drug use exist in Ireland. For example, problematic drug use, in particular the heroin problem is concentrated in inner city areas of our larger cities. Consequently the major policy programmes and financial resources are targeted at these areas of need. However, there is a growing recognition that illegal drugs particularly cannabis and ecstasy are readily accessible in towns and rural areas throughout the country and along with alcohol are becoming an increasing aspect of recreational activity amongst categories of youth in particular. Pockets of heroin use in some larger rural towns have also been reported. Accordingly, Government strategy has begun to address the drug problem on a nation-wide basis, in particular the use of recreational drugs, such as cannabis and ecstasy, particularly among young people. **Regional Drugs Co-ordinators** have been appointed to assist the Regional Health Boards in developing appropriate programmes and services, in relation to drugs awareness, education, prevention and appropriate treatment and rehabilitation when needed. These regional co-ordinators also have a role to co-ordinate the response of agencies at a local level. Since 1992, these programmes and services have been in receipt of a specific financial allocation from the Department of Health and Children [DofTSR, Internal doc. No. 1]. This allocation represented additional funding for the drugs area for the regional health boards.

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APPENDIX 1

Legal Framework – Laws and Regulations

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

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

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

The ***Probation of Offenders Act, 1907***.

The ***Dangerous Drugs Act, 1934*** which was based on international law controlled the import, export, distribution sale and possession of specified drugs.

The ***Medical Preparations (Control of Sale) Regulations, 1966*** regulated the retail sale of amphetamines and their analogues, barbiturates and tranquillisers and limited these to prescription only.

Under the ***Medical Preparations (Control of Amphetamines) Regulations, 1969 & 1970*** the manufacture, sale and distribution of amphetamines and preparations containing amphetamines or their derivatives were prohibited.

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

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

The penalties on being found guilty of an offence under section 15 of the 1977 Act, range from a fine or imprisonment for a term not exceeding twelve months or both on summary conviction, to an unlimited fine or imprisonment for life or both on conviction on indictment.

The maximum penalty for possession of cannabis for personal use is restricted to a fine for first or second offences tried on summary conviction. For third and subsequent offences there is a fine or twelve months in prison, or both. The penalty for a third offence on indictment is an open-ended fine or three years in prison, or both.

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

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

Statutory Instruments (S.I) and Regulations

The following are the **Statutory Instruments (S.I) and Regulations** relating to the Misuse of Drugs Acts, 1977 and 1984 which set out the details of the regulations regarding the misuse of drugs.

Misuse of Drugs Act, 1977 (No.12 of 1977)

(Commencement) Order, 1979 (S.I. No. 28 of 1979)

(Controlled Drugs) (Declaration) Order, 1987 (S.I. No. 251 of 1987)

(Controlled Drugs) (Declaration) Order, 1993 (S.I. No. 328 of 1993)

Misuse of Drugs (Licences Fees) Regulations 1979 (S.I. No 164 of 1979)

(Amendment) Regulations 1988 (S.I. No. 11 of 1988)

Misuse of Drugs (Custodial Treatment Centre) Order 1980 (S.I. No. 30 of 1980)

Misuse of Drugs (Safe Custody) Regulations 1982, (S.I. No. 321 of 1982)

Misuse of Drugs Act, 1984 (No. 18 of 1984)

(Commencement) Order, 1984 (S.I. No. 205 of 1984)

Misuse of Drugs (Committee of Inquiry) Regulations 1984 (S.I. No. 264 of 1984)

Misuse of Drugs (Exemption) Order, 1988 (S.I. No. 326 of 1988)

(Amendment) Order 1993 (S.I. no. 339 of 1993)

Misuse of Drugs Regulations 1988 (S.I. No. 328 of 1988)

Misuse of Drugs (Scheduled Substances)- Regulations 1993 (S.I. No. 338 of 1993)

(Scheduled Substances)- (Exemption) Order 1993 (S.I. 341 of 1993)

Misuse of Drugs Regulations (Designation) Order, 1998 (S.I. No. 69 of 1998)

Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations, 1998 (S.I. No. 225 of 1998)

Misuse of Drugs (Amendment No.1) Regulations, 1999 (S.I. No. 273 of 1999)

Customs-Free Airport (extension of laws) Regulations, 2000 (S.I. No. 169 of 2000)

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

Section 74 of the ***Child Care Act, 1991*** states that where a shopkeeper sells a substance, in particular glue, likely to be inhaled to cause intoxication to a minor, he/she can, on conviction, be fined or imprisoned for up to twelve months. There is a provision for the retailer to put forward a defence that reasonable steps were taken to ensure that this was not a deliberate offence.

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

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

Under the ***Criminal Assets Bureau Act, 1996*** the Criminal Assets Bureau was established on a statutory footing with powers to focus on the illegally acquired assets of criminals involved in serious crime. The aims of the Bureau are to identify the criminally acquired assets of persons and to take the appropriate action to deny such people of these assets. This action is taken particularly through the application of the *Proceeds of Crime Act, 1996*.

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

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

The ***Criminal Justice Act, 1999*** makes amendments to the Misuse of Drugs Act, 1977 to provide for a new drug related offence. The new section (15A) creates a new offence related to the possession of drugs, with a value of IR£10,000/Euro 12,700 or more, for the purpose of sale or supply. A person

found guilty of such an offence may be imprisoned for up to life and be subject to an unlimited fine. The Act also provides for a mandatory minimum sentence of ten years in prison. However where it is found that addiction was a substantial factor leading to the commission of the offence the sentence may be reviewed after half of the mandatory period, at which time the court may suspend the remainder of the sentence on any condition it sees fit.

The Criminal Justice (Theft and Fraud Offences) Bill, 2000 substitutes a section of the 1994 Criminal Justice Act, which deals with money laundering. The new section makes it an offence for a person to remove the proceeds of criminal activity from the State, with the intention of concealing its true nature; or to assist another person to avoid prosecution for criminal offences. The maximum penalty is an unlimited fine or up to 14 years in prison or both. This is a *Bill* as distinct from a *Law* and as such has not as yet been enacted.

Other relevant laws

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

The **Customs Consolidation Act, 1876** was a consolidation of all Customs legislation up to that time and concerns importation, seizures, detention of goods and persons and arrests.

The **Mental Treatment Act, 1945** provided for the compulsory hospitalisation of 'addicts to drugs'. Addiction remains on the statute books as one of the criteria for non-voluntary committal to a psychiatric hospital, but in practice it is not invoked and one of the recommendations of the *White Paper on Mental Health, 1995* was that it be abolished.

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

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

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

The **Criminal Law (Sexual Offences) Act, 1993**, which mainly refers to the decriminalisation of homosexuality, also includes a number of clauses covering prostitution. Under this legislation it is an offence to solicit another

person for the purpose of prostitution. The penalty on conviction is a fine or three months in prison or both.

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

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

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

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

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

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

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

police, on notification by the housing authority to remove squatters who are engaged in anti-social behaviour from local authority housing. The Act also assists housing authorities to discharge their housing estate management function in a positive manner in conjunction with the various other initiatives which have been taken to promote estate management particularly in the area of partnership between the authority and tenants. The Act allows health boards to refuse supplementary welfare allowance, by way of payment to supplement the person's income in respect of rent or mortgage interest, to individuals who have been prosecuted under the Act.

The ***Criminal Justice (Miscellaneous Provisions) Act, 1997*** provides for the reduction of the amount of time spent by police on court-related duties, thus helping to ensure a greater presence of uniformed police on the streets. The Act also speeds up aspects of court procedure in criminal matters. It makes general provision, for the first time, for the issue of search warrants in relation to the commission of serious offences such as murder or rape and extends the application of certain other Garda powers.

The Housing (Traveller Accommodation) Act, 1998, which is the legislative framework within which housing authorities provide for the accommodation needs of Travellers, is a key element in the Government's efforts to promote social inclusion and equality and to counter discrimination. This law applies relevant sections of the Housing (Miscellaneous Provisions) Act, 1997 in respect of the control of anti-social behaviour, such as drug dealing, to halting sites provided by local authorities or by voluntary bodies.

Copies of the above may be purchased directly from Government Publications Sales Office, Sun Alliance House, Molesworth Street, Dublin 2
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PART 2

EPIDEMIOLOGICAL SITUATION

2. Prevalence, Patterns and Developments in Drug Use

– Mary O'Brien

2.1 Main developments and emerging trends

a) Overview of most important characteristics and developments

The main developments are included in this section, see text below for supporting data and references.

- Cannabis is the most commonly used illicit drug, followed to a lesser extent by amphetamine and ecstasy use.
- Drug users in Ireland are young – this reflects the general demographic situation where 47% of the population is under 30 years of age
- The lifetime experience of drug use in the general population of young people in Ireland is significant but this does not necessarily mean that they continue to use drugs after an initial experience, or go on to become regular users.
- Drug use is more prevalent among young Dublin males.
- Heroin is the least used illicit drug and it is the most problematic.
- The profile of the typical problematic drug user is young, unemployed male, leaving school at an early age and living in a socially and economically disadvantaged area.
- The level of employment among problem drug users has increased considerably.
- Problem heroin use is mainly confined to the Dublin area but there are pockets of heroin use in other parts of the country.
- The sharp rise in the number of drug-related deaths can be substantially attributed to more accurate recording procedures, though undoubtedly there has also been a real increase in drug-related death.
- A significant proportion of prisoners, who have a history of drug use, continue to engage in illicit drug use once incarcerated.
- There are indications of increasing homelessness among young drug users.

b) Emerging trends

- There has been a decrease in high-risk behaviours – needle sharing decreased, safe sex (use of condoms) practices increased among clients attending a needle exchange programme over the eight-year period 1990-1997. This is probably due to increases in service provision and the freer availability of clean needles and condoms.
- Women are more at risk than men, but while women tend to be involved in more risky behaviours than male drug users, they do present earlier for treatment.
- Patterns of drug use are changing. Over a number of years, among those presenting to treatment for the first time, there was a trend towards the

smoking, rather than injecting, of heroin. Smoking seems to have been the preferred route for young people starting to use heroin, at least in the initial year or so of their drug careers. However, trends since 1997 show that the route of administration for heroin is tending again towards injecting. The explanation is likely to be a complex one, involving many factors such as the availability of heroin, fluctuations in the price of heroin, but it may be that young people who originally preferred to smoke heroin are now no longer reluctant to inject.

- Injecting drug use continues to be one of the main risk categories to which new HIV positive cases are attributed each year.
- There is an upward trend in the number of HIV positive cases among Irish drug users.
- The prevalence of Hepatitis C among injecting drug users over the past decade has been consistently high.

c) Analysis of drug trends in wider social context

Several factors, including the media, can influence society's perspective on drug use and drug users, and research evidence can sometimes be at variance with what is perceived in society at large. When discussing drug issues 'It is important to look beyond the stereotypes or reliance on the media-fed explanations of phenomena' (NicGabhainn and Walsh 2000: 2).

The KAB study (Bryan et al. 2000:xv) on the knowledge, attitudes and beliefs of the general public in Ireland found that:

- Irish people have a good general awareness of commonly used illegal drugs. However, their perception of the general harmfulness of these drugs indicated a lack of accurate knowledge about the different effects of different types of drugs.
- Societal attitudes to drugs were mostly negative. Younger members of society and those with personal experience of someone with a drug problem tended to have less negative attitudes.
- The public generally perceived drug taking to be common among young people, and there was a high level of concern about the current drug situation in Ireland.

Not many qualitative studies have been carried out in the general population of young people in Ireland. Such studies to date have tended to concentrate on problematic drug use. It is important that there is a general awareness, and in particular awareness among policy makers of the social context of young people's drug taking if suitable and appropriate prevention measures are to be adopted.

The lifetime experience of drug use in the general population of young people in Ireland is widespread but this does not necessarily mean they continue to use drugs after an initial experience, or go on become regular users. A sizeable minority of young people have tried cannabis at some time in their lives. Media reports tend to concentrate on such figures without any reference to what is meant by lifetime prevalence. Drug use in the past year or the past month is more indicative of recent use but such distinctions tend to be ignored

in media reports of drug use. Recent use tends to be considerably less than lifetime use and an increase in lifetime use does not necessarily mean that there is also an increase in recent use (see Tables 2.2b, 2.2d, 2.2e, 2.2f below).

The authors of the KAB study recommend that accurate information of a non-sensationalist type on the relative known risks associated with different types of drugs, should be made available to all age groups of people; and that more positive attitudes towards those who misuse drugs should be promoted. This is important to the social integration of problem drug users and to their willingness to avail of treatment.

2.2 Drug use in the population

a) Main results of surveys and studies

Historically there has been little information available in Ireland on drug use among the general population. The first nation-wide survey of drug use among adults was carried out in 1998. Information on drug use among school pupils is more readily available but most of the studies have been conducted at regional level and use different methodologies, different sample sizes, different questionnaire designs, different age groups, etc.. In addition, differences in theoretical approaches (health behaviours, health promotion, education/prevention, problem drug use behaviours) reflecting different perspectives can preclude meaningful comparisons of survey results.

What is evident (SLÁN; HBSS; Rhatigan and Shelley 1999; Kiernan 1995; et al. 1997) is that alcohol and tobacco are the most widely used drugs in Irish society. Cannabis is the most commonly used illicit drug, followed to a lesser extent by amphetamine and ecstasy use, and their use is widespread (see Sections 2.2c and 2.2b below). Whether drug use is increasing is not clear from general population survey data (see Table 2.2f). Even among young people of school-going age it is difficult to interpret trends from survey results of the past two years. The much quoted, relatively high lifetime prevalence of cannabis use (37%) among 15-16 year old school pupils (Hibell et al. 1997), has not been sustained in more recent school surveys (HBSS; Rhatigan and Shelley 1999).

From the available general population survey data it is apparent that, generally speaking, young men in urban areas are the most likely to have misused drugs, mainly cannabis. However, a distinction must be made between the adult population and young people. Among adults over 18 years of age, after cannabis, amphetamines and ecstasy are the drugs most commonly used, though to a much lesser extent. On the other hand, among young people there is some disparity between different age groups. For example, among young people in general (ages 9-18) after cannabis, solvents are the most widely used substances. However, adolescents between 11-14 years of age are more likely to use solvents (see Section 2.2c). Anecdotal evidence suggests that the recreational use of cocaine is on the increase. Heroin, which is generally considered to be the drug that causes the most

problems for individuals, communities and society, is the drug least used in the general population (see Section 2.3).

b) General population

In 1998, a general population Survey of Lifestyle, Attitudes and Nutrition (SLÁN) was undertaken for the Department of Health and Children by the Department of Health Promotion, National University of Ireland, Galway (results of module on drug use unpublished). This is the largest study undertaken in Ireland to date in which drug use prevalence was measured. The sampling frame was the electoral register, the target population thus being adults of 18 years and over. A proportionate random sampling design was used to select the survey sample. The questionnaires were posted to respondents and were self-administered. The sample size of drug the section of the survey was 10,415. The response rate was 62.2% (n=6,539) (S. Friel, personal communication).

Cannabis was the most commonly used drug, followed by amphetamines and ecstasy (see EMCDDA Standard Table 1a at Appendix 2 (Part 2); Tables 2.2a and 2.2b below). The use of amphetamines was slightly higher than ecstasy use. Heroin was found to be the drug least used in the general population.

Table 2.2a. Ireland 1998. SLÁN Survey. Last 12 months prevalence. Type of drug by age groups. Percentages

Type of Drug	Age Groups		
	18-64	18-34	18-24
Cannabis	9.4	17.7	26.0
Amphetamines	2.6	5.4	8.8
Ecstasy	2.4	4.9	8.1
LSD	1.4	2.9	5.1
Cocaine	1.3	2.6	3.4
Hypnotics and sedatives*	1.2	1.4	2.1
Solvents	0.3	0.8	1.4
Heroin	0.3	0.7	0.8

Source: SLÁN, Dept. Health Promotion, NUI, Galway

*includes benzodiazepines

The highest prevalence rate for cannabis use was found among 18-24 year olds: 33.4% had used cannabis at some time in the past; 26.0% during the last 12 months; and 15.3% in the last 30 days. The rates were lower in older age groups.

Table 2.2b. Ireland 1998. SLÁN Survey. Lifetime, last 12 months, last 30 days prevalence of cannabis use by age groups. Percentages

Prevalence	Age Groups		
	18-64	18-34	18-24
Lifetime	19.9	30.0	33.4
Last 12 months	9.4	17.7	26.0
Last 30 days	5.1	9.7	15.3

Source: SLÁN, Dept. Health Promotion, NUI, Galway

Young men under 25 were the most likely to have used drugs. This was the case for all drug types in the 18-24 age group (see EMCDDA Standard Table 1a). In the older age groups women were slightly more likely to have used hypnotics and sedatives which include benzodiazepines. Interestingly, there were no gender differences in the 55-64 year olds for cannabis use during the past year and the past month, although the rates were small at 0.5%. Geographically, drug users were more likely to live in an urban location.

In the same year (1998) a general population survey (KAB survey), using a much smaller sample (n=1,000), was undertaken by the Drug Misuse Research Division, Health Research Board (Bryan et al. 2000). The fieldwork was carried out by an independent research organisation as part of a broader social omnibus survey. The aim of the survey was to investigate the attitudes of the general public towards drug use and drug users, and to determine the extent of cannabis use. As in the SLÁN study, the sampling frame was the register of electors, target population adults aged 18 years and over. The sampling procedure was a two-stage proportionate to size random sample. The questionnaires were administered face-to-face in the respondents' homes. The final sample size was 1,000 (response rate was 64.5%). Prevalence information on lifetime use of cannabis only was collected. The findings of this survey (see EMCDDA Standard Table 1b at Appendix 2; and Table 2.2c below) were quite similar to those found in SLÁN, particularly so in the case of the 18-24 age group. SLÁN found that lifetime prevalence of cannabis use among 19-24 year olds was 33.4%, the KAB figure was 32.3%. Interestingly, no significant gender difference was found among the KAB 18-24 year olds; lifetime use of cannabis was 32.3% for both males and females. The older age groups in the KAB survey showed somewhat lower prevalences than those found in SLÁN.

Table 2.2c. Ireland 1998. KAB Survey. Lifetime prevalence of cannabis use by age groups. Percentages

Prevalence	Age Groups		
	18-64	18-34	18-24
Lifetime	14.2	26.2	32.3

Source: Knowledge Attitudes & Beliefs Survey, Drug Misuse Research Division, Health Research Board

c) School and youth population

There is more information available on drug use among school pupils, than among adults in the general population in Ireland. However, up to now most of the work has been carried out at regional level. The survey studies vary in a number of ways; objectives, methodologies, focus of data collection, questionnaire design, age groups studied etc.. Differences in theoretical approaches, for example health behaviour, health promotion, education, prevention, problem drug use behaviour, reflect different perspectives. This affects interpretations of survey results and can preclude meaningful comparisons. Therefore, comparisons below are tentative and must be viewed with these variations borne in mind.

A survey of substance use among adolescents of school-going age (12-18 year olds) was conducted in the Western Health Board area (WHB) (Kiernan 1995). A sample of early school-leavers was also included in this study. Cannabis and solvents were the drugs most likely to have been used (see Table 2.2f below).

In 1995 nation-wide school surveys of 15-16 year old (born in 1979) post-primary pupils (ESPAD) were carried out in a number of European countries Hibell et al. 1997: 12). In Ireland the data collection period was March 10 – April 20, 1995 (Hibell et al. 1997: 134). The Irish lifetime prevalence rate for cannabis use (ever having used) was found to be 37%. This was among the highest of the countries participating in the study – UK was higher at 40%. However, this relatively high rate has not been found in subsequent surveys. This may be due to methodological differences.

A survey was carried out in 1996 to examine lifestyles of second level students in the Midland Health Board area (MHB). The results were presented in a short report entitled *Report on school survey of second level students in the Midland Health Board area* (unpublished). Unfortunately, a detailed description of the methodology was not provided. Twelve schools were randomly selected and 1,654 pupils completed a questionnaire in the classroom. Cannabis was the most widely used drug, followed by solvents (Table 2.2f below).

The latest national survey was conducted in 1998 (Irish Health Behaviours in Schools Survey [HBSS], Department Health Promotion, NUI Galway, unpublished) (EMCDDA Standard Table 2a at Appendix 2; Tables 2.2d and 2.2e below). All types of schools were sampled – primary and post-primary schools - from Department of Education & Science lists. Pupils were selected using two-stage random sampling within health board regions and classrooms. The sample size was 8,497; the response rate was 73%. Respondents ranged in age from 9-18 years old. Lifetime prevalence of cannabis use was found to be much less (21.7% for 15-16 year olds) than the ESPAD finding of 37% in 1995 (see Table 2.2d).

Table 2.2d. Ireland 1998. Schools Survey - HBSS. Prevalence of cannabis use by age groups. Percentages

Prevalence	Age Groups			
	11-12	13-14	15-16	17-18
Lifetime	3.0	8.0	21.7	28.5
Last 12 months	2.3	6.5	18.3	24.0
Last 30 days	1.3	4.3	10.5	11.0

Source: Irish Health Behaviours in Schools Survey (HBSS), Department Health Promotion, NUI, Galway

The highest prevalence was among 17-18 year olds; 28.5% had used cannabis at some time in the past (lifetime prevalence); 24% had done so in the past twelve months and 11% had used cannabis recently (in past 30 days). All drug types were more likely to be used by males. However, in the case of lifetime use of cannabis among this (17-18) age group there was very little gender difference – male 28.7%, female 28.5% (EMCDDA Standard Table 2a at Appendix 2). Details on different types of drugs were not provided for drug use experience in the past 12 months.

Among young people in general (ages 9-18) after cannabis, solvents are the most commonly used substances (Table 2.2e below).

Table 2.2e. Ireland 1998. Schools Survey - HBSS. Last 30 days prevalence. Type of drug by age groups. Percentages

Type of Drug	Age Groups				
	11-12	13-14	15-16	17-18	9-18
Cannabis	1.3	4.3	10.5	11.0	5.9
Amphetamines	0.7	0.9	2.4	4.9	1.6
Ecstasy	0.6	0.9	1.9	3.7	1.3
LSD	0.8	0.9	1.7	3.7	1.3
Hypnotics & sedatives*	0.8	1.4	1.9	2.1	1.4
Cocaine	1.9	1.6	1.5	1.8	1.7
Solvents	2.9	5.7	5.9	4.1	4.8
Heroin	0.8	0.8	1.0	2.0	0.9

Source: Irish Health Behaviours in Schools Survey (HBSS), Department Health Promotion, NUI, Galway

*includes tranquilisers or sedatives without prescription (barbs, jellies, downers)

Among 17-18 year olds (Table 2.2e) prevalence of recent cannabis use (11.0%) was followed by amphetamine use (4.9%). Solvents (4.1%) were the next most commonly used substances, and not ecstasy as might be expected. The prevalence of LSD use was similar to that of ecstasy use at 3.7%. The picture which emerged among younger age groups was quite different. Among 15-16 year olds the use of cannabis (10.5%) and solvents (5.9%) was followed by amphetamine use (2.4%). Solvents are the substances most commonly used by 11-14 year olds; followed by cannabis in the case of 13-14 year olds. Surprisingly, among 11-12 year olds, use of solvents (2.9%) was followed by cocaine use (1.9%), even before cannabis use (1.3%). Cocaine

use was in fact highest among 11-12 year olds (1.9%). Heroin use seems higher than would be expected, especially among 17-18 year olds at 2%.

In 1998 also, a school survey was conducted in the eastern region (Eastern Health Board (EHB), now Eastern Regional Health Authority, area) of the country (Rhatigan and Shelley 1999) to study the health behaviours of school pupils. Again, as above, the sampling frame was the schools' list of the Department of Education & Science. A random sample of schools stratified by county and school type was selected. The response rate was 78.2%. The sample size was 6,081 pupils aged between 10-18 years. Cannabis was the most commonly experienced at least once (lifetime) followed by solvents (EMCDDA Standard Table 2b at Appendix 2; Table 2.2f below). These data – lifetime use of cannabis (21%), solvents (13%); and recent use of cannabis (11%), solvents (7%) – are somewhat higher than results from HBSS (Health Behaviours in Schools Survey). This could be expected given that the sample was drawn from the most urbanised eastern region, including Dublin. Prevalence rates (both lifetime and recent) for cocaine use among the whole group are the same, both in the HBSS and the EHB surveys, at 2%.

Tables 2.2f and 2.2g below illustrate the difficulties involved in making comparisons between different studies. Attempting to compare youth surveys for different geographic locations where different methodologies are used must be done with considerable caution. Drug use prevalence among young people also varies quite considerable according to the age groups examined. As an example of the disparity in results - in the HBSS the prevalence of cannabis use for the whole sample (9-18 year olds) was 12% whereas for the 15-16 year olds it was 22%, and for those aged 17-18 it was 29% (see Table 2.2d above).

Table 2.2f. Ireland 1995-1998. Comparison of school/youth surveys of drug use. Lifetime prevalence of drug use by type of drug.

Survey / Year	ESPAD 1995 (National)	WHB 1994 (Local)	MHB 1996 (Local)	HBSS 1998 (National)	EHB 1998 (Local)
Sample size	1,849	2,762	1,654	8,497	6,081
Age group	15-16	13-18	16-18	9-18	10-18
Cannabis	37%	16%	26%	12%	21%
Amphetamine	3%	2%	5%	3%	5%
Ecstasy	9%	2%	7%	2%	3%
LSD or other hallucinogens	13%	9%	9%	4%	3%
Hypnotics & sedatives	7%	2%	4%	3%	3%
Cocaine	2%*	1%	Na	2%	2%
Solvents	19%	14%	17%	10%	13%
Heroin	2%	1%	Na	1%	1%

* 3% also claimed to have ever used crack
Na=not available

The results from the 1995 ESPAD survey show higher prevalence rates for most drug types. In fact the results of this survey give the highest prevalence rates of all school surveys conducted in Ireland to date. No explanation for this is immediately evident but it may be, perhaps, due to methodological

differences in the research. However, the fact that 3% in this survey, conducted in 1995, claimed to have used crack requires further exploration.

Table 2.2g. Ireland 1995-1998. Comparison of school/youth surveys of drug use. Recent prevalence (past 30 days) of drug use by type of drug.

Survey / Year	ESPAD 1995 (National)	WHB 1994 (Local)	MHB 1996 (Local)	HBSS 1998 (National)	EHB 1998 (Local)
Sample size	1,849	2,762	1,654	8,497	6,081
Age group	16	13-18	16-18	9-18	10-18
Cannabis	19%	9%	Na	6%	11%
Amphetamine	Na	1%	Na	2%	3%
Ecstasy	Na	1%	Na	1%	3%
LSD	Na	Na	Na	1%	2%
Hypnotics & sedatives	Na	na	Na	2%	2%
Cocaine	Na	1%	Na	2%	2%
Solvents	Na	Na	Na	5%	7%
Heroin	Na	0%	Na	1%	1%

* Na=not available

What does emerge is that drug use is more prevalent among young Dublin males. What also emerges is the importance of carrying out prevalence surveys using comparable methodologies, if meaningful comparisons are to be made. Also, information on recent use (past 30 days/past month) of drugs is not always as readily available as lifetime use (ever used), even though it is usually a better indication of the current situation.

d) Specific groups – Lucy Dillon

Prisoners : Research has found that a significant proportion of Ireland's prison population has a history of drug use, and that a number of prisoners continue to use drugs while incarcerated. Two recent studies (Allwright et al. 1999; Long et al. 2000) concerned with the prevalence of HIV, hepatitis B and hepatitis C among the Irish prison population, explored the related risk behaviours and drug use engaged in by prisoners. Allwright et al. (1999) found that of 1,205 respondents, 630 (52.3%) reported that they had used heroin and 43.2% reported that they had ever injected drugs. Furthermore, the authors concluded that "drug use within prison was common" (Allwright et al. 1999, p. 18). Forty-five percent of the 334 respondents who reported that they had a history of drug use and had been in prison for longer than three months, reported that they had injected drugs in the previous month. Thirty one percent (n=103) reported that they had injected between 1 and 19 times in the previous month, while 14% (n=48) said they had injected more than 20 times in the previous month (Allwright et al. 1999). The subsequent study of a sample (N=604) of committal³ prisoners found lower rates of prisoners reporting drug use (Long et al. 2000). Thirty five and a half percent of the

³ Committal prisoners were defined as "prisoners who have been admitted to the prison within the preceding 48 hours, accused or guilty of a new crime, excluding those on temporary release or transferred from another prison. The committal population includes individuals entering on remand, following sentence, committed as a result of a bench warrant, and non-nationals without valid documentation" (Long et al 2000).

sample reported that they had ever smoked heroin and/or injected drugs, 29% reported that they had ever injected drugs. Both of these studies suggest that there is a significant proportion of prisoners who have a history of drug use and, furthermore, a significant proportion continues to engage in illicit drug use once incarcerated.

Minorities : Research has not been carried out in Ireland on drug use among minority groups. Recent years have seen a significant change in the migration profile of Ireland. Table 2.2 at Appendix 2 shows that net migration in Ireland has gone from 8,000 in 1996 to an estimated 20,000 for the year 2000. Furthermore, there has been a large increase in the numbers of people applying for asylum in Ireland. In 1992 there were only 39 applications made, whereas for the first 11 months of 1999 the figure had increased to 6,507 (Table 2.2h below).

Table 2.2h. Ireland 1992-1999 (30/11). Total number of applications for asylum in Ireland.

1992	1993	1994	1995	1996	1997	1998	1999 (30/11)
39	91	362	424	1179	3883	4626	6507

Source: Department of Justice, Equality and Law Reform

Anecdotal evidence suggests that some of those coming to Ireland have been engaged in illicit drug use in their countries of origin and that they have continued their drug use since entering Ireland. A change in the nationality profile of people presenting for treatment is not evident from data recorded in the National Drug Treatment Reporting System. For example, in 1998 only 34 of the total number of first treatment contacts (N=1625) were non-nationals (other than Irish). Twenty-eight of these were from Great Britain (O'Brien et al. 2000: 17). While nothing is known about either the extent to which illicit drug use occurs within minority groupings in Ireland or the nature of this use, anecdotal evidence suggests that there is a need to explore drug use in this context. It is important that the necessary information be available to facilitate Irish services to address any specific needs that drug users from minority groups may have and offer services in a way that will encourage these users to access them.

2.3 Problem drug use – Mary O'Brien

a) National and local estimates

Studies on national and local prevalence estimates of problem drug use are quite limited in Ireland. Two exploratory studies were carried out (Comiskey 1996; Comiskey 1999) to estimate the prevalence of problematic opiate use. Using the capture re-capture methodology with three samples of data (methadone treatment list, hospital inpatient data and police record data), the result of the local (Dublin) study estimated that there were between 10,655 and 14,804 opiate users in Dublin in 1996. The estimated national prevalence of opiate misuse in Ireland was found to be between 4,694 and 7,884 with a prevalence rate of between 16.8% and 23.3%. There were difficulties with the samples; for example in the 'local' study, 22% of the police sample contained ambiguous data (7% were non-opiate users; 10% were included because they were found to be in possession of an opiate; and 5% were identified by unspecified means). The data used for this sample was originally collected for another purpose: to examine drug-related crime (Keogh 1997). These studies should be regarded as an exploratory exercise in the development of methodologies, and the resultant estimates of opiate use should be viewed in this light.

Another local area prevalence study was carried out in north-east inner city Dublin, an area with higher than average levels of social and economic disadvantage. This study (Coveney *et al.* 1999) collected data from four sources: five treatment and support agencies; agency waiting lists; a residents' street survey and two general practitioners. Of the 1,657 individuals identified, 477 were residents of the Dublin 1 postal district (north inner city). It was estimated that the prevalence rate of heroin use was 2.0 percent of the population of that area. This is somewhat surprising, given that it is considered to be a high-risk area, but is probably a reflection of the methodology used in the study.

More problematic drug use is represented by the treated population of drug users. This information is collected by the Drug Misuse Research Division, Health Research Board for the National Drug Treatment Reporting System (NDTRS) and refers to people who receive treatment for problem drug use. In recent years there has been an extensive increase in the services provided for problem drug users. Compared to ten years ago services are now decentralised and have become more diversified and dispersed both locally and nationally. Data collected by the National Drug Treatment Reporting System give a good profile of the characteristics of clients, patterns of use and trends over time (see Section 3.1a). Problematic opiate use, mainly heroin, continues to be concentrated in the Dublin area, in localities with high levels of social and economic disadvantage. Pockets of heroin use are being reported in recent times in a number of areas throughout the country.

b) Risk behaviours and trends

Risk behaviours are very important in the transmission of HIV infection; injecting with shared equipment is the crucial transmission route among injecting drug users; sexual contact is likely to be the most common transmission route to the wider population. A retrospective examination of data from the Needle Exchange Programme (NEP) in the Eastern Health Board area was carried out to identify the factors associated with high-risk behaviours (Mullen and Barry 1999). The NEP was set up in 1989. Drug users who attended for the first time between 1990-1997 were included – 6025 in total. The number of first attenders increased from 350 in 1990 to 1039 in 1997. Four needles, on average, were distributed to first attenders; all were offered condoms, 45% accepted. First-time attenders were predominantly male, but over the eight-year period the proportion of women increased from 18% in 1990 to 24% in 1997 - this increase was particularly noticeable in young women under 20 years of age. The mean number of years of injecting drug use of the study group was 4 years. The overall prevalence of needle sharing in the year prior to attendance was 39%, but women (44%) were more likely to share than men (38%). Women (51%) were also more likely to engage in unsafe sex than men (44%). Young injectors under 20 years old, were just as likely as all attenders to share injecting equipment (39%). Those who did not share injecting equipment were more likely to use condoms, than those who did share. Young attenders under 20 years old, were less likely to be involved in unsafe sex than the overall group (see Table 2.3 below).

Table 2.3a. Eastern Health Board area. Characteristics and Risk Behaviours of Needle Exchange Attenders 1990-1997.

Characteristics	All attenders	Young attenders <20 years
Total N	6025	1224
Gender ratio:		
Overall Male:Female	80:20	75:25
1990 Male:Female	82:18	86:14
1997 Male:Female	76:24	68:32
Mean age	25	18.6
Risk behaviour:		
Injecting-mean no. years	4	<1
Sharing prevalence-past year:		
Total	39%	39%
Male	38%	Na
Female	44%	Na
Unsafe sex:		
Male	44%	36%
Female	51%	48%

Source: Mullen and Barry (1999)

* Na=not available

Trends over the time period 1990-1997 showed a significant decrease in high-risk behaviours – needle sharing practices fell and safe sex (use of condoms) practices increased. Women engage in more risky behaviours, and with the proportion of women increasing over time this has serious health implications.

Young injecting drug users are a particularly at-risk group. However, they do seem to present quite early in their drug using careers to needle exchange programmes. The authors state that 'it is crucial that young people do not encounter barriers to protecting themselves, such as parental permission, mandatory treatment, and statutory notification' (Mullen and Barry 1999: 29). The authors argue that this would defeat the purpose of a low threshold service, to which young people are more likely to present. The profile of the attenders at the NEP highlights the importance of providing prevention and early intervention programmes particularly for young people. The authors recommend that more in-depth/qualitative research is needed to increase understanding of injecting drug users – 'the issues surrounding drug use, risk management and sexual relationships' (ibid.: 25) – in order to make prevention strategies more effective.

Another study also highlights the fact that women, although in a minority, are a very at-risk group among drug users (Geoghegan et al. 1999). Taking a somewhat different perspective and focusing on gender differences the research study carried out at the Merchants' Quay Project (a voluntary agency providing a needle exchange service), explored patterns of drug use, risk behaviour, health and well-being among 934 new attenders. Data were collected, between May 1997 and April 1998, from all new clients. A sizeable minority was female (25%) and notable gender differences were found. Women were younger than men and were more likely to:

- have a sexual partner who was an injecting drug user
- be living with an injecting drug user
- share injecting equipment with their sexual partner
- report recent sharing of injecting paraphernalia
- report having problems finding an intravenous site
- report having abscesses and to be suffering from weight loss
- report depression, unable to cope, feeling isolated and having suicidal tendencies
- have attended a GP in the previous 3 months
- have a medical card.

Heroin was the preferred drug of choice of all the study participants. A majority (86%) of the overall group reported that they had smoked heroin prior to injecting – no gender difference was found. However, women had significantly shorter smoking careers and were more likely to present sooner in their injecting careers to treatment services, than men. The authors conclude that this research illustrates that it is important to recognise that women drug users *do* exist and that they 'are more likely than their male counterparts to engage in risk behaviour which has a detrimental effect on their mental and physical health' (Geoghegan et al. 1999: 135).

Data from the National Drug Treatment Reporting System (NDTRS) were used in a study (Smyth et al. 2000) to examine trends in treated opiate use and to identify factors associated with the route of administration of heroin. Dublin clients presenting for the first time for treatment of an opiate problem over the six-year period 1991-1996 were included. The study population was 3981. Over the period there was a three-fold increase in the number of new

clients and the proportion of females increased. The mean age of first opiate use declined and users began presenting for treatment earlier in their opiate-using careers. There was an increase in the proportion who were using heroin as distinct from other opiates, such as morphine sulphate tablets. There was a dramatic increase in heroin smoking after 1994 when it became the most common route of heroin use. Heroin was most likely to be smoked by young, employed people who were using heroin for less than three years.

The reasons for the increase in chasing (heroin smoking) are not clear. It is suggested that while awareness of AIDS and the risks of injecting may be a factor, it would be simplistic to assume that this alone accounts for the change in the pattern of heroin use (Smyth et al. 2000). In a later study of first time attenders at a needle exchange programme between May 1997 and February 1998, a comparative analysis of the risk behaviour of younger and older injectors, i.e. under 25 and over 25 years of age, was carried out. It was found that the younger group (under 25 years old) were significantly more likely to have smoked illicit drugs prior to injecting and to report using heroin as their primary drug (Cassin et al. 1998). It may be that smoking is the preferred route for young people starting to use heroin, particularly for those reluctant to inject. The more acceptable nature of chasing, it was suggested, may attract increasing numbers to use heroin and concern was expressed that 'chasing may prove to be a dragon in sheep's clothing' (Smyth et al. 2000: 1223).

Data from the NDTRS for 1997-1999, suggest that these concerns were warranted. The data show (EMCDDA Standard Table 4 at Appendix 2) that between 1990 and 1996 the proportion of all treated drug users who injected their main drug decreased from 66.3% to 36.9%. However, since then the proportion who inject has increased a little, from 45.3% in 1997, to 48.7% in 1998 and 48.8% in 1999. The explanation is likely to be a complex one, involving many factors (sub-group norms, availability, price of drugs, etc.) but it may be that the young people who preferred to smoke heroin initially are no longer reluctant to inject.

In a qualitative study of a group of prisoners (n=29) it was found that moving from smoking to injecting heroin was motivated by a more efficient use of a scarce commodity. Because of the limited quantity of heroin available in prison, drug-using prisoners managed their drug use in order to ensure that the maximum number of people were facilitated by the heroin which could be accessed. Since smoking was considered to be wasteful this meant that injecting rather than smoking the heroin was more acceptable. Furthermore, injecting was perceived to give a better 'buzz' than smoking, once an individual had become an habitual user (Dillon, forthcoming).

A study of 77 drug-using women (O'Neill and O'Connor 1999) involved in prostitution found them to be a very at-risk group:

- 45 percent started working in prostitution between 13 and 19 years old, mainly to earn money for drugs
- 83 percent had injected in the past month. A quarter of these (n=16) had shared needles in the past month

- less than one-third had been screened for sexually transmitted diseases.

Compared to similar research carried out in 1996 (in O'Neill and O'Connor 1999: 9) the women in the 1999 study:

- tended to be younger
- their children were more likely to be cared for by someone else
- they were more likely to be homeless.

The women in the latter study were found to be a particularly vulnerable and marginalised group who engaged in high-risk behaviours.

The importance of more imaginative education initiatives in harm reduction interventions was demonstrated by a study conducted in a specialised treatment setting (Smyth *et al.* 1999b). The level of knowledge of intravenous drug users regarding hepatitis C (HCV) and the factors influencing this knowledge were assessed using an instrument developed by the research team. The results showed that there were prominent misconceptions about the cause of transmission and natural history of HCV infection. Contact with services did not lead to any significant gain in understanding. The authors concluded that current education approaches in specialist treatment centres and by general practitioners are deficient. They recommend a move away from the 'typical didactic model of fact provision' (*ibid.*: 263) to a more explorative approach where misconceptions are more likely to emerge, thereby providing the opportunity to correct and educate.

In summary, problem drug use studies reviewed above show a number of similar trends:

- drug users are young – this reflects the general demographic situation in Ireland where 47% of the population is under 30 years of age
- lifetime experience of drug use in the general population of young people in Ireland is widespread but may not be as persistent/lasting as is generally perceived. The high lifetime experience of cannabis use (ESPAD, 37%) found five years ago has not been found in more recent studies
- there has been a decrease in high-risk behaviours – needle sharing decreased and safe sex (use of condoms) practices increased among clients attending a needle exchange programme over an eight-year period. This could be due to increase in service provision and the freer availability of clean needles and condoms
- women are more at risk than men, but while women tend to be involved in more risky behaviours than male drug users, they do present earlier for treatment
- patterns of drug use are changing. Over a number of years (1990-1996), among those presenting to treatment for the first time, there was a trend towards the smoking, rather than injecting, of heroin. Smoking seems to have been the preferred route for young people starting to use heroin, at least in the initial year or so of their drug careers. However, trends since 1997 show that the route of administration for heroin is tending again to injecting. The explanation is likely to be a complex one, involving many factors such as the availability of heroin, fluctuations in the price of heroin,

but it may be that young people who originally preferred to smoke heroin are now no longer reluctant to inject.

3. Health Consequences – Mary O'Brien

3.1 Drug treatment demand

a) Characteristics of clients, patterns of use and trends

People encountering very serious problems with drug misuse will more than likely eventually come into contact with treatment services. The treated population of drug users is well represented in the National Drug Treatment Reporting System (NDTRS). Analysis of the characteristics of clients presenting to treatment for the first time, gives a good overview of trends over time.

Drug use patterns in Ireland vary according to geographic location. Problem opiate use, mostly heroin, is mainly confined to the Dublin area. This is beginning to change, with pockets of heroin use now becoming apparent in a number of urbanised areas in regional locations. While the profile of the typical problematic drug user – young, unemployed male, leaving school at an early age and living in a socially and economically disadvantaged area – has not varied much over the years, there has been a change in some trends over the past five years.

Data on clients presenting for treatment for the first time are presented in Table 3.1a below. Gender distribution has not changed much over the five-year period, and the mean age has remained fairly stable at around 22 years. Over 70% of those presenting for treatment for the first time are under 25 years old. This is younger than in other EU countries and is a reflection of the demographic situation in Ireland where the median age of the Irish population is much younger than the EU average. Nearly half the population in Ireland (47%) is under 30 years of age, whereas the median age in other EU countries is between 35 and 40 years of age.

Table 3.1a. Ireland 1995-1999. New clients presenting for treatment. Characteristics and patterns of use. Percentages.

Characteristics	1995	1996	1997	1998	1999
Valid N	1870	2014	1465	1621	1636
Gender ratio Male:Female	80:20	73:27	72:28	74:26	73:27
Mean age	21.1	21.3	22.0	22.1	22.7
Living status – with parental family	79.0	76.5	71.6	71.1	70.2
Early school-leavers (<16 years old)	51.8	50.2	45.8	45.2	43.2
Regular employment	15.2	13.9	19.5	24.8	31.2
Mean age first used any drug (excl alcohol)	15.6	15.4	16.0	15.5	15.7
Main drug - Heroin	54.6	63.2	58.4	55.7	53.5
Main drug - Route of administration- inject	23.8	24.3	29.3	28.8	30.6
Main drug - Route of administration- smoke	56.3	59.6	50.6	53.5	53.0

Source: National Drug Treatment Reporting System (NDTRS), Drug Misuse Research Division, Health Research Board

Between 1995 and 1999 there was a fall in the proportion of clients living in the parental home (Table 3.1). There was a decrease in those who left school before the age of 16 years from 52% in 1995 to 43% in 1999. There was a sizeable increase in the level of employment among problem drug users, from a very low 15% in 1995 to 31% in 1999, again reflecting more general changes in Irish society in relation to improvements in the economy, *inter alia*, over the same period. The mean age of initial drug use was between 15-16 years of age and did not change much over the five-year period. Heroin was the main drug of misuse for over half of those presenting for treatment for the first time. Over the five-year period there was an increase in the proportion injecting their main drug of misuse and a decrease in smoking (c.f. discussion on risk behaviours at Section 2.3).

There is great disparity in the pattern of drug use in different parts of the country. Problematic opiate/heroin use is mainly in the eastern region of the country, around Dublin. Seven out of ten Irish clients receiving drug treatment are residents of the Eastern Health Board area (now the ERHA) (O'Brien et al. 2000). Most of these clients (80%) are treated for heroin misuse (*ibid.*). In other health board areas throughout the country cannabis is the drug for which the majority of people receive treatment (*ibid.*). Of course, the characteristics of clients using different types of drugs varied accordingly. Heroin users were much less likely to be still at school than cannabis users; and they were much more likely to be involved in behaviours with detrimental effects to their health, such as injecting, and sharing injecting equipment.

b) Comments on different client profiles in different types of treatment

The majority of people presenting for treatment for drug use problems in Ireland are treated at non-residential treatment centres. Data from the NDTRS for 1999 show the following proportions presenting to different types of treatment services: 57% non-residential; 34% residential; 6% low threshold; 3% medical doctors in general practice (National Drug Treatment Reporting System, personal communication). It should be stressed that in 1999 not all GPs were reporting to the NDTRS and contacts in prisons were very poorly represented. Men were more likely to be receiving treatment at residential or low threshold services, while women were more likely to present to non-residential or GP services for treatment. Clients living in the parental home were least likely to be attending low threshold services. Unemployed clients were the most likely to be attending low threshold services; those in regular employment were more likely to be receiving treatment from a GP.

Against a background of increasing encouragement of GPs to become more involved in the treatment of drug users, a study was carried out in a specialised drug treatment setting during August-September 1997, to assess the utilisation of primary care services for general health purposes, by injecting opiate users (n=77) (Smyth et al 1999a). A structured questionnaire was used to interview clients. The sample size was 139 with a response rate of 75 percent. The sampling procedure was opportunistic. Despite general policy changes, such as more emphasis on harm minimisation, the findings

were similar to those of a similar study in 1991. In particular, the relative frequency of GP and A&E (hospital accident and emergency department) attendances were unchanged. Concern was expressed by the authors (Smyth et al. 1999a) at the high proportion who were being prescribed benzodiazepines (39%) by GPs. They state that this indicated that there is 'clearly a wide gap' between treatment approaches by psychiatrists specialising in substance misuse at treatment centres, and GPs, in the management of co-morbid disorders, such as anxiety and sleep disorders among drug users. The need for improved communication and co-operation as well as explicit protocols relating to clarity, consistency and continuity in treatment approaches, was stressed.

c) Comments on treatment demand for different drugs

Heroin : A majority of people (around 6 out of 10 new cases each year) presenting to the treatment services have problems with the misuse of heroin, i.e it is the main drug of misuse (National Drug Treatment Reporting System). This is mainly confined to the Dublin area but in recent years pockets of heroin use in other parts of the country are being reported. A sizeable proportion (56% in 1999) of those presenting to treatment services with problem heroin use for the first time are involved in intravenous drug using practices with very serious health and social consequences. This is the highest level in the past five years (38% in 1995; 37% in 1996; 49% in 1997; 48% in 1998) (EMCDDA Table 4 at Appendix 2). See discussion at Section 2.3b.

Cannabis : Since the NDTRS was set up in 1990, the proportion of people presenting for treatment for cannabis use has not varied much: between 11% and 16%. After heroin it is the next drug, at a much lower level, for which treatment is most commonly sought. More than half (55%) started to use cannabis between 15-19 years of age, 37% started before the age of 15 years (Moran et al. 1997).

Cocaine: Treatment demand for problem cocaine use has always been very low: between 1%-2%. Apart from addiction counselling, there are no specific treatments for problem cocaine users in Ireland right now. Of all those presenting for treatment for the first time in 1999 with multiple drug problems (more than one drug) (64%), 7% were seeking treatment for problem cocaine use.

Synthetic drugs : Demand for treatment for problem ecstasy use has decreased somewhat in recent years (from 11% in 1995 to 8.8% in 1999). The proportion of problem amphetamine users presenting for treatment for the first time has increased from 0.4% in 1995 to 2.1% in 1999. A worrying development is that in 1999, 6% of these were injecting the drug. The proportion presenting with problem LSD use has been falling (from 1.6% in 1995 to 0.2% in 1999)

3.2 Drug-related mortality

a) Drug-related deaths, direct and indirect, characteristics and trends

Official Irish statistics on drug-related deaths from the General Mortality Register (GMR) are compiled routinely by the Central Statistics Office. They are recorded according to the International Classification of Diseases, Version 9 (ICD-9), that is, the cause of death is designated as the *underlying cause of death*. This is defined as -

(a) the disease or injury which initiated the train of morbid events leading directly to death, or (b) the circumstances of the accident or violence which produced the fatal injury (WHO, 1977:700)

The underlying cause of death can be from natural or external causes. The definition of external cause of death is as follows:

...a supplementary classification that may be used, if desired, to code external factors associated with morbid conditions classified to any part of the main classifications. For single-cause tabulation of the underlying cause of death, however, the E Code should be used as a primary code if, and only if, the morbid condition is classifiable to Injury and Poisoning (WHO, 1977:xxix)

For the purpose of this report a drug-related death is defined as one where the underlying (natural or external) cause of death was due to drug dependence (ICD-9 Code 304) or opiate poisoning (ICD-9 Code 965.0). These are deaths directly related to problem drug use.

An examination of drug-related deaths recorded between 1990 and 1999 (Table 3.2 at Appendix 2) shows that the number of deaths over the ten-year period increased considerably from 1995 onwards. The highest number was recorded (N=99) in 1998. It was in that year that an amendment was made to the information recorded, in the case of a sudden death, by the Garda Síochána (on Form 104): a question on drug/alcohol dependency was included on Form 104. This was as a result of the work of the National Task Force on Suicide (Department of Health & Children 1996; 1998). The increasing trend did not continue in 1999 when the number of deaths was 80 (Table 3.2 at Appendix 2). In terms of geographic location the vast majority of deaths were in Dublin. The majority were males, between the ages of 15 and 49. Most deaths were due to drug dependence.

Indirect as well as direct drug-related death was the subject of an ad hoc retrospective study carried out in 1999 (Keating et al. 1999). Dublin City and County Coroners' files were examined to study the number of drug-related (direct and indirect) deaths in 1997. The criteria for inclusion were that the death had to have occurred in Dublin (city or county), between 1 January and 31 December 1997, and have positive toxicological evidence of the presence of drugs, and where drugs were implicated in the cause of death - this is a much broader definition than that used for the purpose of the GMR. Toxicological screens included testing for alcohol, opiates, benzodiazepines, tricyclics, barbiturates and cocaine. One-hundred-and-twenty cases were found to be toxicologically positive for drugs and 65 of these were known to be

drug users. The gender ratio was 3:1 (male:female) and more than half of the deaths were in the 20-39 year age group. The drug most commonly identified was benzodiazepine (75 cases) mainly in combination with other drugs. The most common combination of drugs was opiates and benzodiazepines. Methadone was found in 47 cases; alcohol was found in 47 cases; cocaine in 7 cases; MDMA in 2 cases; and amphetamines in 2 cases. A similar study of coroners' files in 1992 (in Keating et al. 1999) found no cocaine, MDMA nor amphetamines in drug-related deaths. The 1992 study found a similar number of drug-related deaths recorded (in Dublin coroners' files) to that recorded in the GMR for that year. However, the total number (120) found in the 1997 study did not correspond with the number (49) recorded in the more narrowly defined GMR for the same year.

In summary, the increase in the number of deaths, as recorded by the GMR, is partly due to more awareness of the need for such information and consequent improvement in the collection procedure of the GMR data; and partly due to a real increase in the number of drug-related deaths.

b) Mortality and causes of death in drug users, trends

An outbreak of 24 cases of illness among injecting drug users in the Dublin area in Summer 2000 resulted in 8 deaths. This was similar to an outbreak of the illness in Glasgow where the first cases were recognised. While the definitive cause of death for all cases has not yet been established, the likely cause has been identified as a toxin-producing strain of *Clostridium novyi*, but other bacteria may be involved. The 'significance of the presence of clostridial species remains to be determined but it may suggest contamination of the drugs or other materials' used by the intravenous drug users (Andraghetti et al. 2000).

Research on mortality among drug users is not yet available, therefore it is not possible to discuss associated mortality trends.

3.3 Drug-related infectious diseases - Lucy Dillon

a) HIV and AIDS

The majority of data collected on drug related infectious diseases are related to HIV. There are two main sources of data that will be discussed below: first, the routine data on HIV positive tests that are reported by the Department of Health and Children; and second, the special studies which have estimated the prevalence of HIV among drug users, mainly in treatment settings.

Routine data on HIV testing

In Ireland, the Department of Health and Children, in collaboration with the Virus Reference Laboratory, produces statistics on HIV positive tests which are published every six months. The figures relating to HIV tests are broken down according to risk category. There are a number of risk categories identified in relation to HIV infection including injecting drug use, homosexual

sex and haemophilic contact. Therefore, it is possible to get a breakdown of the number of positive HIV cases attributable to injecting drug use in a given year. However, there are a number of limitations to this data source that should be noted:

- It is limited to the *tested* population. Nothing can be inferred for those drug users who have *not* been tested.
- It is not possible to identify non-injecting drug users within the data set.
- No socio-demographic data is collected on those who are tested.
- There is only a limited geographical breakdown available.
- A gender breakdown has only been made available since 1997.
- Both risk behaviours (e.g. injecting drug use) and test locations (e.g. prison) are used as categories. This makes the data somewhat unclear. For example, it is not known through what risk activity those tested in the prison setting became infected with HIV.

Despite these limitations, this data source provides the best information with which to examine the epidemiological profile of HIV in Ireland over the past decade and a half.

The cumulative figures for the positive cases of HIV from the start of data collection in 1982 up until 1985, show that just over 60% (n=221) of all positive cases (N=363) were attributed to injecting drug use (see table 3.3a). Since 1985, injecting drug use has continued to be one of the main risk categories, accounting for 41.6% of the cumulative number of positive cases up until December 31st 1999 (see Table 3.3a). Since data have been collected, injecting drug use has continued to be one of the main risk categories for infection. Two possible explanations have been given by O’Gorman (1999) for the high proportion of intravenous drug users in the known HIV positive population. She argues that the culture of injecting drug use that existed among drug users in Ireland during the 1980s, at a time when both information on safe injecting practices and access to clean injecting equipment were limited⁴, resulted in the rapid transmission of HIV among the injecting population. Secondly, she argues, the injecting drug using population may be more likely to have been tested for HIV through their contact with drug treatment services than those individuals who may be at risk of infection through other routes e.g. heterosexual sex (O’Gorman 1999, p. 6).

The proportion of positive cases attributed to the intravenous drug user category generally decreased from 1992 through to 1998. In 1994, for the first time, intravenous drug use accounted for less new positive cases than the ‘homosexual sex’ or ‘heterosexual sex and/or risk unspecified’ categories (see Table 3.3a). In fact, the proportion of positive HIV tests attributed to intravenous drug use fell from 49.7% in 1989, to a low of 17.6% in 1997 (see Table 3.3a). It is suggested that the reduction both proportionately and in absolute numbers over this period may be attributed, at least in part, to the expansion of services aimed at reducing the spread of HIV among injecting drug users, i.e. substitution and needle exchange programmes. In an analysis

⁴ The first needle exchange programme in Dublin was established in 1989.

of the trends up until 1998 the National AIDS Strategy Committee has commented that:

"Epidemiological surveillance of HIV would indicate that in recent years the overall incidence of HIV among intravenous drug users is reducing. While we must be wary of drawing major conclusions from short term changes in infection patterns service providers are optimistic that this trend is as a result of the intervention through a combination of substitution therapy with methadone and needle exchange services."

(National AIDS Strategy Committee 2000: 63)

Table 3.3a. Ireland 1985-1999. HIV positive cases by risk category. Numbers and percentages

Year	IVDUs n (%)	Homosexual Sex n (%)	Heterosexual Sex/ Risk unspecified n (%)	Other n (%)	Total n (%)
1985	221 (60.9)	39 (10.7)	0	103 (28.4)	363 (100.0)
1986	112 (66.3)	11 (6.5)	21 (12.5)	25 (14.8)	169 (100.0)
1987	72 (49.7)	21 (14.5)	26 (17.9)	26 (17.9)	145 (100.0)
1988	58 (50.4)	17 (14.8)	20 (17.4)	20 (17.4)	115 (100.0)
1989	57 (49.1)	33 (28.5)	0	26 (22.4)	116 (100.0)
1990	50 (45.1)	25 (22.5)	24 (21.6)	12 (10.8)	111 (100.0)
1991	34 (36.9)	27 (29.4)	25 (27.2)	6 (6.5)	92 (100.0)
1992	82 (40.8)	58 (28.9)	50 (24.9)	11 (5.5)	201 (100.1)
1993	52 (38.0)	48 (35.0)	21 (15.3)	16 (11.7)	137 (100.0)
1994	20 (23.5)	31(36.5)	22 (25.9)	12 (14.1)	85 (100.0)
1995	19 (20.9)	33 (36.3)	30 (33.0)	9 (9.9)	91 (100.1)
1996	20 (18.9)	41 (38.7)	27 (25.5)	18 (17.0)	106 (100.1)
1997	21 (17.7)	37 (31.1)	40 (33.6)	21 (17.7)	119 (100.1)
1998	26 (19.1)	37 (27.2)	47 (34.6)	26 (19.1)	136 (100.0)
1999	69 (33.0)	40 (19.1)	59 (28.2)	41 (19.6)	209 (99.9)
Total	913 (41.6)	498 (22.7)	412 (18.8)	372 (17.0)	2195 (100.1)

Source: Department of Health and Children

Despite the apparent reduction in the proportion of positive cases attributed to injecting drug use and the actual number of positive tests, figures from 1999 show a substantial increase in the number of positive cases. Between 1998 and 1999 the total number of new cases of HIV increased from 136 to 209. Furthermore, the number of new positive cases attributed to injecting drug use increased from 26 of the total new cases (n=136) in 1998 to 69 of the new cases (n=209) in 1999. Therefore, proportionately, injecting drug use as a risk category increased from accounting for 19% of new HIV positive cases within this data source in 1998, to 33% in 1999. This is the highest annual proportion of new positive cases attributed to injecting drug use since 1993.

Anecdotal evidence suggests a couple of explanations for the increase in the number of positive cases being attributed to injecting drug use during 1999. Firstly, leading on from the *Protocol for the Prescribing of Methadone* issued in 1993, guidelines were developed for GPs prescribing methadone within the general practice setting and for pharmacists in their dispensing of methadone. Following the completion and evaluation of a pilot programme, in January 1998 the Report of the Methadone Treatment Services Review Group made a

* Cumulative figures

number of recommendations on tightening control on both the prescribing and dispensing of methadone, in accordance with the 1993 protocol. Consequently, the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations, 1998 were drawn up. The regulations aim to create a more controlled environment for the prescribing and dispensing of methadone. Within this context, all those who were receiving methadone in Ireland were integrated into a structured programme. Furthermore, drug users were integrated into a structured programme setting where there is an active policy of carrying out virology in relation to HIV and hepatitis. It is suggested therefore, that this may have resulted in an increase in the number of injecting drug users being tested for HIV and, in turn, an increase in the number of positive cases being attributed to injecting drug use during 1999. Secondly, it has also been suggested anecdotally that perceptions may be beginning to change among the drug using population in relation to HIV. It is argued that the availability of new treatment (HAART) and the visibility of individuals in the community for whom treatment has been effective, has encouraged people to come forward for testing so that they can avail of treatment if necessary.

Prisoners : As mentioned above, within the Department of Health and Children's reporting system on HIV positive tests, those who are tested in prison are categorised according to the testing location, i.e. prison. While the proportion of positive cases from the testing location category of prison which are attributable to injecting drug use is *not* known, anecdotal evidence suggests that most of those being tested have a history of injecting drug use. Since 1989, a total of 39 new positive cases have been attributed to 'prisoners', 13 of whom tested positive in 1999. The use of both risk categories and testing locations in the Department of Health and Children's reporting system does not allow for any conclusions to be drawn as to the significance of these figures in relation to the injecting drug using population. It is important that the risk category of these cases be clarified.

Gender : While there are no socio-demographic data collected on those who are tested for HIV from the Department of Health and Children's Data source, the gender of the individual being tested has been reported since 1997. An examination of the figures by gender suggests a possible change in the gender distribution of those who are testing positive for HIV in Ireland (see table 3.3b). In 1997, females only accounted for 3 of the 21 new positive cases attributed to injecting drug use. In 1998 this had increased to 10 of the 26 positive cases among injecting drug users, and in 1999 it had increased further to account for 34 of the 69 positive cases. Speaking in percentage terms, women have increased from representing 14.3% of the positive tests among injecting drug users in 1997, to 38.5% in 1998 and finally 49.3% in 1999. Due to the lack of information on gender prior to 1997, it is not possible to explore trends over a more extended period of time. Anecdotal evidence suggests that these figures may reflect a real increase in the number of women injecting drug users who are becoming infected with HIV. However, it is also suggested that these women may be becoming infected through their sexual behaviour rather than their injecting drug use. Once identified as an injecting drug user however, their infection will tend to be attributed to their injecting drug using behaviour. Anecdotal evidence also suggests that a

growing number of women may be attending for testing in order to be able to minimise the risk of infection to their baby were they to become pregnant.

Table 3.3b. Ireland 1997-1999. HIV seropositive intravenous drug users by gender. Numbers and percentages.

Year	Male n (%)	Female n (%)	Total n (%)
1997	18 (85.7)	3 (14.3)	21 (100)
1998	16 (61.5)	10 (38.5)	26 (100)
1999	35 (50.7)	34 (49.3)	69 (100)

Source: Department of Health and Children

AIDS : Since recording began in 1982 and up until December 31st 1999, there have been 691 AIDS cases reported in Ireland, and 349 AIDS related deaths (see Table 3.3, Appendix 2). In 1999 there were 41 new AIDS related cases recorded. Intravenous drug users continue to represent one of the main risk categories recorded in this data source. In 1999, intravenous drug users accounted for 39% of new AIDS cases, and 41% of the year's AIDS related deaths.

Special Studies

A number of special studies have been carried out which have explored the prevalence of HIV among drug users in a range of study locations mainly in treatment settings. The studies include drug users located in: the community, drug treatment centres, needle exchange programmes and prisons. A summary of the research findings on the prevalence of HIV infection among drug users is presented in Table 3.3c below.

One of the first studies of drug use in Dublin began in 1985 when O'Kelly *et al.* (1996) identified a cohort of known intravenous drug users in an inner city area. The prevalence of HIV infection among this group was monitored over the next decade. In 1991, 57.3% of the total cohort (N=82) were known to be HIV positive, by 1994, 64.6% of the cohort had tested positive for HIV. In total, 18 of those who had tested positive by 1994 had died. O'Kelly *et al.* (1996) argue that the high prevalence rate of HIV among this cohort reflect the context in which their intravenous drug use developed. It was argued that "the uncontrolled use of injected drugs and the sharing of scarce equipment were commonplace at the time; the true impact of these practices is now clear in terms of the spread of HIV infection among the young people who lived there" (O'Kelly *et al.* 1996, p. 114). Another study carried out with a cohort who had begun injecting during the same period found similar rates of HIV prevalence. Williams *et al.* (1990) found that of a cohort of sixty-nine individuals on a methadone maintenance programme 70% were HIV positive.

These high prevalence rates of HIV were not found in studies subsequent to those of O'Kelly *et al.* (1996) and Williams *et al.* (1990). Johnson *et al.* (1994) found that in 1991, 14.8% of a sample recruited from a needle exchange programme were HIV positive. The Dorman *et al.* (1997) study, which was carried out in 1992 in the context of a World Health Organisation multi-national research initiative, found that 8.4% of a sample of 180 injecting drug

users, recruited from both in and out of treatment, were HIV positive. In contrast, the Smyth et al. (1998) study of a drug treatment sample tested between 1992 and 1997 found a prevalence rate for HIV of only 1.2%. This is low in contrast to an estimated 8% prevalence rate (based on laboratory reports) among injectors attending Eastern Health Board methadone clinics in 1997 (Joe Barry, cited in Allwright et al. 1999:2).

More recently, two studies have been carried out which report on HIV prevalence among the Irish prison population (Allwright et al. 1999; Long et al. 2000). Included in the data are the prevalence rates for those prisoners who have a history of injecting drug use. It was found that 5.8% of committal prisoners⁵ (Long et al. 2000) and 3.5% of general prisoners (Allwright et al. 1999) with a history of injecting drug use were HIV positive. Among those prisoners who reported no history of injecting drug use the infection rates were 0.5% among the committal population (Long et al. 2000) and 0.9% within the general prison population (Allwright et al. 1999). In an environment where injecting drug use is on-going in the absence of any provision for clean injecting equipment, the risk for the spread of infection within this population is high.

Table 3.3c. Ireland 1991-1999. Summary of research findings on the prevalence of HIV infection among particular cohorts of drug users

Author	Study period	Sample Source	Self Report/ Test	Serum/ Saliva	Sample size tested	% infected of those tested
Long et al (2000)	1999	Committal prisoners N=593	Test	Saliva	IDUs ⁶ (n=173)	IDUs 5.8%
Allwright et al (1999)	1998	Irish Prison Population N= 1178	Test	Saliva	IDUs (n=509)	IDUs 3.5%
Smyth et al (1998)	1992-1997	Drug treatment centre N=735	Test	Serum	IDUs (n=600)	IDUs 1.2%
Dorman et al (1997)	1992	Drug treatment centre & non-treatment IDUs N=185	Test	Serum and saliva	IDUs (n=180)	IDUs 8.4%
O'Kelly et al (1996)	1984-1995	IDUs in community N=82	Test	Serum	IDUs (n=66)	IDUs 65%
Johnson et al (1994)	1991	Needle exchange N=106	Test	Saliva	IDUs (n=81)	IDUs 14.8%

In summary, injecting drug use continues to be one of the main risk categories to which HIV positive cases are attributed each year. Despite the rates of new HIV positive cases attributed to injecting drug use plateauing in the early and mid 1990s, recent figures suggest that there is an upward trend in the number of new HIV positive cases among Irish drug users. The information available on those who are testing positive for HIV remains limited. Analysis of the

⁵ Committal prisoners are prisoners who have been admitted to the prison within the preceding 48 hours, accused or guilty of a new crime, excluding those on temporary release or transferred from another prison. The committal population includes individuals entering on remand, following sentence, committed as a result of a bench warrant and non-nationals without valid documentation (Long et al. 2000: p.2).

⁶ IDUs: Injecting drug users

figures highlights the need for more information, in particular of a socio-demographic and behavioural nature, to facilitate comprehensive epidemiological analysis of the trends.

b) Hepatitis B and C

There is very little information in Ireland on the prevalence and incidence of hepatitis B among both the general population and the injecting drug using population. While data are collected on the number of positive tests carried out for hepatitis B by the Virus Reference Laboratory, no behavioural data is collected and therefore those infected through drug use cannot be identified. Information on prevalence rates is therefore confined to a small number of special studies that have been carried out in the field.

The Smyth *et al.* (1998) study of drug users located within a treatment setting found that only 1% were infected with Hepatitis B. However, more recent research carried out in the prison setting found significantly higher prevalence rates among injecting drug users. Allwright *et al.* (1999) and Long *et al.* (2000) found 18.5% and 17.9% prevalence rates for hepatitis B, respectively. While these figures suggest that hepatitis B may be prevalent among the injecting drug user population, the lack of data prohibits any in-depth epidemiological analysis of the situation in Ireland.

Table 3.3d. Ireland 1992-1999. Summary of research findings on the prevalence of Hepatitis B infection among particular cohorts of drug users

Author	Study period	Sample Source	Self Report/ Test	Serum/ Saliva	Sample size tested	% infected of those tested
Long et al (2000)	1999	Committal prisoners N=593	Test	Saliva	IDUs (n=173)	IDUs 17.9%
Allwright et al (1999)	1998	Irish Prison Population N= 1178	Test	Saliva	IDUs (n=509)	IDUs 18.5%
Smyth et al (1998)	1992-1997	Drug treatment centre N=735	Test	Serum	IDUs N=729	IDUs 1%

In Ireland, there are no routine data collected on hepatitis C. However, there have been a number of special studies carried out among samples of drug users in a variety of study settings (see table 3.3e).

The first study of hepatitis C infection among injecting drug users was carried out between August 1992 and August 1993 by Smyth *et al.* (1995). The study sample was identified through a treatment centre where all new attenders and re-attenders who presented during the study period and who reported a history of injecting drug use were encouraged to take part. In total, 272 injecting drug users took part and a prevalence rate of 84% for infection with hepatitis C was found. Among those injectors who had been injecting for between six months and two years inclusive the prevalence rate was 70%. Among those with a longer injecting history, i.e. an injecting history of longer than two years, the prevalence rate was 95%. Furthermore, there was a significant difference between genders in terms of infection. 156 of the 194

males (80%) tested positive, whereas 73 of the 78 females (94%) were positive.

Further studies were carried out by Smyth *et al.* (1998, 1999a), which examined the prevalence of hepatitis C among in-treatment populations. Consecutive new attenders at a treatment service who attended between July 1993 and December 1996 were approached to take part in the study. In all, a sample of 353 injecting drug users who reported an injecting history of less than 25 months were recruited. Overall, a prevalence rate of 52.1% was recorded within this sample. In an extension of this study cohort, Smyth *et al.* (1998) later found that of 733 consecutive new attenders between September 1992 and September 1997 at the same treatment centre, 61.8% were hepatitis C positive.

In two prison studies, which have been discussed in previous sections, the prevalence of hepatitis C among prisoners was explored (Long *et al.* 2000; Allwright *et al.* 1999). The prevalence of hepatitis C was found to be high within this population. Allwright *et al.* (1999) found that among 509 prisoners with a history of injecting drug use, 81.3% tested positive for hepatitis C. In contrast, 3.7% of those prisoners who did not report a history of injecting drug use had tested positive for hepatitis C. A follow-up study of the committal prisoner population (Long *et al.* 2000) found that of 173 prisoners with a history of injecting drug use, 71.7% were hepatitis C positive. Only 1.4% of those prisoners who reported that they had no history of injecting drug use tested positive for hepatitis C.

While it is not possible from the available data to analyse infection trends over time, it would appear from the studies available that hepatitis C infection has been prevalent among Irish injecting drug users over the past decade. Anecdotal evidence suggests that the relative ease with which hepatitis C can be spread through injecting drug use, and a lack of knowledge among users about hepatitis C and the associated risks, have all contributed to its spread. In summary, the prevalence rate for hepatitis C has been found to be consistently high within the drug using population over the past decade.

Table 3.3e. Irealnd 1992-1999. Summary of research findings on the prevalence of Hepatitis C infection among particular cohorts of drug users

Author	Testing period	Sample Source	Self Report/ Test	Serum/ Saliva	Sample size tested	% infected of those tested
Long et al (2000)	1999	Committal prisoners N=593	Test	Serum	IDUs (n=173) Non IDUs (n=420)	IDUs 71.7% Non IDUs 1.4%
Allwright et al (1999)	1998	Irish Prison Population N= 1178	Test	Serum	IDUs (n=509) Non IDUs (n=669)	IDUs 81.3% Non IDUs 3.7%
Smyth et al (1999a)	1993-1996	Drug treatment centre N=353	Test	Serum	IDUs N=353	IDUs 52.1%
Smyth et al (1999b)	1997	Drug treatment centre N=84	Self-report	n/a	IDUs N=84	IDUs 89%
Smyth et al (1998)	1992-1997	Drug treatment centre N=735	Test	Serum	IDUs N=733	IDUs 61.8%
Smyth et al (1995)	1992-1993	Drug treatment centre N=272	Test	Serum	IDUs (n=272)	IDUs 84%

In summary, the most comprehensive data available on drug related infectious diseases in Ireland are for HIV. While the number of new positive tested cases for HIV, which were attributable to injecting drug use, appeared to stabilise in the mid-1990s, figures for 1999 show an increase in the number of cases. For both hepatitis B and C, analysis is dependent solely on data from special studies. Despite the absence of comprehensive data it appears from the evidence available that hepatitis C continues to be highly prevalent among Irish injecting drug users. Overall, it would appear from the data that are available that drug related infectious diseases continue to be an issue of concern in relation to Irish injecting drug users. Furthermore, this highlights the need for more comprehensive data collection in the area of all drug related infectious diseases in order to monitor changes in the trends over time.

c) Other drug related infectious diseases

Data have not been collected on other drug-related infectious diseases in Ireland. Anecdotal evidence suggests however that tuberculosis may be increasing in prevalence among Irish drug users.

Chronic drug effects: The most obvious consequences of HIV and hepatitis B and C are the impact these diseases have on the individual's health. There are no data available on the number of drug users who develop chronic hepatitis C or require care for hepatitis B infection. The only routine data collected on the health consequences of drug related infectious diseases are those on AIDS related cases and deaths. Since recording began in 1982 and up until December 31st 1999, there have been 691 AIDS cases reported in Ireland, and 349 AIDS related deaths. In 1999 there were 41 new drug-related AIDS cases recorded. Intravenous drug users continue to represent one of the

main risk categories recorded in this data source. In 1999, intravenous drug users accounted for 39% of new AIDS cases, and 41% of the year's AIDS deaths.

Table 3.3f. Ireland 1997-1999. AIDS cases and deaths by risk category

Risk Category	1997		1998		1999	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Intravenous Drug Use Related ⁷	10	1	12	8	16	7
Homo/ Bisexual	12	3	13	9	13	5
Haemophiliacs/ Heterosexuals/ Others	8	2	14	4	11	5
Undetermined	2	1	2	0	1	0
Total	32	7	41	21	41	17

Source: Department of Health and Children/ Virus Reference Laboratory

3.4 Other drug-related morbidity – Mary O'Brien

a) Non-fatal drug emergencies

Information on non-fatal drug emergencies is not available in Ireland.

b) Psychiatric co-morbidity

National policy on the treatment of alcohol and drug misuse (Department of Health 1984) stipulates that the emphasis in the management of alcohol and drug-related problems be on community-based intervention, rather than on specialist inpatient treatment. Despite the general policy of providing treatment for problem drug use at non-residential services in the community, drug-related admissions to psychiatric inpatient hospitals are continuing to rise (see Appendix 2, Table 3.4). The proportion of drug-related admissions – with a primary or secondary diagnosis - increased from 2.2% in 1995 to 3.6% in 1999 for all admissions (National Psychiatric Inpatient Reporting System [NPIRS], personal communication). For first admissions (admission for the first time ever) the proportion increased from 2.4% to 5.0% in the same period. This is in contrast to the general trend of a decrease in overall admissions to psychiatric hospitals.

The rates (per 100,000 population) increased from 16.2 in 1995 to 24.6 in 1999 for all admissions, and in the case of first admissions the rate doubled between 1995 and 1999 from 4.7 to 9.8 per 100,000 population. Admission rates for 'drug dependence' to inpatient psychiatric hospitals vary according to geographic location (see Table 3.4a). This is not necessarily an indication of morbidity but may perhaps be linked to drug treatment provision in different areas and/or more willingness in certain areas to admit people with drug problems to psychiatric hospitals.

⁷ Includes categories 'intravenous drug users', 'homo-bisexual/intravenous drug users' and 'babies born to intravenous drug users'.

Table 3.4a. Ireland 1997-1999. First Admissions to Inpatient Psychiatric Hospitals. Drug dependence diagnosis. Rates per 100,000 population aged 16 years and over.

Health Board Area	1997	1998	1999
Eastern	10.9	13.4	13.4
Midland	10.1	8.0	17.4
Mid-Western	10.6	10.2	13.2
North-Eastern	6.3	6.8	8.6
North-Western	6.5	6.5	2.6
South-Eastern	7.1	8.0	8.7
Southern	6.6	6.1	6.1
Western	5.4	6.5	7.7
Total	8.7	9.6	10.6

Source: National Psychiatric Inpatient Reporting System, Mental Health Division, The Health Research Board.

The NPIRS data from 1997 to 1999 did not show any noteworthy psychiatric co-morbidity (NPIRS, personal communication). Close family ties and good family supports could be a factor in preventing people with psychiatric disorders from becoming involved in problematic drug use.

In an attempt to draw attention to concerns of the Irish Council of Attention Deficit Disorder Support Groups (INCADDS) a submission was made on their behalf to the National Drugs Strategy Review which took place during 2000. The submission was made as a result of concern that attention deficit hyperactivity disorder (ADHD) may be a significant risk factor for involvement in substance misuse; and that people with ADHD are more likely to self medicate. The aim was to highlight the need to identify drug users who suffer from ADHD and ensure the provision of appropriate treatment programmes for their care and management.

c) Other important health consequences

The Medical Bureau of Road Safety, Department of Forensic Medicine, National University of Ireland, Dublin, in collaboration with the Garda Síochána (police) has undertaken a study to determine current trends in driving under the influence of drugs in Ireland. A survey being carried out in the year 2000 will investigate the presence of amphetamines, benzodiazepines, cannabis, cocaine, opiates and methadone in blood and urine samples taken by the Gardai under the Road Traffic Act, 1994. One thousand samples will be randomly selected and another 1,000 from those who are *under* the legal alcohol limit for driving. Preliminary results (see Table 3.4b) from 338 samples (under the legal alcohol limit) showed that cannabis was most frequently found (34%), followed by benzodiazepines (25%). Cocaine was the drug least commonly found at 4% of the sample (Moane et al. 2000). These results indicate that there has been a significant increase in driving under the influence of drugs since 1987, when a similar study was carried out and 14.6% of samples (under the legal alcohol limit) tested were found positive for drugs. The current preliminary study found that the percentage had risen to 37%. The results of this survey will identify the types of drugs being taken and their combination with other drugs, including alcohol.

Table 3.4b. *Drugs Driving in Ireland 2000. Preliminary Study of Prevalence of Driving under the Influence of Drugs - for sample under legal alcohol limit. Type of Drug. Percentages*

Type of Drug	Percentages
Cannabis	34
Benzodiazepines	25
Amphetamines	16
Opiates	14
Methadone	7
Cocaine	4

Source: Moane et al. 2000

4. Social and Legal Correlates and Consequences

4.1 Social problems – Paula Mayock

a) Social exclusion

For several years, professionals working in disadvantaged communities and in the field of drug treatment have been aware that the development of long-term and damaging drug careers is most often associated with social marginalization and exclusion (McCarthy and McCarthy 1995; Loughran 1996). Research in Ireland has, over the past two decades, consistently demonstrated a link between concentrations of drug use and various indicators of poverty and social exclusion, such as unemployment, poor housing, one-parent families and low educational attainment (Dean et al. 1983; O'Kelly et al. 1988; McKeown et al. 1993; O'Higgins and O'Brien 1995; Coveney et al. 1999). In 1996, Irish Government drug policy recognised the link between poverty and concentrations of serious drug problems in the *First Ministerial Task Force on Measures to Reduce the Demand for Drugs*. As Butler (1991) has commented, the role of *setting*, that is the impact of environmental or contextual factors in the development of drug-related problems, was acknowledged for the first time. The Irish National Drugs Strategy, which aims to provide an integrated response to the problems posed by drug misuse, can be characterised as supporting general initiatives to tackle social exclusion and specific initiatives targeted at drug related problems.

The mid-1990s in Ireland witnessed increased attention to the plight of families, parents and children living in neighbourhoods with high concentrations of drug use and related illegal activity. In 1996, community members engaged in direct action by marching on the homes of suspected drug dealers with the intention of intimidating them. Media attention to the activities of resident anti-drug and vigilante groups increased substantially during this time, raising public awareness of drug-related activities as well as the link between drug use and crime. The murder of journalist Veronica Guerin in 1996, resulting in public outrage and heightened intolerance of drug-related activities, forced the drugs issue to the top of the political agenda (Memery and Kerrins 2000). In December 1996, the Government introduced the Housing (Miscellaneous Provision) Bill which was enacted in July, 1997. According to Section (1), (a) and (b) of the 1997 Act, anti-social behaviour includes either or both of the following :

- (a) the manufacture, production, preparation, importation, exportation, sale supply, possession for the purposes of sale or supply, or distribution of a controlled drug (within the meaning of the Misuse of Drugs Act, 1997 and 1984),*
- (b) any behaviour which causes or is likely to cause and significant or persistent danger, injury, damage, loss or fear to any person living, working or otherwise lawfully in or in the vicinity of a house provided by a housing authority under the Housing Acts, 1966 to 1997, or a housing estate in which the house is situated and, without prejudice to the foregoing, includes violence, threats, intimidation, coercion, harassment or serious obstruction of any person.*

This legislation, which gave powers to local authorities to evict tenants on grounds of anti-social behaviour, was and remains strongly criticised by several sectors involved in the care and rehabilitation of drug users, and is equally strongly supported by certain community activists. According to the Merchants Quay Project, a voluntary service which provides a range of services to drug users seeking help, the Housing Act 1997 has contributed to an increase in homeless drug users in Dublin (Memery and Kerrins 2000). The Merchants Quay Project has noted an increase of young drug users sleeping rough in its recently published annual report. They claim that “both homelessness and lack of experience of drug use make these drug users a particularly vulnerable group in terms of risk of infection and general health and well being” (Merchants Quay Project, 2000: 1).

Research evidence across a range of studies suggests that the Housing Act 1997 has impacted negatively on drug users. The Costello and Howley (2000) qualitative study of fifteen homeless drug users found that several of their respondents perceived the 1997 Act as leading to their further exclusion in gaining access to independent housing. The respondents’ perception that they are discriminated against by local authority and resident committees because of their drug use was reported as creating a considerable barrier to their seeking accommodation. Similarly, Woods (2000), reporting on a study of female drug users’ experience of parenting, found that respondents described the Housing Act 1997 as “anti-woman” and “anti-family”. Respondents recounted several cases where drug users have been delivered the ultimatum to either access treatment or leave their communities.

The Cox and Lawless (1999) study of homeless drug users in Dublin city highlights the extreme vulnerability of this group, among whom they found low levels of educational attainment, high unemployment and histories of serving prison sentences. Fifty-six percent of the study’s respondents reported that their drug use had escalated as a result of being out of home. This group of homeless drug users was found to engage in very high levels of risk behaviour, with 66% of clients injecting in public places, 49% reporting sharing injecting equipment and a further 24% stating that they recently borrowed used injecting equipment. This highly marginalised group meet further exclusion at some of the homeless services due to a policy of non-acceptance of active drug use in most direct access accommodation, such as hostels or shelters. Costello and Howley (2000) note the numerous negative consequences of excluding drug users from accommodation services for homeless people, including increased likelihood of sharing needles, lack of

safe places to store and dispose of needles, lack of access to clean injecting equipment, and the lack of a clean safe environment in which to inject.

The impact of the Housing (Miscellaneous Provision) Act 1997 has been recently assessed by Memery and Kerrins (2000). This report documents an increase in evictions related to anti-social behaviour by Dublin Corporation since the introduction of the Housing Act, 1997. These authors conclude :

Instead of working to resolve the wider and complex drug issues for these communities and address the needs of drug users directly, a very blunt piece of legislation was put in place with the emphasis on excluding those involved with drugs from local authority housing. (ibid.: 29).

b) Public nuisance, community problems

The links between local authority rental tenure and various forms of disadvantage are well-documented in Ireland (Nolan et al. 1998). Less attention has been given to the investigation of the impact of social and environmental conditions on areas characterised by extreme deprivation, despite the susceptibility of such communities to a range of social problems, including drug misuse. However, one recent study of living conditions in seven local authority estates in urban areas throughout Ireland (Fahey 1999), highlights a range of social order problems in the study's estates. O'Higgins (1999) notes that the nature of social order problems experienced in the seven estates varied. At one end of the scale, social problems consisted of relatively minor "nuisance behaviour", while at the other, a number of estates endured more serious problems, ranging from illegal drug use and dealing to intimidation and harassment. This study found that the use of heroin and other "hard" drugs was confined mainly to Dublin estates, and was particularly acute in one large local authority flat complex located in Dublin's south inner city. The profound negative effects of concentrations of drug problems emerged strongly from the reports of children living in the estate, and interviewed for the purpose of the research. Children in focus groups recounted routine encounters with drug users and made casual reference to the presence of drugs paraphernalia on the stairs, on balconies and in the stairwells. Coupled with this, parents expressed extreme anxiety about the negative consequences of high level of exposure to drugs for their children. Drug use and activities related to the distribution of illegal drugs were considered to be among the most enduring problems on the estate, and one which impacted negatively on the quality of life of a high proportion of residents.

In another study of a local authority estate, Corcoran (1998) similarly reported that all aspects of the drug problem, including drug-taking in public areas and the sale and distribution of drugs, were perceived as the biggest problem. Both Corcoran (1998) and O'Higgins (1999) note that the activities surrounding the distribution of drugs draw a steady stream of non-residents onto estates. This among other factors, exacerbates the "palpable sense of tension" (Corcoran, 1998: 21) in the area. There was a widespread belief among residents that the drug situation was out of the control of both residents and the Gardai (McAuliffe and Fahey 1999). Reporting on research

carried out in another large inner-city flat complex with a long history of social problems, Morley (1998) also highlighted the perceived negative impact of drug problems on the quality of life in the community. The socio-economic profile of this estate revealed in the research - high rates of long-term unemployment, low educational attainment levels and high rates of early school leaving - is again indicative of a community struggling with the issues of social exclusion and marginalisation. This estate also hosted a large number of problem opiate users.

The management of social order problems on local authority estates has involved, inter alia, evictions of problem tenants, particularly those individuals associated with drug dealing and related activities. Fahey (1999) notes that while the use of exclusionary strategies has resulted in some improvements in social order in a number of estates, they can lead to further social problems which ultimately exacerbate social exclusion.

4.1 Drug offences and drug-related crime – Mary O’Brien

a) ‘Arrests’ for use/possession/traffic and trends

The *use per se* of drugs, excluding opium, is not a criminal offence in Ireland. *Possession* and *trafficking/dealing/supplying* are illegal activities under the Misuse of Drugs Acts, 1977 and 1984 (MDA). In 1999 prosecutions under Section 3 of the Misuse of Drugs Acts (*possession* offences) made up 68% of the total prosecuted; 28% were prosecuted under Section 15 of the Misuse of Drugs Acts (drug-related *trafficking* offences) (Table 4.2a below). A breakdown by region shows that most offences (38%) were in the Dublin Metropolitan area (N=2719), followed by 25% in the Southern region (N=1770). The proportion of *possession* offences was almost the same in these two areas (Dublin 29%, N=1437; Southern 29%, N=1394). Over half (56%, N=1097) of trafficking (*supply/dealing*) offences were in Dublin.

Table 4.2a. Ireland 1999. Drug law offences by type of drug and region. Numbers and percentages.

Region/Offence Type	Possession (Section 3 MDA)	Supply/Dealing (Section 15 MDA)	Obstruction (Section 21 MDA)	Other offences	Total
Eastern	616	258	0	0	874
Dublin metropolis	1437	1097	127	58	2719
Northern	215	56	0	4	275
South Eastern	534	103	11	4	652
Southern	1394	341	14	21	1770
Western	687	116	12	32	847
Total	4883	1971	164	119	7137
	68%	28%	2%	2%	100%

Source: Annual Report of An Garda Síochána 1999

With regard to the type of drug involved more than half (59%) were cannabis offences and of these slightly more were in the southern region than in Dublin (Table 4.2b). Ecstasy accounted for 14% of drug law offences and the majority of these were in the southern region. The vast majority of heroin offences (852 out of a total of 887, 96%) were detected in the Dublin region.

Table 4.2b. Ireland 1999. Drug law offences by type of offence and region. Numbers and percentages.

Region/Drug Type	Cannabis	Heroin	LSD	Ecstasy	Amphetamine	Cocaine	Other	Total
Eastern	543	19	3	200	83	9	17	874
Dublin metropolis	1208	852	2	211	70	126	250	2719
Northern	187	0	1	60	16	4	7	275
South Eastern	437	1	11	81	92	6	24	652
Southern	1227	12	5	368	108	10	40	1770
Western	583	3	4	103	95	14	45	847
Total	4185	887	26	1023	464	169	383	7137
	59%	12%	0%	14%	7%	2%	5%	100%

Source: Annual Report of An Garda Síochána 1999

Trends over the five-year period between 1995 and 1999 show an increase in the number of drug charges, from 4146 in 1995 to 7137 in 1999 (Table 4.2c). There was a particularly sharp rise in cannabis offences in 1999. In 1998 cannabis offences (N=2190) made up 39% of total drug law offences, this increased to (N=4185) 59% in 1999. Heroin offences have been steadily increasing over the five-year period. Amphetamine offences increased more than three-fold from 138 in 1995 to 464 in 1999. The most dramatic jump in 1999 was in relation to ecstasy offences which had been relatively stable in the preceding four years. This may have been as a result of a combination of an increased number of large-scale dance music events, and more intensive police activity at such events and in general.

Table 4.2c. Ireland 1995-1999. Drug law offences by type of drug. Numbers.

Type of Drug	1995	1996	1997	1998	1999
Cannabis	2600	1834	2671	2190	4185
Heroin	296	432	564	789	887
Other opiates	0	0	6	0	0
Cocaine	30	42	97	88	169
Amphetamine	138	152	239	273	464
LSD	70	24	39	13	26
Ecstasy	645	340	475	439	1023
Other offences	385	454	65	1839	383
Total	4146	3278	4156	5631	7137

Source: Annual Reports of An Garda Síochána 1990-1999

b) Convictions and court sentences for drug offences

Currently in Ireland no data are available on convictions or court sentences for drug offences.

c) Drug-related crime

A study to examine the association between drug use and crime in Dublin Metropolitan Area was carried out by the Garda Research Unit (Keogh 1997). The 'population' (N=4,105) was drawn from police records and from (police) local knowledge. It included all those who had come in contact with the Gardai through being arrested, charged or suspected of criminal activity between August 1995 and September 1996. The inclusion criterion was 'individuals involved in hard drug use'; opiates, stimulants, hypnotics and hallucinogens were included in the definition of 'hard drugs'. During the study period 19,046 serious crimes were detected and 7,757 individuals were apprehended for these crimes: of these 3,365 (43%) were identified as known hard drug users. It was deduced that the drug users were responsible for 12,583 (66%) of the crimes.

A sample of (n=351) of these agreed to be interviewed to provide more detailed information. Over a third (37%) had left school before the official school leaving age of 15; and 84% were unemployed. While three-quarters of the respondents had at some time sought treatment for problem drug use and most had received it, a number (n=81) had never sought treatment of any kind. A majority said they had a poor understanding of the effects of drug use. It was found that 51% had been involved in crime before their involvement with drugs; 48% said family members were involved in crime.

The authors of the National Crime Forum Report (1998: 74) stated that they were 'deeply concerned with the impact of drug abuse on crime and the response of the criminal justice system to that issue'. The authors were impressed by suggestions to keep otherwise law-abiding young people out of the criminal justice system – that young experimental users of cannabis and ecstasy should be diverted to the Juvenile Diversion Programme. (The aim of this programme, which was established by the Garda Síochána, is crime

prevention and to provide an alternative for juvenile offenders. Rather than being dealt with under criminal law, they enter the programme and thus are diverted from the formal criminal justice system). The case for the decriminalisation of certain drugs was presented to the Forum which agreed that the issue was important and required more careful study. Those against decriminalisation argued that public opinion was opposed to such a change. A general population survey (Bryan et al. 2000) to examine drug-related knowledge, attitudes and beliefs, could be interpreted to support this view – 66 percent agreed that cannabis should be against the law. Results from the same study found that drug-related crime is considered to be a major problem in Ireland by 94 percent (n=998) of those interviewed, and three-quarters of the sample felt that the drug problem was out of control.

In 1998 a study was conducted by the Garda Research Unit to explore the links between alcohol/drug use and crime (Millar et al. 1998). Gardai at 27 stations throughout the country (12 in Dublin, 15 in the other 5 Garda divisional regions) were asked for their 'informed opinion' (ibid.:2) as to whether alcohol or drugs were involved in offences where a person was 'arrested, charged, summonsed, or diverted under the Juvenile Diversion Programme' (ibid.:1). Offences under the Misuse of Drugs Acts and the Liquor Licensing Acts were excluded. A total of 4,334 offences (no indication is given as to whether these refer to individuals or incidents) were noted during the study period (March-May 1998). Forty-two percent of cases were considered to be related to alcohol consumption, 17 percent to drugs and 4 percent to alcohol and drugs (drugs were implicated in 913 cases). Alcohol was most likely to be associated with public order offences, while drugs were most often linked to robberies. In Dublin heroin was the drug most likely to be involved (83 percent of cases), while outside of Dublin cannabis (37 percent) and ecstasy (26 percent) were the drugs most commonly cited (see Table 4.2d).

Table 4.2d. Ireland 1998. Juvenile Diversion Programme. Drug-related crime by drug. Percentages.

Main drug involved	Dublin	Other areas
Opiates	83.1	20.1
Cannabis	13.5	37.4
Ecstasy	0.9	25.9
Amphetamines	0.9	1.1
Barbiturates	0.6	0.6
Cocaine	0.2	1.1
Hallucinogens	0.2	0.0
Other	0.6	13.8
Valid n	534	174
Missing n	136	69
Total n	670	243

Source: Garda Research Report No. 7/98

4.2 Social and economic costs of drug consumption - Paula Mayock

a) Studies and estimates of healthcare costs, other social costs

Studies to estimate the healthcare or other social costs of drug consumption have not been carried out in Ireland. Nor are estimates available on the economic costs to society from drug use. Accepting that the “social costs” incurred by drug use can be defined and interpreted variously, and that no research has been undertaken in Ireland with the specific aim of estimating such costs, a number of research findings can be drawn upon to illustrate evidence of significant costs to individuals, families and communities as a result of drug use.

As might be expected, this evidence arises primarily from research on a range of social problems associated mainly with disadvantaged communities. Numerous researchers have documented the perceived negative impact of high levels of drugs misuse on communities where drug use is concentrated (O’Higgins 1999; Corcoran 1998; Morley 1998). Residents of estates where drug use is concentrated consistently draw attention to the destructive effect of drug use and drug trafficking on community life. Furthermore, they are acutely aware of the negative way in which their community is perceived by outsiders. Mayock (2000), in a qualitative study of drug use by young people in a Dublin inner-city community noted that respondents made constant reference to the area’s drug problem. Furthermore, these young people expressed resentment of outside representations of their neighbourhood. They were particularly critical of the negative effects of disparaging media reports of drug problems in their community, which they felt exaggerated the issue. Many clearly felt stigmatised by virtue of living in a locality where drug use and associated activities are concentrated.

There is relatively little research available pertaining to the consequences of drug problems for individual families. For example, there is no available estimate of the number of individuals affected by familial drug use. However, the issue of how children are affected by drug misuse has emerged as an issue of critical concern. Hogan (1997), in an exploratory study of the social and psychological needs of children of drug using parents, found that the majority of children whose parent(s) were heroin users were experiencing difficulties at school. Key workers interviewed for the purpose of the research expressed concern about the quality and consistency of care-giving by drug using parents.

b) Estimates of total consumption/demand/expenditure on drugs

In Ireland, there are no estimates of consumption nor demand nor expenditure on drugs available.

5. Drug Markets - Mary O'Brien

5.1 Availability and supply

a) Availability of different drugs, trends and possible reasons

The ESPAD 1995 nationwide school survey of 15-16 year-old post-primary school pupils (Hibell et al. 1997) found that ecstasy was perceived as very easy to obtain in Ireland – 54% said that they could get it 'very easy' or 'fairly easy'. Amphetamines were also reported to be easy to obtain – by one-third of the respondents.

Seizures may, with caution, be taken as an indirect indication of the availability of illicit drugs. However, since the number of seizures and the amounts of illicit drugs seized can be affected by factors such as the resources committed to detection, changes in the quality of intelligence on illicit drugs trafficking etc., they can not be used as a reliable indicator of trends in relation to the amount of drugs available on the market. The fact also, that not all drugs seized in Ireland are destined for the Irish market, but are in transit elsewhere, complicates the issue even further (Garda Síochána, personal communication).

In Ireland there was a sizeable increase in the *quantity* of drugs seized in 1995 over previous years. This can be partly attributed to the setting up of the Garda National Drugs Unit and the Customs National Drugs Team in 1995. In that year there were two major seizures of cannabis, and one seizure of ecstasy contained 40,000 tablets. Measuring the availability of drugs is a very difficult task given the illicit nature of the activity. Special studies would need to be undertaken in order to explore the issues involved.

b) Sources of supply and trafficking patterns within Ireland

The sources of supply vary according to the type of drug. Cannabis comes mainly from Morocco, while some smaller seizures are known to have originated in Pakistan, Afghanistan and Lebanon (Garda Síochána, personal communication). Recently, some cannabis seizures were known to have originated in South Africa. Heroin seized in Ireland is thought to come from Asia, mainly Afghanistan, Pakistan, India and Laos. Cocaine traffic is believed to originate in South America. The main place of origin for ecstasy seized in Ireland is the Netherlands and to a lesser extent Belgium (Garda Síochána, personal communication).

Police report that most of the trafficking in cannabis to Ireland takes place between Morocco and the south coast of Ireland. It is transported in articulated trucks using cross-channel ferries, and on sea-going yachts. The south-west of Ireland is a major trans-shipment point. The bulk of heroin seizures are transported to Ireland through the UK and some through the Netherlands. Individual drug couriers travelling by air, bring smaller amounts from Europe.

The police believe that most of the drugs seized in Ireland in recent years are for the home market. In the case of very large shipments it is speculated that Ireland with its long coastline isolated in many areas, is used as an access point for transit to the UK and Europe. The police also believe that the distribution of drugs within the country is organised by networks of criminal gangs. In some cases these gangs involve members of the same family.

Sale patterns at street level in Dublin differ from area to area, with price and purity of drugs varying according to supply and demand factors. No research studies have been conducted in this area as yet in Ireland.

5.2 Seizures

Trends in quantities and numbers of seizures

In Ireland it is not possible as yet to distinguish between police and customs seizures in relation to the quantities and numbers of drugs seized. All seizures, by both police and customs, are included in published Annual Reports of An Garda Síochána (police). Police and customs authorities increasingly work on a collaborative basis and following approaches (by HRB) to both organisations there is a willingness to provide separate information on seizures in the future.

Between 1995 and 1999 the number of seizures of all drugs, except for LSD, increased (Table 5.2 below).

Table 5.2. Ireland 1995-1999. Quantity (kgs) and number of seizures of illicit drugs.

Type of Drug	1995		1996		1997		1998		1999	
	N*	Q**	N*	Q**	N*	Q**	N*	Q**	N*	Q**
Cannabis	3205	15606.5	3449	1935.4	4102	1282.7	4513	2201.7	4538	2577.3
Heroin	209	6.4	664	10.8	599	8.2	884	38.3	767	17
Cocaine	42	21.8	93	642	157	11	151	333.2	213	85.6
Amphetamines	89	1.5	217	7.6	475	102.9	680	45	467	13.4
Ecstasy***	571	123699	534	23012	423	20434	509	609301	1074	229101
LSD	62	819	42	5901	48	1851	19	5901	29	577
Benzodiazepines	na		152	7146	219	4942	181	2885	175	15393
Other drugs	0		93		159		93		55	
Total number seizures	4178		5244		6182		7030		7318	

* N=Number of seizures

** Q=Quantity seized in kilograms; number of tablets in the case of ecstasy and benzodiazepines, and number of doses in the case of LSD.

*** Ecstasy includes MDMA, MDEA, MDA, ephedrine

Source: Annual Reports of Garda Síochána

The *number* of seizures of all drugs has increased from 4178 in 1995 to 7318 in 1999. There are more seizures of cannabis than any other drug: the number increased from 3205 in 1995 to 4538 in 1999. In fact, over the ten-year period 1990 to 1999, cannabis accounts for most of the drugs seized (see Figure 5.2a, Appendix 2). During the same period the *number* of heroin seizures more than tripled (from 209 to 767). Cocaine increased five-fold (from 42 to 213), as did amphetamine (from 89 to 467). The *number* of ecstasy seizures increased quite considerably from 509 in 1995 to 1074 in 1999. It should be noted that 'ecstasy' can include various substances such as MDMA, MDEA, MDA, ephedrine or ketamine.

The *quantity* of different types of drugs seized fluctuated from year to year. Apart from the very large seizure in 1995 the quantities of cannabis have been increasing each year. There was a very large seizure of illicit benzodiazepines (15,393 tablets/capsules) in 1999. The majority of these (13,389) were diazepam and one seizure alone that year constituted 7,800 diazepam. All benzodiazepines are controlled under Section 15 of the Misuse of Drugs Acts - it is illegal to supply or deal them other than by prescription. However, in the case of flunitrazepam (Rohypnol) and temazepam they are controlled under both Section 15 and Section 3 of the Misuse of Drugs Acts - it is illegal to *supply* or *possess* them other than by prescription. Seized *quantities* of other drugs have tended to fluctuate in the same period – but in general quantities are increasing (Figure 5.2b, Appendix 2).

5.3 Price, purity

It is not possible from the information available to distinguish between the price of drugs at street level and trafficking level. The Gardai collect information on the street prices of drugs (EMCDDA Standard Table 16, Appendix 2). The data available up to now do not show any change in price over the past five years. However, this does not match with anecdotal evidence, which suggests that the prices fluctuate according to the market forces of supply and demand. For example, the price of heroin increases when supply is limited. No information is currently available on prices at trafficking level.

Drug seizures by the police are analysed at the Forensic Science Laboratory of the Department of Justice, Equality and Law Reform, to ascertain purity levels of heroin, cocaine and amphetamine. Cannabis purity is not analysed. Between 1995 and 1999 the purity levels of heroin decreased and in 1999 a minimum purity level of 0.25% was recorded. Purity levels of amphetamine seizures have also decreased somewhat. Cocaine purity levels have fluctuated in the five-year period but the trend is downward (Table 5.3).

Table 5.3. Ireland 1995-1999. Purity of seized drugs. Average percentages

Type of Drug	1995	1996	1997	1998	1999
Heroin	45	49	46	35	33
Cocaine	47	62	54	38	41
Amphetamine	4.7	9.8	3.5	6	3

Source: Forensic Science Laboratory, Department of Justice, Equality and Law Reform

6. Trends per Drug - Mary O'Brien

Cannabis

- Cannabis remains the most widely available and the most commonly used drug in Ireland. Use is more experimental than habitual (see Section 2.2).
- Around 20% of those aged between 18-64 years have tried cannabis at least once (see Section 2.2).
- Nine percent of those aged 18-64 have used cannabis in the past 12 months; 5% in the past month (see Section 2.2).
- Cannabis use is most prevalent among young people between 18-24 years; around a third have tried it at least once. A quarter of this age group used it in the past 12 months; and 15% in the past month (see Section 2.2).
- The relatively high prevalence rate among 15-16 year olds found in the ESPAD 1995 study has not been sustained in subsequent research (see Section 2.2).
- The proportion of all contacts presenting for treatment for problem cannabis use has increased slightly from 15% in 1995 (the first year for which national data are available) to 17% in 1999.
- Of all the illicit drugs, cannabis features most frequently in prosecution and seizure data. Cannabis offences account for 59% of drug law offences. The number of prosecutions increased from 2600 in 1995 to 4185 in 1999. The number of cannabis seizures over the past five years has increased from 3205 in 1995 to 4538 in 1999. However, quantities of cannabis seized tend to fluctuate (Figures 5.2a and 5.2b at Appendix 2).
- Preliminary results from the study to determine current trends in driving under the influence of drugs found that cannabis was the drug most frequently found (34%) (Moane et al. 2000).

Synthetic drugs

- After cannabis, although much less prevalent, amphetamines and ecstasy are the second most commonly used drugs in the general population.
- Amphetamine use is more common than ecstasy in general population studies. Around 3% of those aged between 18-64 had used amphetamines in the past year (see Section 2.2). However, the picture among school pupils is quite different. Recent use of amphetamine, ecstasy or LSD is preceded by solvent misuse (see Table 2.2e at Section 2.2).
- Among school pupils of all ages, recent prevalence rates of amphetamine, ecstasy and LSD use are quite similar.
- The proportion presenting for treatment (for the first time) for ecstasy use has decreased, from 11% in 1995 to 9% in 1999 (EMCDDA Table 4 at Appendix 2).
- Treatment for amphetamine use is quite low but has increased a little; from 0.4% in 1995 to 2% in 1999.
- After cannabis, ecstasy is the drug which features next in prosecutions and seizures data. Up to 1998, the trend in ecstasy offences was fairly stable but in 1999 the number of offences increased considerably (Table 4.2c at Section 4.2).
- Preliminary results from the study to determine current trends in driving under the influence of drugs found that amphetamine was found in 16% of cases (Moane et al. 2000).

Heroin/opiates

- Heroin dependence is still mainly concentrated in and around the Dublin area, although this seems to be changing with diffusion to urban areas throughout the country. The 'visible' users have serious health and social problems. Unlike treated heroin users in other EU countries, they are *not* an ageing population: around 80% of all contacts presenting for treatment are between 15 and 29 years of age; up to 90% of those presenting for treatment for the first time are aged between 15 and 29. Nor are there, as yet, indications of serious psychiatric problems among treated drug users.
- Heroin is the least used drug in Ireland but it is the most problematic with serious health and social consequences.
- The trend some years ago (among treated heroin users) towards smoking rather than injecting heroin now seems to be changing. Smoking was the preferred route for people starting to use heroin, at least initially. However, latest trends show that heroin is more likely to be injected. It seems that people who originally preferred to smoke heroin are now no longer reluctant to inject (O'Brien et al. 2000).
- Heroin offences constitute 12% of total drug law offences. The *number* of heroin seizures is increasing, the *quantities* seized fluctuates.
- Preliminary results from the study to determine current trends in driving under the influence of drugs found opiates in 14% and methadone in 7% of cases (Moane et al. 2000).

Cocaine/crack

- Cocaine is used by about 2% of the general population in Ireland.
- Treatment demand for problem cocaine use has always been very low: between 1%-2%. Apart from addiction counselling, there are no specific treatments for problem cocaine users in Ireland right now. Of all those presenting for treatment for the first time in 1999 with multiple drug problems (64%), 7% were seeking treatment for problem cocaine use.
- The number of cocaine seizures is increasing.
- A small-scale (N=10) qualitative study of recreational cocaine users found that cocaine is more easily available in Ireland than previously, and that more people are perceived to be using it. It is used in private social settings, such as home-based parties, rather than in public settings (Mayock, forthcoming).
- Preliminary results from a study to determine current trends in driving under the influence of drugs found that cocaine was present in 4% of cases (Moane et al. 2000).

Multiple use

- In 1999, 64% of clients presenting for treatment for the first time were using two or more drugs. Cannabis was the most frequently cited (26%) secondary drug of misuse followed by ecstasy (21%); benzodiazepines (10%); amphetamines (9%); cocaine (7%); and methadone (7%) (National Drug Treatment Reporting System).
- A review of drug treatment services in the ERHA areas (Farrell 2000) found high rates of benzodiazepine use among those attending treatment suggesting a major problem of polydrug use.
- A study on drug-related death in 1999 found that benzodiazepine was the drug most commonly identified (in 75 cases), and was mainly in combination with other drugs. The most common combination of drugs was opiates and benzodiazepines (Keating et al. 1999).
- Benzodiazepines are now widely prescribed and need to be regulated (Quigley, presentation to European Society for Social Drug Research (ESSD) 11th Annual Conference, Trinity College Dublin, September 2000). A Committee has recently been established by the Minister for Health and Children to examine the nature and extent of benzodiazepine prescribing in Ireland. This Committee will examine current trends and make recommendations on good prescribing practices, paying particular attention to the management of drug users.
- Preliminary results from a study to determine current trends in driving under the influence of drugs found quite a high prevalence of benzodiazepines - 25% of cases (Moane et al. 2000).

7. Conclusions

7.1 Consistency between indicators

A graphic analysis of the consistency between different indicators is presented in Figures 7.1a and 7.1b (at Appendix 2) using data of four indicators of drug misuse - treatment; drug-related death; prosecutions for drug offences;

seizures of illicit drugs, from 1990 to 1999. The data used in the graph are the relative levels of each indicator compared with 1990 (index year 1990=100). All these indicators show an upward trend. Broadly speaking they present a picture of increasing activity in the demand for and the supply of illicit drugs.

Other indicators such as general population surveys do not present as clear a picture. Methodologies for estimating local and national prevalence rates are at the development stage and cannot be examined for trends. The collection of comparable information on drug-related infectious diseases is also at the initial stages.

With regard to possible relationships between indicators, for example treatment and prosecutions, apart from some isolated periods (between 1995 and 1997 when treatment increased and prosecutions decreased), the Irish data provide no conclusive evidence that there is an inverse correlation between them. All the indicators presented show a fairly consistent increase over several years.

7.2 Implications for policy and interventions

a) Possible hypotheses and reasons for main trends and new developments in drug use

With regard to law enforcement statistics, increased resources, for example the establishment of the Garda National Drug Unit in 1995, is likely to have improved detection rates nationwide (see Sections 4.2 and 5.2). The most obvious increase – in drug-related deaths – appears to be substantially attributable to more accurate recording procedures, though undoubtedly there has also been a real increase in drug-related deaths. Equally, the increase in treatment demand could be partially attributed to an improvement in the provision of drug treatment services. The system now includes drug users who would previously not have had access to treatment. As with drug-related deaths, allowing for improvements in data collection procedures or institutional changes, it is strongly indicated that there has been a rise in drug use in Ireland.

b) Relevance to policy issues or interventions for policy makers and professionals

With regard to policy issues more in-depth qualitative research studies are needed in order to understand more about injecting drug users, and thus help towards making prevention strategies more effective.

Data from different indicators over several years show high levels of social deprivation among problem drug users. Economically, Ireland is relatively better off than in previous times but not all its people have access to the means of benefiting from the economic boom. While the Irish economy continues to grow certain sectors of society are excluded from participating in the benefits of the so-called 'Celtic tiger'. Lack of material and cultural capital such as having a job, having a decent place to live, access to education, having good skills, even having expectations, prevents people from availing of the current opportunities. This is not just confined to so-called marginalised urban areas. Key policy areas which require attention in this context are; economic and fiscal policy, housing policy, education policy, employment policy, and the operation of the criminal justice system. New policies and strategies in the context of the National Development Plan and Local Drugs Task Forces (see Parts 1 & 3 of this report) aim at addressing the drug problem in the broader socio-economic context and will help towards the alleviation of such adverse social conditions.

7.3 Methodological limitations and data quality

Methodological limitations, evaluation of data quality, new information needs and priorities for future work

- General population surveys to study the extent of drug use in Ireland vary in objectives, methodologies, focus of data collection, questionnaire design, age groups studied etc.. Comparisons are therefore tentative and must be viewed with these variations borne in mind. If meaningful interpretations and comparisons are to be made a priority for future work should be that prevalence surveys are carried out using comparable methodologies. Information on recent and annual use should be available as well as lifetime experience of drug use. Surveys should be comparable nationally as well in the wider European sense where possible. It is also important that these surveys be replicated at frequent interval if trends over time are to be available.
- More work needs to be carried out on the evaluation of data quality.
- More in-depth qualitative research studies are needed to understand more about injecting drug users, and thus help towards making prevention strategies more effective.
- Interest in the availability of drugs has been growing. However, measuring this is a very difficult task given the illicit nature of the activity. Special studies would need to be undertaken in order to explore the issues involved.

- In Ireland, there are no estimates of consumption or demand or expenditure on drugs available. Nor are there any estimates of healthcare or other social costs available. This is an area that will need examination.

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Part 2 – Epidemiological Situation

Appendix 1

Table 2. Ireland. Census of Population 1996.

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

Source: Central Statistics Office.

Part 2 – Epidemiological Situation

Appendix 2

Table 2.2. Ireland. Estimated migration classified by country of destination/origin, 1995-2000.

Year ending April	Emigrants					Immigrants					Net migration
	UK	Rest of EU	USA	Rest of World	Total	UK	Rest of EU	USA	Rest of world	Total	
						000's					
1995	13.3	5.1	8.2	6.6	33.1	15.6	6.3	3.8	5.5	31.2	-1.9
1996	14.1	5.1	5.2	6.8	31.2	17.6	7.2	6.4	8.0	39.2	8.0
1997*	12.9	4.1	4.1	7.9	29.0	20.0	8.1	6.6	9.3	44.0	15.0
1998*	8.5	4.3	4.3	4.1	21.2	21.1	8.7	4.9	9.3	44.0	22.8
1999*	10.2	4.5	5.4	8.9	29.0	21.6	10.0	5.7	10.2	47.5	18.5
2000*	6.3	4.3	3.2	8.5	22.3	16.4	9.8	4.6	11.5	42.3	20.0

* Preliminary

Source: Central Statistics Office

Table 3.2. Ireland 1990-1999. Drug-Related Deaths from Drug Dependence and Opiate Poisoning. Numbers and percentages.**

		1990	1991	1992	1993	1994	1995	1996	1997*	1998*	1999*
Ireland	N	7	8	14	18	19	43	53	55	99	80
(All ages)	%	100	100	100	100	100	100	100	100	100	100
Dublin	N	6	8	14	16	17	39	43	49	76	66
(All ages)	%	86	100	100	89	89	86	81	89	77	83
Gender	% M	86	100	79	89	95	86	83	87	76	74
	% F	14	0	21	11	5	14	17	13	24	24
Under 30 years old	N	7	4	8	8	11	22	30	34	53	35
	%	100	50	61	44	58	51	57	62	54	44
15-49 years old	N	7	7	14	16	19	39	50	52	90	70
	%	100	88	100	89	100	91	94	96	91	88
Drug dependence	N	4	5	13	13	15	38	42	43	90	75
(ICD-9 Code 304)	%	57	63	93	72	79	88	79	78	91	94
(All ages)											

Source: Central Statistics Office

*** provisional data**

****** For the purpose of this report a drug-related death is defined as one where the underlying or external cause of death was due to drug dependence (ICD-9 Code 304) or opiate poisoning (ICD-9 Code 965.0).

Table 3.3. Ireland 1982-1999. AIDS cases and deaths by risk category.

Risk category	1982 – 1992		1993		1994		1995		1996		1997		1998		1999	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Intravenous Drug Use Related ⁸	142	61	43	21	22	27	25	27	34	17	10	1	12	8	16	7
Homo/Bisexual Haemophiliacs/ Heterosexuals/ Others	109	45	13	14	27	11	16	11	34	16	12	3	13	9	13	5
	52	27	12	9	18	6	13	8	11	1	8	2	14	4	11	5
Undetermined	5	3	0	0	0	0	1	0	0	0	2	1	2	0	1	0
Total	308	136	68	44	67	44	55	46	79	34	32	7	41	21	41	17

Source: Department of Health / Virus Reference Laboratory

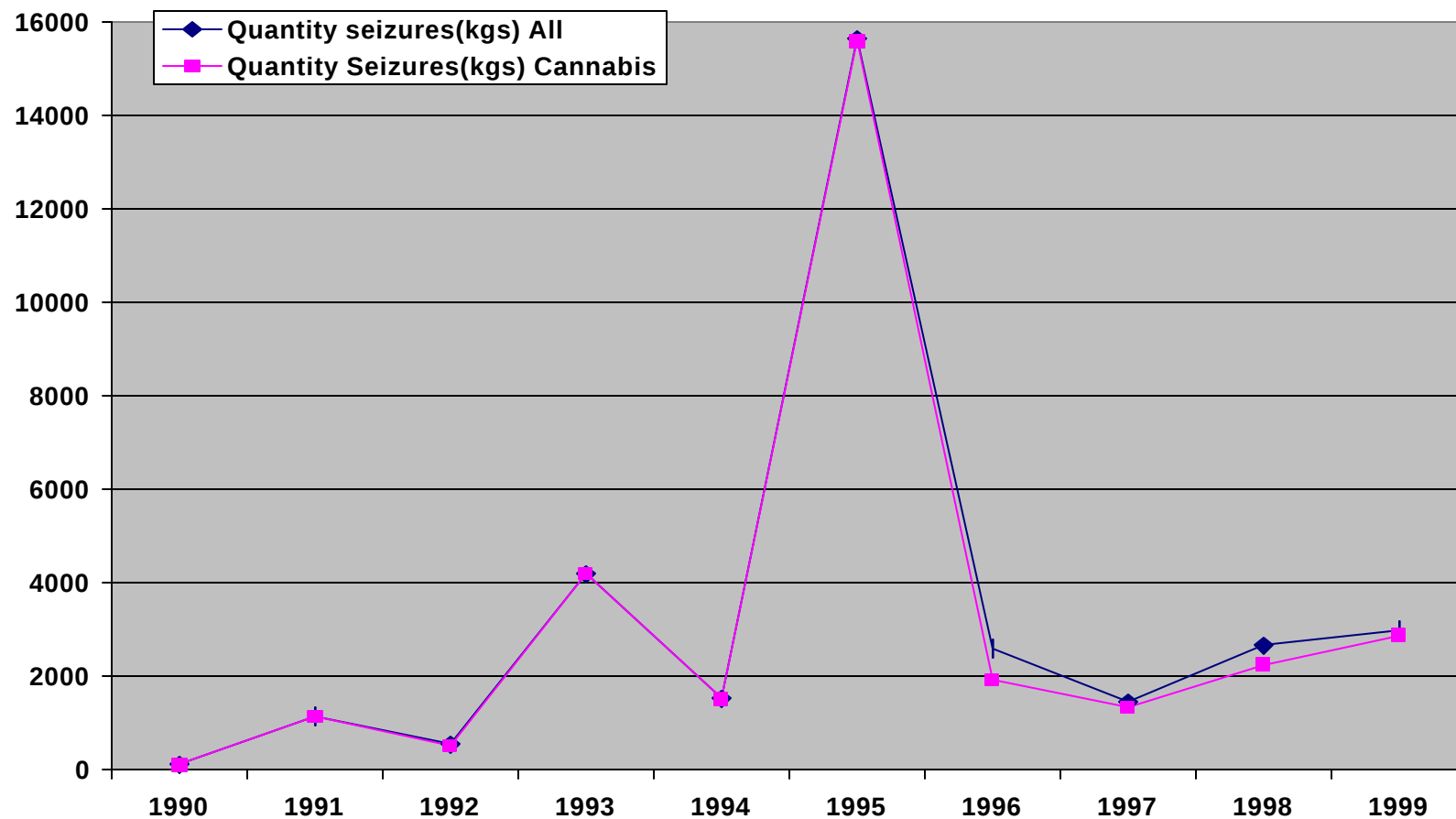
⁸ Includes categories 'intravenous drug users', 'homo-bisexual/intravenous drug users' and 'babies born to intravenous drug users'.

Table 3.4 Ireland 1994-1999. All and First Admissions to Inpatient Psychiatric Hospitals. All Ages. Numbers, percentages and rates.

	1995		1996		1997		1998		1999	
<i>Admissions</i>	<i>All</i>	<i>First</i>	<i>All</i>	<i>First</i>	<i>All</i>	<i>First</i>	<i>All</i>	<i>First</i>	<i>All</i>	<i>First</i>
<i>Drug-related admissions (N)</i>	580	172	678	263	691	280	846	308	893	354
<i>Admissions for all disorders (N)</i>	26440	7246	26656	7130	26069	7049	25295	7137	25118	7147
<i>Drug-related (%) (primary or secondary diagnosis)</i>	2.2	2.4	2.5	3.7	2.7	4.0	3.3	4.3	3.6	5.0
<i>Rate per 100,000</i>	16.2	4.7	18.7	7.2	19.1	7.7	23.3	8.5	24.6	9.8

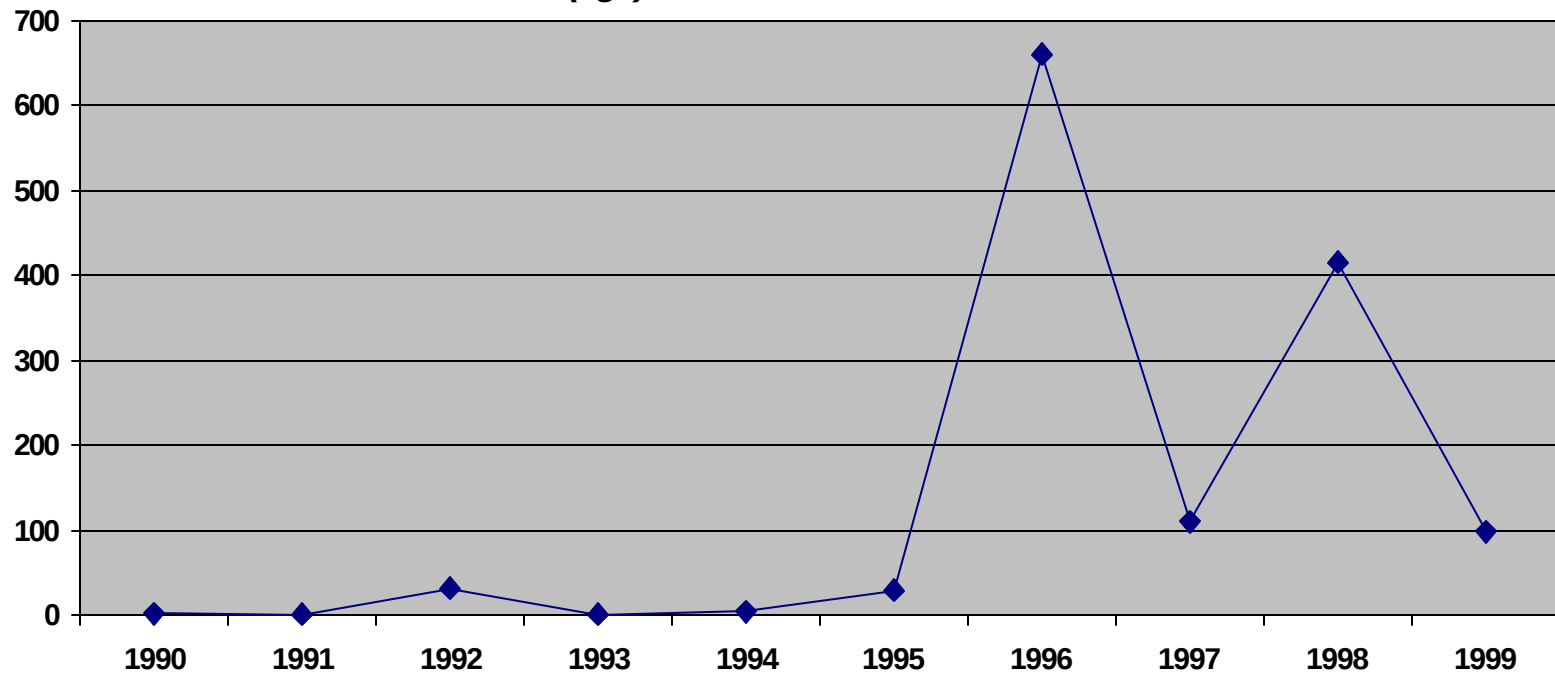
Source: National Psychiatric Inpatient Reporting System (NPIRS), Mental Health Division, Health Research Board

Figure 5.2a Ireland 1990-1999. Quantity of Drug Seizures(kgs)



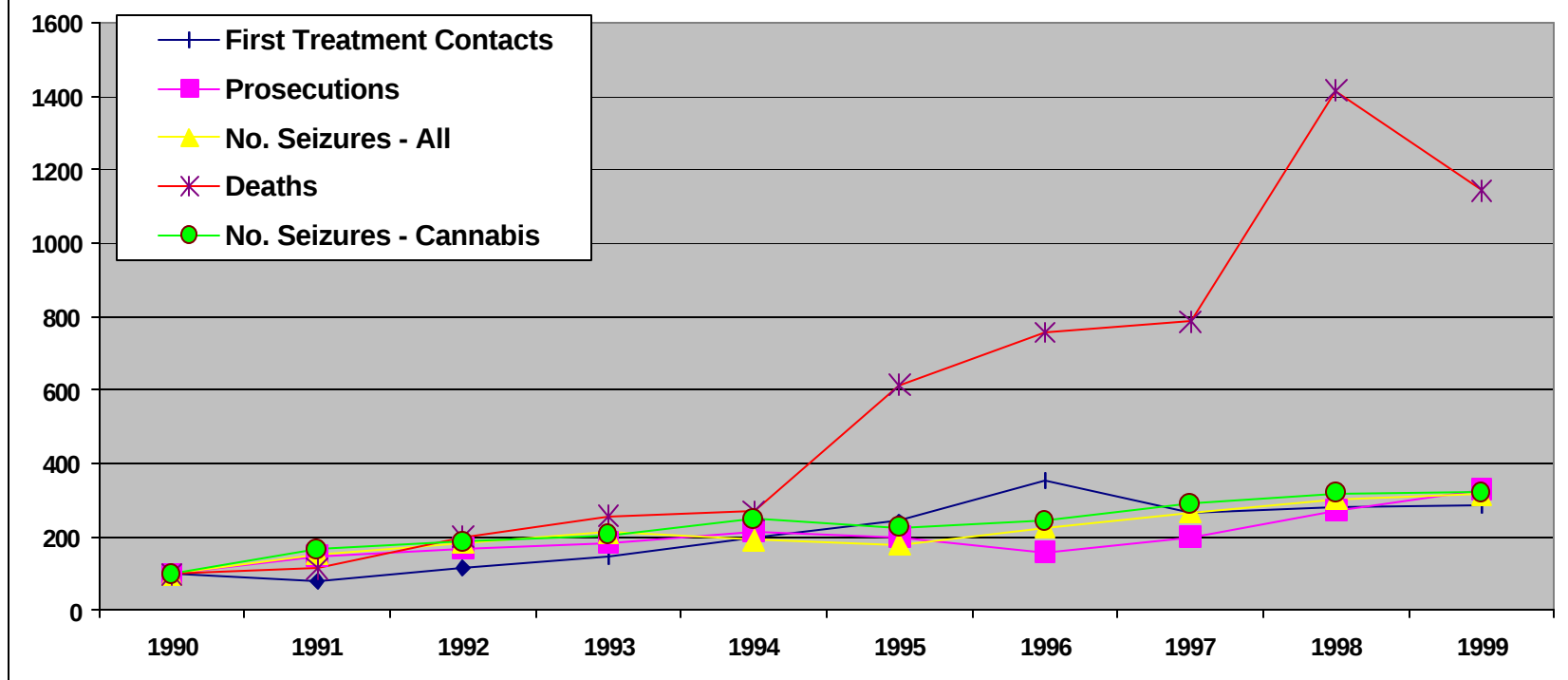
Source: Annual Reports of An Garda Siochana

Figure 5.2b Ireland 1990-1999. Quantity of Drug Seizures other than cannabis (kgs)



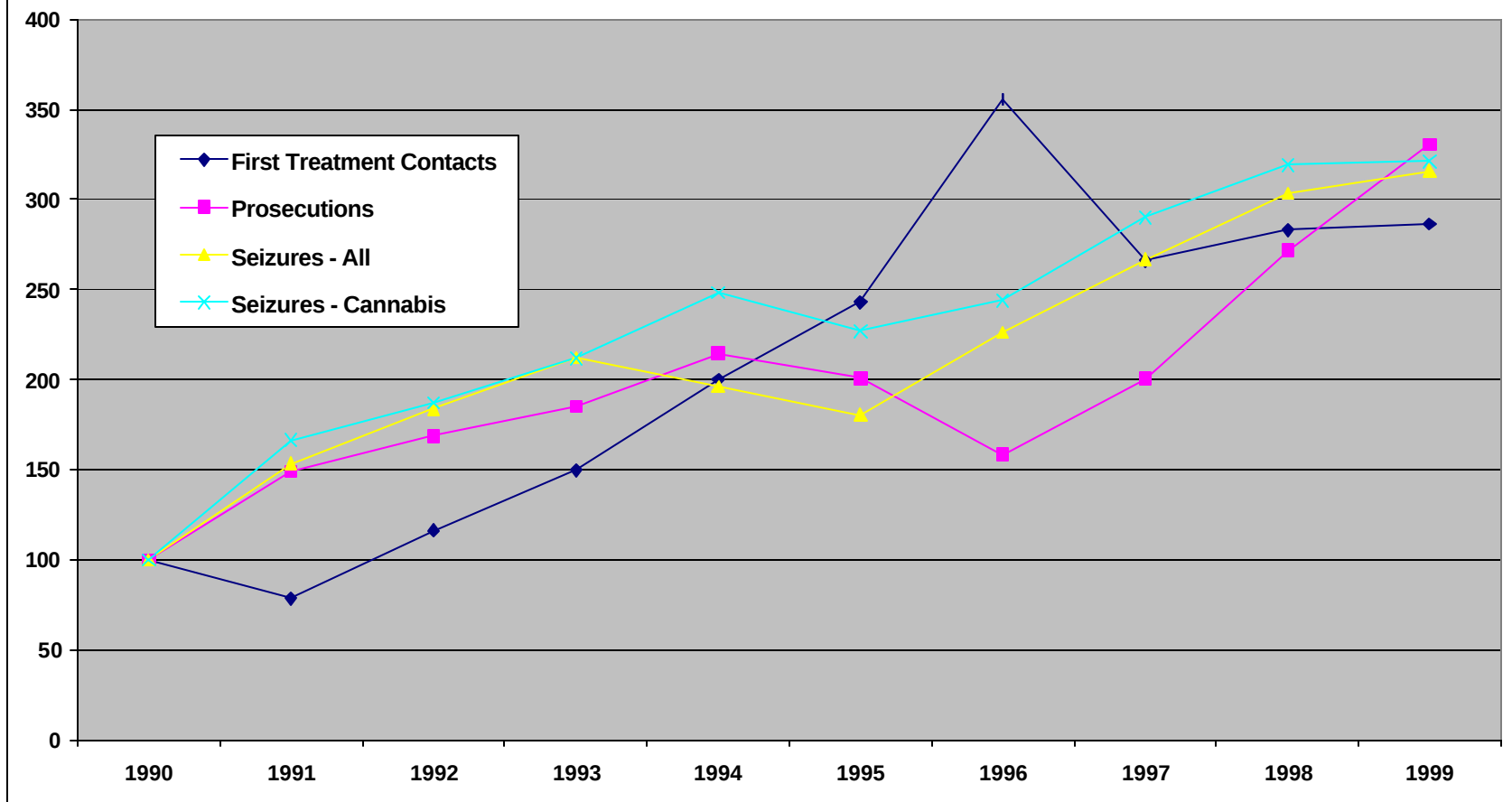
Source: Annual Reports of An Garda Síochána

Figure 7.1a Ireland 1990-1999. Indicators of Drug Misuse. Index year 1990=100.



Sources: National Drug Treatment Reporting System - Treatment
 Annual Reports of An Garda Siochana – Prosecutions, seizures
 Central Statistics Office - Deaths

Figure 7.1b Ireland 1990-1999. Indicators of Drug Misuse. Index 1990=100.



Sources: National Drug Treatment Reporting System - Treatment
 Annual Reports of An Garda Siochana – Prosecutions, seizures
 Central Statistics Office - Deaths

EMCDDA Standard Tables

STANDARD TABLE 01a: BASIC RESULTS AND METHODOLOGY OF POPULATION SURVEYS ON DRUG USE

NOTES: Include information on national (or relevant regional) surveys on drug use conducted during the last five years
 Here only summarised results are requested. In Table (PO-SUR-A) results are requested broken down by five years age groups.
 Age groups presented are partly due to maintenance of consistency with other EMCDDA indicators and other International Organizations

COUNTRY Ireland	All adults			Young adults			Broad age groups														
DRUGS (important: see "drug definitions" in the Methodology box)	LIFETIME PREVALENCE (%)																				
	15-64			15-34			15-24			25-34			35-44			45-54			55-64		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1. any illegal drugs	11.0	6.3	8.5	18.3	9.5	13.4	23.2	12.9	17.9	13.6	7.1	9.8	7.2	4.1	5.5	4.7	3.4	4.1	2.8	2.6	2.0
2. cannabis	23.1	16.5	19.9	36.7	24.6	30.0	37.9	29.1	33.4	35.5	21.6	27.4	21.3	14.6	17.6	12.0	5.1	8.8	3.1	1.0	2.0
3. opiates (total)																					
4. heroin																					
5. other opiates (specify)																					
5. cocaine (total, including crack)																					
8. amphetamines																					
9. ecstasy																					
10. hallucinogens (total)																					
11. LSD																					
12. other hallucinogens (specify)																					
13. hypnotics and sedatives (total)																					
14. benzodiacepines																					
15. other medic. (specify)																					
16. solvents																					
17. steroids																					
18. other (specify)																					

M = Male / F = Female / T= Total

COUNTRY	All adults			Young adults			Broad age groups														
DRUGS (important: see "drug definitions" in the Methodology box)	LAST 12 MONTHS PREVALENCE (%)																				
	15-64			15-34			15-24			25-34			35-44			45-54			55-64		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1. any illegal drugs																					
2. cannabis	11.9	7.3	9.4	22.9	13.4	17.7	30.3	21.9	26.0	15.7	7.5	10.9	4.5	2.2	3.2	1.9	1.4	1.7	0.5	0.5	0
3. opiates (total)	0.4	0.1	0.2	0.8	0.2	0.5	0.7	0.4	0.5	0.9	0.1	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
4. heroin	0.5	0.2	0.3	1.1	0.3	0.7	0.9	0.6	0.8	1.2	0.1	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
5. other opiates (specify)	0.2	0.0	0.1	0.5	0.2	0.3	0.5	0.2	0.3	0.6	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
5. cocaine (total, including crack)	1.9	0.8	1.3	4.1	1.5	2.6	4.9	2.1	3.4	3.3	1.1	2.0	0.2	0.1	0.2	0.0	0.0	0.1	0.0	0.0	0
8. amphetamines	3.7	1.5	2.6	8.2	3.1	5.4	11.7	6.1	8.8	4.9	1.0	2.6	0.5	0.0	0.2	0.0	0.3	0.1	0.0	0.0	0
9. ecstasy	3.0	1.8	2.4	6.5	3.6	4.9	9.6	6.7	8.1	3.7	1.4	2.4	0.3	0.1	0.2	0.5	0.3	0.4	0.0	0.0	0
10. hallucinogens (total)	2.1	0.4	1.4	4.6	1.4	2.8	7.6	2.4	4.9	1.9	0.8	1.2	0.2	0.4	0.3	0.3	0.0	0.1	0.0	0.0	0
11. LSD	2.0	0.9	1.4	4.3	1.8	2.9	6.3	3.1	5.1	1.5	0.9	1.1	0.2	0.3	0.2	0.3	0.0	0.1	0.0	0.0	0
12. other hallucinogens (specify)	2.3	0.6	1.4	5.0	1.1	2.8	8.0	1.6	4.7	2.3	0.7	1.3	0.2	0.4	0.3	0.3	0.0	0.1	0.0	0.0	0
13. hypnotics and sedatives (total)	1.3	1.2	1.2	1.8	1.1	1.4	2.7	1.6	2.1	1.0	0.7	0.8	0.5	0.8	0.7	1.2	2.2	1.7	1.1	1.2	1
14. benzodiazepines																					
15. other medic. (specify)																					
16. solvents	0.5	0.2	0.3	1.2	0.4	0.8	1.8	1.0	1.4	0.6	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0
17. steroids																					
18. other (specify)																					

M = Male / F = Female / T= Total

COUNTRY	All adults			Young adults			Broad age groups														
DRUGS (important: see "drug definitions" in the Methodology box)	LAST 30 DAYS PREVALENCE (%)																				
	15-64			15-34			15-24			25-34			35-44			45-54			55-64		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	
1. any illegal drugs																					
2. cannabis	7.2	3.2	5.1	14.1	6.0	9.7	20.7	10.0	15.3	7.8	3.1	5.1	2.2	0.7	1.3	1.6	0.7	1.2	0.5	0.5	
3. opiates (total)																					
4. heroin																					
5. other opiates (specify)																					
5. cocaine (total, including crack)																					
8. amphetamines																					
9. ecstasy																					
10. hallucinogens (total)																					
11. LSD																					
12. other hallucinogens (specify)																					
13. hypnotics and sedatives (total)																					
14. benzodiazepines																					
15. other medic. (specify)																					
16. solvents																					
17. steroids																					
18. other (specify)																					

M = Male / F = Female / T= Total

TABLE TAB 01a:

METHODOLOGY

REFERENCE:	SLAN (Survey of Lifestyle, Attitudes and Nutrition). Dept. Health Promotion, NUI, Galway. Drug section of s
year	1998
single/repeated study	to be repeated, four years
context (health/crime/drugs only...)	health and lifestyle behaviours
area covered	national, Republic of Ireland
age range	18+ years
data collection procedure	postal, self-administered questionnaire
sample size	10,415
sampling frame	Electoral register
sampling procedures	proportionate random sample based on Health Board population size, and urban/rural breakdown.
oversampled groups	none
weighting procedures	none
response rate 15-69 (M,F,T) 15-34 (M,F,T)	Total n=6539, 62.2%
Remarks	

DRUGS DEFINITIONS	Provide a detailed description of what is included in each drug category
1. any illegal drugs	tranquilisers or sedatives, amphetamine, LSD, cocaine, heroin, ecstasy, solvents, magic mushrooms
2. cannabis	marijuana or cannabis
3. opiates (total)	
4. heroin	heroin
5. other opiates (specify)	
5. cocaine (total, including crack)	cocaine (coke, crack)
8. amphetamines	amphetamines
9. ecstasy	ecstasy (E, XTC)
10. hallucinogens (total)	LSD and magic mushrooms
11. LSD	LSD (acid, trips)
12. other hallucinogens (specify)	magic mushrooms (pucal, mushies)
13. hypnotics and sedatives (total)	tranquilisers or sedatives without prescription (barbs, downers, jellies)
14. benzodiazepines	
15. other medic. (specify)	
16. solvents	solvents (e.g. glue, gas)
17. steroids	
18. other (specify)	

STANDARD TABLE 01b: BASIC RESULTS AND METHODOLOGY OF POPULATION SURVEYS ON DRUG USE

NOTES: Include information on national (or relevant regional) surveys on drug use conducted during the last five years
 Here only summarised results are requested. In Table (PO-SUR-A) results are requested broken down by five years age groups.
 Age groups presented are partly due to maintenance of consistency with other EMCDDA indicators and other International Organizations

COUNTRY Ireland	All adults			Young adults			Broad age groups														
DRUGS (important: see "drug definitions" in the Methodology box)	LIFETIME PREVALENCE (%)																				
	15-64**			15-34**			15-24**			25-34			35-44			45-54			55-64		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1. any illegal drugs																					
2. cannabis	17.5	10.9	14.2	28.7	23.3	26.2	32.3	32.3	32.3	23.6	16.0	19.6	12.9	5.4	9.0	9.2	4.9	6.7	4.7	0.0	2
3. opiates (total)																					
4. heroin																					
5. other opiates (specify)																					
5. cocaine (total, including crack)																					
8. amphetamines																					
9. ecstasy																					
10. hallucinogens (total)																					
11. LSD																					
12. other hallucinogens (specify)																					
13. hypnotics and sedatives (total)																					
14. benzodiazepines																					
15. other medic. (specify)																					
16. solvents																					
17. steroids																					
18. other (specify)																					

M = Male / F = Female / T= Total

** minimum age is 18 years

COUNTRY	All adults			Young adults			Broad age groups														
DRUGS (important: see "drug definitions" in the Methodology box)	LAST 12 MONTHS PREVALENCE (%) <i>not collected</i>																				
	15-64**			15-34**			15-24**			25-34			35-44			45-54			55-64		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1. any illegal drugs																					
2. cannabis																					
3. opiates (total)																					
4. heroin																					
5. other opiates (specify)																					
5. cocaine (total, including crack)																					
8. amphetamines																					
9. ecstasy																					
10. hallucinogens (total)																					
11. LSD																					
12. other hallucinogens (specify)																					
13. hypnotics and sedatives (total)																					
14. benzodiazepines																					
15. other medic. (specify)																					
16. solvents																					
17. steroids																					
18. other (specify)																					

M = Male / F = Female / T= Total

COUNTRY	All adults			Young adults			Broad age groups														
DRUGS (important: see "drug definitions" in the Methodology box)	LAST 30 DAYS PREVALENCE (%) <i>not collected</i>																				
	15-64**			15-34**			15-24**			25-34			35-44			45-54			55-64		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1. any illegal drugs																					
2. cannabis																					
3. opiates (total)																					
4. heroin																					
5. other opiates (specify)																					
5. cocaine (total, including crack)																					
8. amphetamines																					
9. ecstasy																					
10. hallucinogens (total)																					
11. LSD																					
12. other hallucinogens (specify)																					
13. hypnotics and sedatives (total)																					
14. benzodiazepines																					
15. other medic. (specify)																					
16. solvents																					
17. steroids																					
18. other (specify)																					

M = Male / F = Female / T= Total

METHODOLOGY

REFERENCE:	Bryan,A., Moran,R., Farrell,E. and O'Brien,M. (2000) <i>Drug-Related Knowledge, Attitudes and Beliefs in Ireland</i>
year	1998
single/repeated study	ad hoc (to be repeated)
context (health/crime/drugs only...)	general social omnibus survey
area covered	Ireland
age range	18 years and over
data collection procedure	questionnaire, face-to-face interview
sample size	1000
sampling frame	Electoral Register
sampling procedures	two-stage proportionate to size random sampling design
oversampled groups	none
weighting procedures	none
response rate 18+ (Total)	64.5
Remarks	

DRUGS DEFINITIONS	Provide a detailed description of what is included in each drug category
1. any illegal drugs	not collected
2. cannabis	cannabis
3. opiates (total)	not collected
4. heroin	not collected
5. other opiates (specify)	not collected
5. cocaine (total, including crack)	not collected
8. amphetamines	not collected
9. ecstasy	not collected
10. hallucinogens (total)	not collected
11. LSD	not collected
12. other hallucinogens (specify)	not collected
13. hypnotics and sedatives (total)	not collected
14. benzodiazepines	not collected
15. other medic. (specify)	not collected
16. solvents	not collected
17. steroids	not collected
18. other (specify)	not collected

STANDARD TABLE 02a :
METHODOLOGY AND RESULTS OF SCHOOL SURVEYS ON DRUG USE
NOTES:

- a) Include information on national (or relevant regional) surveys on drug use conducted during the last five years
- b) A year by year estimate is asked due to the sharp increase of drug experience with age. 15-16 group is used to maintain potential comparability with previous years and other international projects

COUNTRY	Ireland		Total sample			blank cells = information not available											
DRUGS (important: see "drug definitions" in the Methodology box)	LIFETIME PREVALENCE(%)																
	(9-18)			11 12			13 14			15 16			17 18				
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T		
1. any illegal drugs	22.3	15.3	18.1	10.9	5.7	8.0	19.5	13.2	16.2	32.0	23.0	27.5	33.2	32.5	32.8		
2. cannabis	16.2	8.7	12.3	4.9	1.5	3.0	12.0	4.1	8.0	27.0	16.1	21.7	28.7	28.5	28.5		
3. opiates (total)																	
4. heroin	2.4	0.3	1.3	2.1	0.2	1.0	1.8	0.3	1.0	2.8	0.3	1.8	3.8	0.4	2.2		
5. other opiates (specify)																	
5. cocaine (total, including crack)	2.9	1.7	2.3	3.2	1.8	2.4	2.4	1.6	2.0	3.0	1.5	2.2	4.8	2.1	3.5		
8. amphetamines	3.9	1.3	2.6	1.9	0.3	1.0	2.4	0.7	1.5	6.1	2.2	4.2	8.0	5.3	6.6		
9. ecstasy	3.3	0.6	2.1	2.3	0.2	1.2	2.4	0.2	1.3	4.3	1.3	2.8	6.8	4.3	5.7		
10. hallucinogens (total)	6.8	2.0	4.4	3.8	0.5	2.0	5.2	1.6	3.4	10.3	3.3	6.9	10.0	4.9	7.5		
11. LSD	3.6	0.9	2.3	2.0	0.3	1.1	2.6	0.4	1.5	5.1	1.7	3.4	8.4	2.5	5.5		
12. other hallucinogens (specify)	5.6	1.8	3.6	3.4	0.4	1.7	4.2	1.5	2.8	8.3	2.6	5.5	7.7	3.5	5.7		
13. hypnotics and sedatives (total)	3.2	2.4	2.8	2.2	0.7	1.4	2.4	3.0	2.7	4.5	3.2	3.9	4.2	3.2	3.7		
14. benzodiazepines																	
15. other medic. (specify)																	
16. solvents	11.5	8.3	9.9	5.9	2.9	4.3	12.4	9.2	10.7	14.5	11.4	13.0	14.4	13.7	14.2		
17. steroids																	
13. other																	

COUNTRY Ireland	Total sample					blank cells = information not available											
DRUGS (important: see "drug definitions" in the Methodology box)	LAST 12 MONTHS PREVALENCE (%)																
	(9-18)			11_12			13_14			15_16			17_18				
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T		
1. any illegal drugs																	
2. cannabis	14.1	6.7	10.3	3.9	1.0	2.3	10.1	3.1	6.5	23.8	12.7	18.3	25.8	22.4	24.0		
3. opiates (total)																	
4. heroin																	
5. other opiates (specify)																	
5. cocaine (total, including crack)																	
8. amphetamines																	
9. ecstasv																	
10. hallucinogens (total)																	
11. LSD																	
12. other hallucinogens (specify)																	
13. hypnotics and sedatives (total)																	
14. benzodiacepines																	
15. other medic. (specify)																	
16. solvents																	
17. steroids																	
13. other																	

COUNTRY Ireland	Total sample					blank cells = information not available											
DRUGS (important: see "drug definitions" in the Methodology box)	LAST 30 DAYS PREVALENCE (%)																
	(9-18)*			11 12			13 14			15 16			17 18				
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T		
1. any illegal drugs	12.8	7.4	10.0	6.9	3.4	5.0	11.9	6.8	9.3	18.0	10.8	14.4	15.0	13.4	14.3		
2. cannabis	8.9	3.1	5.9	2.3	0.5	1.3	7.1	1.5	4.3	15.3	5.7	10.5	11.6	10.4	11.0		
3. opiates (total)																	
4. heroin	1.8	0.1	0.9	1.7	0.1	0.8	1.4	0.2	0.8	1.9	0.1	1.0	3.4	0.4	2.0		
5. other opiates (specify)																	
5. cocaine (total, including crack)	2.2	1.2	1.7	2.3	1.6	1.9	2.1	0.2	1.6	2.1	0.9	1.5	2.7	0.7	1.8		
8. amphetamines	2.5	0.6	1.6	1.3	0.2	0.7	1.6	0.2	0.9	3.8	0.9	2.4	5.7	3.9	4.9		
9. ecstasy	2.2	0.5	1.3	1.2	0.1	0.6	1.8	0.1	0.9	3.1	0.6	1.9	4.2	2.9	3.7		
10. hallucinogens (total)	3.5	0.9	2.2	2.4	0.2	1.2	2.8	0.8	1.8	4.6	1.4	3.0	6.1	2.2	4.2		
11. LSD	2.2	0.3	1.3	1.3	0.1	0.8	1.7	0.2	0.9	2.7	0.5	1.7	5.3	1.8	3.7		
12. other hallucinogens (specify)	2.8	0.6	1.7	2.2	0.1	1.1	2.3	0.7	1.4	3.7	1.1	2.3	3.0	0.7	2.0		
13. hypnotics and sedatives (total)	1.8	1.1	1.4	1.2	0.4	0.8	1.4	1.4	1.4	2.2	1.5	1.9	2.7	1.1	2.1		
14. benzodiazepines																	
15. other medic. (specify)																	
16. solvents	8.0	3.7	4.8	4.5	1.6	2.9	6.7	4.6	5.7	6.7	0.5	5.9	5.3	2.5	4.1		
17. steroids																	
13. other																	

* 9-18 included here

METHODOLOGY Standard Table 2a

REFERENCE:	Irish Health Behaviours in Schools Survey, Dept. Health Promotion, NUI Galway. Not yet published.
year	1998
single/repeated study	Single, to be repeated in 2002
context (health/crime/drugs only...)	Health behaviours and perceptions
area covered	National: Republic of Ireland - 26 counties
type of school	All
age range	9-18 included here
data coll procedure	self-completed questionnaire
sample size	8497
sampling frame	School, primary and post-primary from Department of Education & Science lists
sampling procedures	Two-stage random sample, within Health Board regions and classrooms
oversampled groups	none
weighting procedures	none applied here
absents of school at the time of survey	6% in primary schools, 14% in post-primary schools
response rate (M,F,T)	92% of primary schools, 86% of post-primary schools. Total, including absentees = 73%. Gender break

DRUGS DEFINITIONS	Provide a detailed description of what is included in each drug category
1. any illegal drugs	tranquilisers or sedatives, amphetamine, LSD, cocaine, heroin, ecstasy, solvents, magi
2. cannabis	marijuana (grass, pot) or cannabis (hash, hash oil)
3. opiates (total)	
4. heroin	heroin (smack, skag)
5. other opiates (specify)	
5. cocaine (total, including crack)	cocaine (coke, crack)
8. amphetamines	amphetamines (speed, whizz)
9. ecstasy	ecstasy (E, XTC)
10. hallucinogens (total)	LSD and magic mushrooms
11. LSD	LSD (acid, trips)
12. other hallucinogens (specify)	magic mushrooms (pucal, mushies)
13. hypnotics and sedatives (total)	tranquilisers or sedatives without prescription (barbs, downers, jellies)
14. benzodicepines	
15. other medic. (specify)	
16. solvents	solvents (e.g. glue, gas)
17. steroids	
18. other (specify)	

METHODOLOGY AND RESULTS OF SCHOOL SURVEYS ON DRUG USE

STANDARD TABLE 02b :

NOTES:

a) Include information on national (or relevant regional) surveys on drug use conducted during the last five years

b) A year by year estimate is asked due to the sharp increase of drug experience with age. 15-16 group is used to maintain

potential comparabilty with previous years and other international projects

COUNTRY	Ireland	Total sample					blank cells=information not available									
DRUGS (important: see "drug definitions" in the Methodology box)		LIFETIME PREVALENCE (%)														
		(10-18)*			11_12 na			13_14 na			15_16 na			17_18 na		
		M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1. any illegal drugs																
2. cannabis		25.9	14.5	20.5												
3. opiates (total)																
4. heroin		1.9	0.4	1.1												
5. other opiates (specify)																
5. cocaine (total, including crack)		2.8	1.2	2.0												
8. amphetamines		6.3	2.8	4.6												
9. ecstasy		4.6	1.6	3.1												
10. hallucinogens (total)																
11. LSD		4.8	1.7	3.3												
12. other hallucinogens (specify)		7.4	2.5	5.1												
13. hypnotics and sedatives (total)		3.7	3.0	3.3												
14. benzodicepines																
15. other medic. (specify)																
16. solvents		15.1	9.9	12.6												
17. steroids																
13. other																

* age group (10-18)

COUNTRY	Total sample			blank cells=information not available											
DRUGS (important: see "drug definitions" in the Methodology box)	LAST 12 MONTHS PREVALENCE (%) not available														
	e.g. (12-18)			11_12			13_14			15_16			17_18		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
1. any illegal drugs															
2. cannabis															
3. opiates (total)															
4. heroin															
5. other opiates (specify)															
5. cocaine (total, including crack)															
8. amphetamines															
9. ecstasy															
10. hallucinogens (total)															
11. LSD															
12. other hallucinogens (specify)															
13. hypnotics and sedatives (total)															
14. benzodiacepines															
15. other medic. (specify)															
16. solvents															
17. steroids															
13. other															

COUNTRY	Total sample					blank cells=information not available											
DRUGS (important: see "drug definitions" in the Methodology box)	LAST 30 DAYS PREVALENCE (%)																
	(10-18) *			11_12 na			13_14 na			15_16 na			17_18 na				
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T		
1. any illegal drugs																	
2. cannabis	14.4	6.2	10.5														
3. opiates (total)																	
4. Heroin **	1.3	0.5	0.9														
5. other opiates (specify)																	
5. cocaine (total, including crack)**	2.1	0.8	1.5														
8. Amphetamines **	4.5	2.0	3.4														
9. Ecstasy **	4.2	1.4	2.9														
10. hallucinogens (total)																	
11. LSD**	2.7	1.2	2.0														
12. other hallucinogens (specify)**	4.7	1.5	3.2														
13. hypnotics and sedatives (total)**	2.0	1.9	1.9														
14. benzodiacepines																	
15. other medic. (specify)																	
16. Solvents**	8.7	5.3	7.1														
17. steroids																	
13. other																	

**post-primary schools only

METHODOLOGY

REFERENCE:	Rhatigan,A., & Shelley, E. (1999) <u>Health behaviours of school pupils in the Eastern Health Board</u> . Dublin: Eastern Health Board.
year	1998
single/repeated study	single
context (health/crime/drugs only...)	health
area covered	Local: Eastern Health Board area
type of school	Primary and post-primary schools
age range	10-18 year olds
data coll procedure	self-administered questionnaire (based on WHO Health Behaviour in school-aged children questionnaire)
sample size	6081
sampling frame	Schools list
sampling procedures	A random sample of schools stratified by county and by school type (the latter in the case of post-primary schools only)
oversampled groups	none
weighting procedures	none
absents of school at the time of survey	pupils: absent (n=674); refused (n=24); parental consent not given (n=264)
response rate (M,F,T)	T=78.2%. Gender not reported

DRUGS DEFINITIONS	Provide a detailed description of what is included in each drug category
1. any illegal drugs	not reported
2. cannabis	cannabis or marijuana
3. opiates (total)	not reported
4. heroin	heroin, smack, skag
5. other opiates (specify)	not reported
5. cocaine (total, including crack)	cocaine, coke, crack
8. amphetamines	amphetamine, speed, whizz
9. ecstasy	ecstasy, E, XTC
10. hallucinogens (total)	not reported
	LSD, acid,
11. LSD	trips
12. other hallucinogens (specify)	magic mushrooms, pucai, mushies
13. hypnotics and sedatives (total)	tranquilisers, sedatives, barbs, downers, jellies, (without a doctors prescription)
14. benzodiazepines	not reported separately
15. other medic. (specify)	not reported
16. solvents	solvents, glue, gas
17. steroids	not reported
18. other (specify)	drugs by injection with a needle

STANDARD TABLE 04: EVOLUTION OF TREATMENT DEMANDS (A) ALL TREATMENTS

COUNTRY Ireland 1995-1999. Dublin 1990-1994										
CHARACTERISTICS	1990*	1991*	1992*	1993*	1994*	1995	1996	1997	1998	1999
Nr. of ALL treatment cases/demands	1575	1722	1931	2043	2250	3609	3924	3879	5081	4277
Sex distr. Male (%) / Female (%)	76/24	78/22	78/22	78/22	81/19	80/20	73/27	70/30	71/29	70/30
Mean age (years)	25	25.3	24.7	23.7	22.8	22.6	22.8	23.6	24.3	24.6
Age distribution <15	1	1.7	2	1.2	2.1	1.3	1	0.8	0.7	0.7
15-19	17.6	15.7	20.1	26.4	33.4	35.8	34	28.6	23.9	21
(%) 20-24	32.2	28.8	31.2	34.4	33.3	35.7	36.4	35.6	35.8	36.9
25-29	29.4	31.6	25.2	21.2	17.1	14.6	14.7	18.4	20.6	22
30-34	12.9	14.2	14.6	10.7	9.8	7.2	8.7	10.3	10.6	10.8
35-39	4.7	5.5	5	3.9	3	3	3.2	4.1	5.3	5.6
40-44	1.5	1.5	1.3	1.7	0.8	1.4	1.3	1.2	1.8	1.7
45-49	0.2	0.8	0.3	0.2	0.4	0.5	0.7	0.7	0.8	0.7
50-54	0.2	0.1	0.2	0	0.1	0.3	0.1	0.1	0.3	0.4
55-59	0.1	0	0.1	0	0	0.1	0.1	0.1	0.1	0.1
60-64	0.1	0.1	0	0	0	0.1	0	0.1	0.1	0.1
>=65	0	0	0	0	0	0.1	0	0.1	0	0
Number of cases with missing inform on ag	36	33	13	10	15	19	10	15	18	20
Currently injecting any drug (%)	53.1	50.4	51.8	50.8	46	32.4	31.8	38.1	36.7	34.4
Ever injected any drug but not currently (%)	24.2	23.1	17.4	17.1	18.1	16.5	16	18.8	23.5	24.9
Ever injected any drug (%)	78.4	75.8	70	68.9	64.7	50.5	48.8	58.7	63.4	61.7
IV route of ad. main drug (%)	66.3	59.9	56.8	57.8	55.3	39.4	36.9	45.3	48.7	48.8

Main/primary drug (%) -- (% IV use)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)
Opiates (total)	78.2(84)	75.1(79)	72.8(77)	77.3(75)	80.5(69)	72.1(55)	76.9(48)	77.2(59)	78.8(62)	73.3(66)
Heroin	34.6(88)	34.9(85)	35.0(78)	49.3 (76)	59.0(69)	62.1(54)	71.3(49)	69.0(64)	70.8(67)	68.6(69)
Methadone (any)	1.7(16)	3.5(5)	4.7(3)	5.2 (1)	4.8(12)	3.4(0)	2.9(0)	6.4(5)	5.6(4)	3.1(11)
other opiates	41.8(83)	36.7(81)	33.0(86)	22.8(89)	16.7(84)	6.6(89)	2.6(74)	1.8(57)	1.7(69)	1.7(51)
Cocaine (total)	0.7(18)	0.4(0)	0.5(30)	0.3(0)	0.4(13)	0.5(6)	0.6(9)	1.0(11)	1.6(11)	1.2(14)
Cocaine CIH	0.7(18)	0.4(0)	0.5(33)	0.3(0)	0.3(17)	0.5(6)	0.6(9)	0.9(11)	1.5(11)	1.1(15)
Crack	0	0	0.1(0)	0	0.1(0)	0	0	0	0	0
Stimulants (total)	0.3(0)	0.8(8)	3.3(2)	5.1(2)	3.3(1)	8.0(0)	6.5(0)	7.1(0)	4.9(0)	6.4(2)
Amphetamines	0.3(0)	0.5(13)	0.5(0.0)	0.6(17)	0.5(9)	0.4(7)	0.4(7)	1.3(0)	1.4(2)	1.4(10)
MDMA and derivates	0	0.3(0)	2.8(2)	4.4(0)	2.8(0)	7.4(0)	6.0(0)	5.8(0)	3.6(0)	4.9(0)
other stimulants	0	0	0	0	0	0.2(0)	0.1(0)	0	0	0
Hypnot. and sedat. (total)	3.8(7)	5.2(0)	3.7(11)	2.8(0)	1.6(6)	2.3(1)	1.5(2)	1.7(3)	2.1(2)	1.4(0)
Barbiturates	0	0.3(0)	0	0.1(0)	0	0.1(33)	0	0	0	0
Benzodiazepines	3.6(7)	4.7(0)	3.5(12)	2.2(0)	1.5(6)	1.8(0)	0.9(3)	1.3(2)	1.8(2)	1.1(0)
others	0.1(0)	0.2(0)	0.3(0)	0.6(0)	0.1(0)	0.4(0)	0.6(0)	0.4(7)	0.3(0)	0.2(0)
Hallucinogens (total)	0.3(20)	0.8(8)	1.4(4)	2.1(2)	1.8(0)	1.4(0)	0.4(6)	0.6(0)	0.3(0)	0.2(0)
LSD	0.3(20)	0.7(8)	1.4(4)	2.1(2)	1.4(0)	1.1(0)	0.4(6)	0.6(0)	0.3(0)	0.2(0)
others	0	0.1(0)	0	0	0.3(0)	0.3(0)	0	0	0	0
Volatile inhalants (total)	2.4(0)	2.5(0)	2.5(0)	0.9(0)	0.9(0)	0.7(0)	0.6(0)	0.6(0)	0.7(0)	0.6(0)
Cannabis (total)	13.4(1)	14.5(1)	15.3(1)	11.4(0)	11.5(0)	14.9(0)	13.4(0)	11.8(0)	12.1(0)	16.6(0)
Others substance (total)	0.8(8)	0.6(0)	0.5(11)	0.3(0)	0.1(0)	0.2(0)	0.1(0)	0	0.1(0)	0.3(0)
Nr. Inpatient / Residential UNITS reporting	3	2	2	2	2	5	11	18	18	17
Nr. Outpatient / Nonresidential UNITS reporting	8	9	10	10	11	13	31	45	76	75
Nr. Low threshold UNITS reporting	1	1	1	0	0	2	1	2	6	7
Nr. General Practitioners reporting	1	1	0	0	0	4	4	0	1	32
Nr. Treatment Unit in Prison UNITS reporting	3	2	2	1	1	2	1	0	0	2
Remarks on coverage changes (1)	see footnote	see footnote	see footnote	see footnote	see footnote	see footnote	see footnote	see footnote	see footnote	see footnote

(1) residential, non-residential(very good coverage); GPs(1990-1998(poor coverage), 1999(good coverage), prisons(poor coverage). The incorporation of GPs w

* Dublin

TABLE TAB 04: EVOLUTION OF TREATMENT DEMANDS (B) FIRST TREATMENTS

COUNTRY Ireland 1995-1999. Dublin 1990-1994										
CHARACTERISTICS	1990*	1991*	1992*	1993*	1994*	1995	1996	1997	1998	1999
Nr. of FIRST treatment cases/demands	624	450	668	859	1150	1870	2014	1465	1621	1636
Sex distr. Male (%) / Female (%)	75/25	81/19	79/21	80/20	83/17	80/20	73/27	72/28	74/26	73/27
Mean age (years)	22.8	21.9	21.5	21.1	20.6	21.1	21.3	22	22.1	22.7
Age distribution <15	2.3	5.4	5.1	2.3	3.5	2.4	1.7	1.6	1.6	1.5
15-19	33.1	34.9	37	42.4	47.8	45.9	44.1	38.3	36.5	32.2
(%) 20-24	33.6	34.2	35.8	36.6	32.8	33.7	34.8	36.5	36.2	38.2
25-29	17.5	14.4	12.8	11.9	9.3	10.7	11.3	14	15.8	16.3
30-34	7.8	7	53.7	4.2	5	4	4.5	5.3	5.4	6.4
35-39	3.6	2.3	2.7	1.8	1.2	1.7	2.2	2.7	2.6	3.2
40-44	1.6	0.5	0.5	0.4	0.3	0.9	0.8	1	0.9	1.3
45-49	0	0.9	0.3	0	0.1	0.3	0.5	0.3	0.4	0.3
50-54	0.2	0.2	0.2	0	0.1	0.3	0.1	0.1	0.4	0.3
55-59	0.2	0	0	0	0	0.1	0	0	0.1	0.1
60-64	0	0.2	0	0	0	0	0	0.1	0.1	0.2
>=65	0.2	0	0	0	0	0.1	0	0.1	0	0
Number of cases with missing inform on ag	8	6	3	2	5	6	2	5	4	10
Currently injecting any drug (%)	38.7	31.3	31.7	38.8	36.8	19.8	20.9	24.6	22.8	22.7
Ever injected any drug but not currently (%)	17.7	11.9	9.5	11.4	15.4	10.9	10.8	11	12	15.2
Ever injected any drug (%)	58.9	44.2	41.7	50.8	52.5	32	32.1	36.8	37.2	39.3
IV route of ad. main drug (%)	48.3	36.2	33.9	44.1	46.7	23.8	24.3	29.3	28.8	30.6

Main/primary drug (%) -- (% IV use)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)	dr. % (IV%)
Opiates (total)	61.1(78)	49.0(73)	48.9(67)	64.0(69)	74.7(62)	60.5(39)	65.5(37)	61.2(48)	59.8(48)	55.4(55)
Heroin	22.1(83)	24.0(74)	26.3(61)	46.2(67)	59.0(63)	54.5(38)	63.1(37)	58.6(49)	56.3(50)	53.2(56)
Methadone (any)	1.2(29)	1.1(20)	1.4(0)	2.6(0)	3.7(12)	2.2(0)	1.3(0)	1.7(4)	2.5(3)	1.2(15)
other opiates	37.6(77)	23.8(75)	21.2(79)	15.2(85)	12.0(77)	3.8(87)	1.2(48)	0.8(50)	1.0(50)	1.1(39)
Cocaine (total)	1.0(0)	1.1(0)	0.6(50)	0.4(0)	0.3(0)	0.5(0)	0.8(6)	1.4(0)	2.0(0)	1.6(8)
Cocaine CIH	1.0(0)	1.1(0)	0.6(50)	0.4(0)	0.3(0)	0.5(0)	0.8(7)	1.4(0)	1.9(0)	1.6(8)
Crack	0	0	0	0	0	0	0.1(0)	0	0.1(0)	0
Stimulants (total)	0.5(0)	1.1(0)	5.9(3)	8.6(1)	4.1(0)	11.6(0)	10.4(1)	13.1(0)	9.6(0)	11.0(1)
Amphetamines	0.5(0)	0.7(0)	0.2(0)	0.7(17)	0.5(0)	0.4(0)	0.6(8)	2.2(0)	2.3(0)	2.1(6)
MDMA and derivates	0	0.5(0)	5.7(3)	7.9(0)	3.6(0)	11.0(0)	9.6(0)	10.8(0)	7.3(0)	8.8(0)
other stimulants	0	0	0	0	0	0.2(0)	0.2(0)	0.1(0)	0.1(0)	0
Hypnot. and sedat. (total)	5.7(9)	5.5(0)	4.5(3)	2.6(0)	1.0(0)	1.8(0)	1.1(0)	1.7(0)	1.9(0)	1.0(0)
Barbiturates	0	0.5(0)	0	0	0	0.1(0)	0	0	0	0
Benzodiazepines	5.3(9)	4.8(0)	4.2(4)	2.0(0)	0.8(0)	1.1(0)	0.7(0)	1.3(0)	1.5(0)	0.8(0)
others	0.3(0)	0.2(0)	0.3(0)	0.6(0)	0.2(0)	0.7(0)	0.5(0)	0.5(0)	0.4(0)	0.2(0)
Hallucinogens (total)	0.5(0)	1.8(0)	2.4(0)	3.6(0)	2.3(0)	1.9(0)	0.5(0)	0.8(0)	0.4(0)	0.2(0)
LSD	0.5(0)	1.6(0)	2.4(0)	3.6(0)	1.7(0)	1.6(0)	0.5(0)	0.8(0)	0.4(0)	0.2(0)
others	0	0.2(0)	0	0	0.5(0)	0.3(0)	0	0	0	0.1(0)
Volatile inhalants (total)	4.7(0)	6.6(0.0)	5.4(0)	1.6(0)	1.1(0)	1.0(0)	0.9(0)	0.8(0)	1.4(0)	1.2(0)
Cannabis (total)	25.4(0.7)	34.1(0.7)	30.9(1)	18.6(0)	16.3(1)	22.4(0)	20.7(0)	21.0(0)	24.7(0)	29.4(0)
Others substance (total)	1.2(0)	0.7(0)	1.4(11)	0.6(0)	0.3(0)	0.2(0)	0.1(0)	0	0.3(0)	0.2(0)
Nr. Inpatient / Residential UNITS reporting	2	2	2	2	2	5	10	13	16	12
Nr. Outpatient / Nonresidential UNITS reporting	8	7	9	10	11	13	29	40	72	69
Nr. Low threshold UNITS reporting	1	1	1	0	0	2	1	1	2	4
Nr. General Practitioners reporting	1	0	0	0	0	4	3	0	1	19
Nr. Treatment Unit in Prison UNITS reporting	3	2	1	1	1	2	1	0	0	2
Remarks on coverage changes (1)										

(1) Incorporation of GPs greatly improved in 1999.

method of data collection (eventual changes over time)	Standard questionnaire completed [hard copy] at treatment agencies and returned to HRB Changes have been made to original questionnaire to ensure compatibility with TDI standard
geographical coverage (eventual changes over time)	1990-1995 Dublin only; 1995-1999 Ireland
FIRST TREATMENT	
Definition of case	An individual who received treatment for the first time, i.e. had never previously been treated anywhere for pro
Double-counting controlled (Y)	Double counting within centres is checked. Should be no double counting, as these are first time ever contacts
(eventual changes over time)	From 2000 onwards, an anonymous attributor code will be used to avoid double counting
ALL TREATMENTS	
Definition of case	Treatment contacts during a given year, excluding 'carryover clients' (those in continuous treatment since year)
Double-counting controlled (Y)	Double counting within centres checked; double counting between centres not possible up to now.
(eventual changes over time)	From 2000 onwards, an anonymous attributor code will be used to avoid double counting.
Remarks	
Changes in coverage	GPS and Prisons to be included in the NDTRS. Possibility of inclusion of Needle Exchange Programmes being

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STANDARD TABLE 16: PRICE*** IN EUROS AT STREET LEVEL OF SOME ILLEGAL SUBSTANCES

Please, fill in this table for each routine statistic or ad-hoc study reporting on price of illicit drugs

NAME OF THE SOURCE: Garda National Drugs Unit															
COUNTRY: Ireland															
YEAR	1995			1996			1997			1998			1999		
SIZE OF THE SAMPLE	N = not known			N = not known			N = not known			N = not known			N = not known		
	Min.	Max.	Average	Min.	Max.	Average	Min.	Max.	Average	Min.	Max.	Average	Min.	Max.	Average
Cannabis resin (per gram)	na	na	13	na	na	13	na	na	13	na	na	13	na	na	13
Cannabis leaves (per gram)	na	na	3	na	na	3	na	na	3	na	na	3	na	na	3
Heroin brown (per gram)	100	300	190	100	300	190	100	300	190	100	300	190	100	300	190
Heroin white (per gram)	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na
Cocaine powder (per gram)	na	na	102	na	na	102	na	na	102	na	na	102	na	na	102
Crack (per rock)	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na
Amphetamines powder (per gram)	10	13	12	10	13	12	10	13	12	10	13	12	10	13	12
'Ecstasy' (per tablet)	19	25	22	10	15	13	10	15	13	10	13	12	10	13	12
LSD (per dose)	10	15	13	10	15	13	10	15	13	10	15	13	10	15	13
na: not available															
<i>Methodological comments</i>															
Type of study:	ad-hoc - estimations of street prices by police, from street work														
Geographical coverage:	local (Dublin prices - number of sites covered not known)														
Sampling frame:	street work by police														
Sampling bias:	police intervention														
Price reported by:	law enforcement agency - police														
Method of estimation:	user's report to police street workers														
Source references:	personal communication - police														
Bibliographic references:	personal communication - police														

PART 3

DEMAND REDUCTION INTERVENTIONS

8. Strategies in Demand Reduction at National Level : Eimear Farrell

8.1 Major strategies and activities

As outlined in Part 1, the Government's approach to drug policy is embedded in a social inclusion framework which aims to combat poverty and exclusion. The structural framework in relation to policies on reducing the demand for drugs is similar to that for the general drug policy

The general objective of the Irish national drug policy is to maintain people in, or restore people to, a drug-free lifestyle. However, it is acknowledged that this may not be a viable option for many drug users in the short term. Accordingly, a pragmatic approach has been adopted which recognises the need for harm reduction. In Ireland, as in many countries, the initial introduction of harm reduction strategies was motivated by the need to respond to the threat posed to Irish society by HIV. While a number of harm reduction initiatives have been introduced including methadone maintenance, needle exchange, outreach and low threshold programmes, Kiely & Egan (2000) argue that 'there is no strong policy framework underpinning harm reduction in relation to illicit drug use in Irish society which has meant that no legal framework has been built around the strategy of harm reduction' p.20.

The Government's drug policy involves a range of responses, which address both the causes and consequences of drug misuse as noted in Part 1. The Irish drug policy encompasses both general initiatives to tackle social exclusion and specific initiatives designed to address the drug problem. General initiatives target issues which are believed to contribute to the drug problem such as unemployment and social deprivation. Such programmes provide scope for agencies and communities affected by the drugs problem to avail of financial and other resources to tackle problems implicated in drug misuse in their communities. Two of the most important specific initiatives introduced by the Government to deal with the drug problem, are the Local Drug Task Force structures and the Young People's Facilities and Services Fund. These initiatives are described briefly below (see part 4.12 for detailed description).

Local Drugs Task Forces

Local Drugs Task Forces were established to provide a strategic local response by statutory, community and voluntary sectors, to the drugs problem in the areas worst affected. Task forces have been set up in priority areas (12 Dublin, 1 Cork,

1 Bray) where drug misuse is a serious problem. The Task Forces comprise representatives from statutory bodies such as the Health Boards, Gardaí, Local Authorities, FAS (employment) and the Vocational Education Committees as well as from voluntary and community groups.

Young People's Facilities and Services Fund (YPFSF)

This fund was established by the Government in 1998 to assist in the development of preventative strategies in a targeted manner through the development of youth facilities, including sport and recreation facilities and services in disadvantaged areas, where a significant drug problem exists or has the potential to develop. The aim of the fund is to attract "at risk" young people in disadvantaged areas into these facilities and activities, thereby diverting them from the dangers of substance misuse.

Overall, the approach to the drug problem in Ireland could be described as an integrated holistic intersectoral one which involves the co-ordination of drug programmes and services at local level and which focuses on actions to deal with the drug problem in communities where it is most severe.

In terms of financing the drug policy, the Government has overall responsibility for the provision of financial support in the drugs area which is channelled through the budgets of the relevant Government Departments, Regional Health Boards, local government structures, the Local Drugs Task Forces and the Young People's Facilities and Services Fund (YPFSF) in the context of structures set up under the National Development Plan 2000-2006 (see Part 1).

With regard to education and information provision in relation to drugs, at Government level, the Departments of Health & Children and Education & Science are responsible for education and information relating to drug misuse. The Department of Health and Children operates mainly through its Health Promotion Unit, the Regional Health Boards, and cooperates with the Community and Voluntary Sectors etc. The Department of Education and Science operates mainly through the formal education system. The two departments liaise closely on a bilateral basis and are both represented on the National Drugs Strategy Team and active in intersectoral structures set up to address the drugs issue [see Part 1]. Both departments also support initiatives in the non-formal education sector as does the Department of Tourism, Sport and Recreation.

The Department of Health and Children, through the Health Promotion Unit, is responsible for the dissemination of information on drug misuse to the general public and to at-risk groups. The Department and the Health Boards work closely with the Community and Voluntary Sectors in providing prevention programmes, and through outreach and harm reduction programmes aimed at current drug users.

The National Health Promotion Strategy produced by the Department of Health and Children during 2000, outlines a number of objectives relating to drug misuse. The principle aim of the strategy is to support models of best practice which promote the non-use of drugs and minimise the harm caused by them. The objectives include :

- to ensure each Health Board has in place a comprehensive drugs education and prevention strategy*
- to continue to support the implementation of existing drug related health promotion programmes*
- to work in partnership with relevant government departments (e.g. Department of Education and Science) and other bodies to co-ordinate health promotion activities*
- to develop prevention and education programmes with particular emphasis on schools, the youth sector and on interventions in areas where drug misuse is most prevalent.*

There has been a proliferation of local community based drug initiatives particularly in relation to drug awareness over the last number of years, owing to the increased availability of funding for projects to tackle the drug problem through the Local Drug Task Forces, the Young People's Facilities and Services Fund and other more general social inclusion initiatives. A sample of these initiatives will be presented in Section 9.1.4 – Community Programmes.

Currently, the National Drug Strategy is under review. To date, a comprehensive consultative process has taken place. Public fora have been held throughout the country and interested groups were asked to make submissions in relation to the review. Consequently, there have been no major changes in drug policy during 2000 as policy makers await the results of the review. The Minister for State with responsibility for the drugs area has promised that a revised strategy will be in place by the end of 2000. This is likely to have implications for policy in the demand reduction area.

8.2 Approaches and New Developments

• New and innovative approaches

There is an increased emphasis on rehabilitation in drug services in Ireland. This is reflected in the service plans produced by the Eastern Regional Health Authority, representing the three Health Board areas where the majority of drug users reside. The ERHA have also devised a rehabilitation/re-integration blueprint to guide the development of rehabilitation services and will be appointing three rehabilitation co-ordinators to develop the rehabilitation aspect of drug treatment.

- **Socio-cultural developments relevant to demand reduction**

In Ireland, a holistic inter-sectoral approach (health, education, employment, housing, estate management, policing etc.) has been adopted to address the drug problem which has concentrated on tackling the problem in the communities where it is most severe. This approach has focused on co-ordinating drug services at local level and involving communities in the development and delivery of locally based strategies.

A partnership approach has also prevailed in the drugs area in recent years, as reflected by the LDTF structures which include representation from community, voluntary and statutory agencies.

- **Developments in public opinion**

A survey of Knowledge, Attitudes and Beliefs towards illegal drugs & their users/misusers in Ireland was published by the Drug Misuse Research Division, of the Health Research Board during 2000. The survey on which the research was based constituted a module of the 1998 Irish Social Omnibus Survey. A total of 1,000 adults 18 years and over, randomly selected from the 1997 Register of Electors for the Republic of Ireland, took part in the study. Data was collected using face-to-face interviews between February and April 1998. The survey findings reveal that the general public in Ireland hold very negative attitudes towards individuals addicted to drugs; believe that experimentation with drugs is commonplace amongst young people; are supportive of drug prevention education in primary schools and agree with present treatment policy/options. The survey also revealed widespread public concern about the current drug situation. A very high percentage of the sample perceived all illegal drugs to be harmful to health while 56% agreed that alcohol abuse caused more problems in society than drug abuse. Respondents were also asked about their levels of knowledge of a range of illegal drugs. The study found that respondents had a good general awareness of commonly used illegal drugs. However, their perception of the general harmfulness of these substances indicates a lack of accurate knowledge about the different effects associated with different types of drugs. Consequently, the study recommends that accurate non-sensationalist information about the relative known risks associated with different types of drugs be provided to all age groups. Given the negative attitudes of the Irish general public towards drug users, the study also emphasises the need to promote more positive attitudes towards those who misuse drugs, particularly among older people and those with less education. The report concludes that a positive attitudinal climate is important to the social integration of problem drug users and to their willingness to avail of treatment.

- **New research findings**

A National Advisory Committee on Drugs has been established which has identified a three year programme of research priorities in the drugs area. The Drug Misuse Research Division is due to publish research findings in relation to drug use amongst prisoners, the ERHA mobile clinic, and cocaine use in the near future.

- **Specific events during the reporting year**

Young People and Drugs - EHB Conference

This two day conference organised by the EHB, was held in Dublin Castle on 17 and 18 of February 2000. A range of papers were presented focusing on current trends of drug use among young people, current settings for drug use and treatment and suitable responses to the problem. Practitioners, administrators and community groups addressed issues such as research, prevention, education, treatment and rehabilitation. The need for early intervention and to develop treatment programmes specifically for young people which adopt a life skills approach and if possible involve parents was emphasised.

- **Dissemination of information on demand reduction among professionals (networks, Internet, etc.)**

Drugnet Ireland

The Drug Misuse Research Division of the Health Research Board publish and distribute the newsletter "Drugnet Ireland" twice yearly. This magazine fulfils an important role in the distribution of information, news and research among health professionals and other interested parties involved in the drugs area in Ireland. Its readership includes : community groups, policy makers, academics, treatment providers and educationalists. The newsletter contains information on : ongoing research in drug misuse, recently published materials and reviews, recent and upcoming events, developments in the EU, local and world news and information on research funding and fellowships.

EDDRA

EDDRA also plays a role in the demand reduction field by raising awareness of types of demand reduction activities that are in place throughout the country. During 2000, an EDDRA brochure was developed and distributed with DrugNet Ireland and at various seminars, workshops and conferences attended by members of Drug Misuse Research Division. In addition a training session on evaluation was conducted by the Drug Misuse Research Division with regional drug co-ordinators et al. in attendance.

Regional Drug Co-ordinator Meetings

Regional drug co-ordinators have been appointed in all the health board areas with the exception of the ERHA. Regional drug co-ordinator meetings are held on a regular basis to discuss new developments in the drugs field in an Irish context.

9. Intervention Areas

9.1 Primary prevention

9.1.1 Infancy and Family

Infancy

The ERHA is in the process of employing three drug liaison midwives to make contact with substance misusing pregnant women and to liaise between the obstetric hospitals and the drug treatment services. The midwives are responsible for ensuring that the medical, psychological, obstetrical and social needs of each woman have been accurately assessed and for preparing a detailed clinical/psychological/social care plan for each women (EHB 1998). No statistics or evaluation results are available. No information on specific training is available.

Infancy and Family

The Lorien Project

The Lorien project, based in Tallaght, a large suburb of Dublin provides a range of early year's services to the children and siblings of drug users. It also provides support services for the families of drug users. The project, managed by Barnardos (a large voluntary childcare charity) has three staff members and provides a service for 60 families. No detailed statistics or evaluation results are available. No information on specific training is available.

Family

The government has made available IR£2.4 million/Euro 3.05m each year for the period 1998 to 2000 in order to set up family support projects for children and families at risk within particular communities. Projects have been established in a number of locations both urban and rural throughout the country including : Dublin, Cork, Galway and Sligo (Department of Health and Children 2000).

The Springboard Initiative

This initiative was established by the Department of Health and Children to assist vulnerable children and their families in thirteen areas throughout the country. Projects established under the initiative work intensively with children and their families and provide necessary supports, in a co-ordinated manner to strengthen the capacity of families. *No statistics or evaluation results are available. No information on specific training is available.*

Fás le Chéile (Grow Together)

Fás le Chéile is a support programme for parents of primary school children which was set up by the North Western Health Board area to train parents to act as group leaders and to run courses for parents in conjunction with local primary schools. The programme is aimed at mothers and fathers who have children in primary schools and who are interested in meeting other parents for support and information in relation to the healthy development of their family. It is based on social learning theory and the emphasis is on group discussion and peer-led facilitation. The overall purpose of the programme is to promote a positive relationship between parents and their children. The substance misuse component of the programme encourages dialogue amongst family members about drugs, provides accurate information about drugs and alcohol, increases awareness of the importance of self-esteem in preventing substance abuse and builds parents confidence and skills in handling difficult situations. An evaluation carried out in 1999 revealed that the parents were very satisfied with the programme. Participants reported that their communications and listening skills had improved with both their partners and their children. Participants also experienced an increase in confidence in their own parenting skills and they felt that the social learning approach was conducive to learning. No statistics on participation are available.

Family communication and self esteem

The programme was developed in response to a need for parents to develop skills to equip them to deal with the issue of the prevention of misuse of alcohol, drugs and other substances. The programme focuses on the parents as the primary educators and seeks to exploit the connection between prevention of drug misuse and family communication. The programme has two main aspects: parenting education and drug education. The emphasis of the programme is on: empowering and enabling participants to help themselves, building up self-esteem and developing interpersonal skills and resources. An evaluation of the programme indicated that both parents and tutors responded very positively to the programme. Parents highlighted many learning outcomes and provided concrete examples of how they have been putting into practice, new skills learned. No statistics on programme participation are available.

9.1.2 School programmes

The Department of Education and Science in collaboration with the Department of Health and Children has developed specific substance abuse prevention programmes for both primary and secondary school children. The programmes known respectively as 'On My Own Two Feet' and 'Walk Tall' place an emphasis on self-esteem, feelings, influences, drug awareness and decision-making skills to help children withstand pressures to use drugs.

An outcome evaluation of 'On My Own Two Feet' found that compared to a control group, students who participated in the programme had less positive attitudes to drug/alcohol use, and stronger beliefs in the negative outcomes of such use (Morgan et al. 1996). A formative evaluation by Morgan (1998) found that the 'Walk Tall' programme incorporates the approaches demonstrated to be most effective in preventing substance abuse. The evaluation also indicated that there was a very high rate of satisfaction with the programme among teachers who participated in the programme. No statistics on programme participation are available for either programme.

It is planned that the new Social, Personal and Health Education (S.P.H.E.) programme to be introduced in second level schools from September 2000, will subsume "On my Own Two Feet" and that S.P.H.E. will become an integral part of the curriculum for all junior cycle students. A National Co-ordinator has been appointed for the implementation of the S.P.H.E. programme and ten Regional Development Officers are being recruited. The initiative is being supported by the Departments of Education and Science and of Health and Children and the regional Health Boards. The Regional Development Officers currently being recruited will work in partnership with Health Promotion personnel from the Health Boards. They will also collaborate with other statutory and voluntary bodies to offer a co-ordinated support service.

The Healthy Schools Project

At the regional level, a school based programme known as the 'The Healthy Schools Project' has been introduced. This initiative was developed by the North Eastern Health Board (NEHB) for schools in the NEHB catchment area. The central objective of the programme is to encourage students to take responsibility for their own health and behaviour. The programme places an emphasis on the development of life skills including decision making, assertiveness and self-esteem. An evaluation of the programme indicated that there were significant differences between the pilot and the control group on items relating to acceptance of responsibility, self-esteem, positive outcomes in adulthood and attitudes to substance abuse (Morgan 1997). No statistics on programme participation are available.

Killinarden Drug Primary Prevention Group

A local based project, situated in one of the major urban areas in the Dublin region, the Killinarden Drug Primary Prevention Group run a number of drug education / self esteem programmes in schools in Killinarden. The project is run by local parents and the programmes are delivered to children at both primary and secondary level. This project has two part time staff and occasional facilitators. No statistics or evaluation results are available. No information on specific training is available.

9.1.3 Youth programmes outside schools

Young People's Facilities and Services Fund (YPFSF)

This fund was established by the Government in 1998 to assist in the development of preventative strategies in a targeted manner through the development of youth facilities, including sport and recreation facilities and services in disadvantaged areas, where a significant drug problem exists or has the potential to develop. The aim of the fund is to attract "at risk" young people in disadvantaged areas into these facilities and activities, thereby diverting them from the dangers of substance misuse.

Copping On

The Copping On Programme, a national crime awareness programme targeted at early school leavers and young people at risk, was established in 1996. The programme aims to reduce the risk and incidence of offending behaviour among young people and to decrease harmful and damaging behaviour such as bullying, alcohol and drug use. There are two main strands to the programme. The first strand involves providing training to professionals who work with early school leavers and with young people at risk. The training focuses on creating a greater awareness of the factors influencing offending behaviour, examination of personal values and underlying principles and identifying effective responses to the target group. The second strand of the programme consists of training for early school leavers and young people at risk. The course content focuses on similar topics to the training for professionals, including communications, relationships, drugs and alcohol, moral education, understanding the criminal justice system. At the end of the programme individuals are invited to provide feedback through specially designed evaluations. A recent evaluation (Bowden 1998) concluded that both trainers and young participants reacted positively to the programme. No statistics on programme participation are available. No information on specific training is available.

National Youth Health Programme

The National Youth Health Programme is a partnership between the National Youth Council of Ireland, the Health Promotion Unit of the Department of Health and Children and the Youth Affairs Section of the Department of Education. The aim of the programme is to provide broad based flexible youth health education within the non-formal education sector. It assists youth workers, leaders and volunteers working within the youth services and other community groups in addressing the health needs of young people. The service provides training at an organisational, regional and national level and gives advice and support to youth and community organisations that are developing their own health education programmes and initiatives.

The project has developed a Youth Work Support Pack dealing with the drugs issue. The pack covers a number of issues and is divided into four sections; 1) Youth work in a drug using society; 2) Youth work responses to drug use; 3) Policy development and 4) Supporting information. No statistics or evaluation results are available. No information on specific training is available.

Sound Decisions

This initiative established in the North Eastern Health Board region is targeted at nightclub and disco staff and young people attending discos and nightclubs. One of the main objectives of the project is to raise awareness of the dangers of drugs among young people and nightclub staff. It was also designed to increase the competence of nightclub staff in dealing with drug related issues. The programme consists of training sessions to inform nightclub staff about the legal implications relating to drug use, to enable them to recognise signs of drug use and to respond effectively to drug related emergencies. Promotional materials such as pins, posters, leaflets, stickers and t-shirts are used to highlight for club-goers the dangers associated with drugs. *No statistics or evaluation results are available. No information on specific training is available.*

The Staying Alive Campaign – A Dublin Safer Dancing Initiative

This initiative introduced in 1997 in the Eastern Health Board area is designed to provide training and support to night club staff in order to allow them to respond more effectively to drug related situations in night clubs (Harding 2000). A similar initiative has been organised in the South County Dublin area between the Dun Laoghaire/Rathdown Local Drugs Task Force and the Eastern Health Board. The first and second phase of this project involved the organisation of training programmes for club owners/managers and door supervisors which focused on increasing participants knowledge about drugs, exploring their attitudes towards drugs and examining legal, health and safety issues. The third phase of this project is designed to allow young club goers to obtain access to accurate information about drugs. *This phase, currently in the pilot stage, will involve*

distributing information about drugs in the form of a small credit card sized booklet known as the Vital Information Pack (VIP) through a number of venues including third level colleges and clubs (Harding 2000). Phases four and five of the project have also been planned. In phase four, a one day conference will be organised to gain support from the music/dance industry for the development of acceptable policies in dance venues across the ERHA region. Phase five will involve standardising training for door supervisors where different training elements will be provided in modular form. No statistics on programme participation are available. No statistics or evaluation results are available. No information on specific training is available.

Health Advice Café

Funding has been approved for the establishment of a health advice café in Galway's city centre. Galway is located in the Western Health Board region. However, no suitable premises for the project have yet been found. The main aim of the café will be to offer young people direct access to health services and to health information and advice. The café will incorporate a range of drug prevention and education strategies and provide information about available treatment services. It will also place an emphasis on 'fun drug free activities' to illustrate to young people that it is possible to have a good time without using drugs. *No statistics or evaluation results are available. No information on specific training is available.*

9.1.4 Community programmes

There has been a proliferation of local community based drug initiatives particularly in relation to drug awareness over the last few years, owing to the increased availability of funding for projects to tackle the drug problem. The initiatives organised by community groups include: drug awareness programmes, family support groups and the development of strategies to reduce the demand for drugs in local areas. *A few examples of the different types of initiatives that are in place are presented here.*

Southside Communities Drugs Initiative (Waterford)

The Waterford Community Based Drugs Initiative (CWCBDI) was established in November 1999 and aims to :

- *Increase the awareness of drug related issues*
- *Develop strategies for the reduction of demand for drugs*
- *Support local communities to respond to local needs relating to drug related issues and to improve the quality of life of those affected by drug misuse.*

The project is currently involved in the following initiatives : determining what local people think about drug related issues (needs analysis); providing drug awareness programmes to youth groups and schools; running parent support groups and promoting the development of drug policies in various organisations.

CWCBDI adopts a multi-faceted approach to its work. Representatives from statutory, community, and voluntary organisations are involved in the management committee of the project. This means that local people are involved in the management of the project and in making any major decisions relating to the project. It also ensures that the work is inclusive and consultative of local needs and issues. No statistics or evaluation results are available. No information on specific training is available.

Drug Questions - Local Answers

This community-based training programme produced by the Health Promotion Unit of the Department of Health and Children is aimed at health/education professionals, Gardaí (Police), community groups, doctors, youth workers etc. The objective of the five unit, ten hour training course is to help participants cope better with alcohol- and drug-related problems which they meet in their work/lives. and to contribute to community based responses to the drugs problem. The Health Promotion Unit of the Department of Health and Children, in conjunction with the eight regional health boards has provided convenor training programmes to demonstrate to instructors how to use the training materials effectively. No statistics or evaluation results are available. No information on specific training is available.

Crew Network

The Crew Network, based in the Eastern Health Board area, is a non-profit making organisation dedicated to the care, rehabilitation, education and occupational re-integration of those affected by substance misuse. The network is engaged in a number of demand reduction activities including school-based programmes and parent and community awareness nights. It has developed a community leadership and substance misuse awareness course accredited by National University of Ireland, Maynooth. The Crew network also provides a family and counselling service. *No statistics or evaluation results are available. No information on specific training is available.*

DAP - Crosscare

The Drug Awareness Programme (DAP) operated by a registered charity – Crosscare, helps groups and communities in the Dublin area, to develop a comprehensive approach to drug prevention. DAP provides a wide range of services including needs assessment for local drug prevention, drug awareness training and peer education programmes. DAP also provides a counselling,

support and telephone helpline service. *No statistics or evaluation results are available. No information on specific training is available.*

Community Addiction Response Programme (CARP)

CARP began as a partnership between the local community and a medical practitioner in the West Dublin area of Tallaght, with the aim of providing a methadone prescription service. The service has since expanded to include various activities for those receiving methadone including artwork, homeopathy, bowling and football. *The overall purpose of the programme is to deliver a user-friendly, client-centred service to opiate users of Killinarden so that they can re-integrate themselves into the community. The programme is targeted at those aged 16 and older who are problem drug users, although it will also cater for younger drug addicts who present for treatment. While the programme is primarily targeted at those with heroin addiction, it also offers a service for those abusing other substances. CARP also aims to help families affected by drug use and has established a support group for parents of drug users.*

CARP has forged links with various vocational training programmes in the area to allow clients in receipt of methadone maintenance to gain access to further training. CARP also produces a newsletter, which is distributed to the local community every quarter, and members of the organisation give talks on drugs to local schools. *An evaluation report (Bowden 1997) showed that participants generally viewed the programme in positive terms and the programme allowed participants to develop the ability to resist heroin. No statistics or information on specific training are available.*

Ballymun Youth Action Project

This project offers a range of services to individuals and families in the Ballymun area of Dublin. There are three main strands to the project 1) individual and family services 2) education and training and 3) community work. Advice, referral, information, counselling and family support are offered under the individual and family services aspect of the project. The education and training component consists of providing community education on drug abuse, developing drug/alcohol awareness programmes targeted to meet the needs of specific groups and delivering primary school programmes (See Section 10.4 Urrus/Ballymun Youth Action Project for more details). The community work element of the project consists of liaising and networking with other groups and agencies, contributing to policy development, empowering local people to participate in responding at a local level and researching how community development principles can be put into practice in relation to drug issues. No statistics or evaluation results are available. No information on specific training is available.

Ballymun Community Action Programme

This project, which is run by a management committee of local people who live and work in Ballymun, acts as a community resource centre and development programme. It aims to respond to the needs of local groups, initiate activity where gaps in service provision may exist and to draw lessons from the experience of local groups that can inform policy. The project is actively involved in influencing policy from a community perspective and in encouraging local people to contribute positively to policy development in relation to the drug issue. No statistics or evaluation results are available. No information on specific training is available.

Adult Substance Misuse Education Programme

This programme developed by the Kilkenny Drugs Initiative (KDI) is designed to help build the capacity of local communities to deal with the issue of substance abuse in their local area so they can further facilitate and train other people in the community. The programme is delivered to groups of between 6 and 12 participants and consists of between two and five sessions which are two hours in duration and cover aspects of substance misuse such as effects of drugs, signs and symptoms of drug use and drugs in a legal context. No statistics or evaluation results are available. No information on specific training is available.

As part of their remit to involve communities in the development of locally based strategies to reduce the demand for drugs, The Local Drugs Task Forces provide financial support to community based programmes. The following are examples of some of the types of projects that have been evaluated under the Local Drug Task Force evaluation initiative (See 10.2 Evaluation of LDTF funded projects for further details).

Jobstown Assisting Drug Dependency (JADD)

Jobstown Assisting Drug Dependency (JADD) was established in 1996, by a group of local people, in response to the growing problem of heroin abuse in Jobstown, a suburb of Dublin city. JADD emerged from a series of local community meetings concerning the drugs problem. The overall purpose of the programme is to support and help drug users and their families and to help drug users re-integrate back into the community. The project works with active drug misusers, drug misusers who are drug free and drug misusers who are participating in methadone programmes. The majority of JADD clients are male, early school leavers and unemployed. The clients are targeted through word of mouth, contact with healthcare professionals and current clients. One of the main services offered by JADD is methadone maintenance and gradual detoxification. JADD also provides a counselling service, a drop-in centre, primary health care and after care. The drop-in facility is opened five days a week. The counselling and drop-in services are also available to family members. Clients can take part in education and training

programmes such as drama, art, computer skills, literacy skills, creative writing, career guidance, job searching and sport/fitness. JADD has a Family Support Group which meets once a week for two hours. JADD also aims to inform and educate the local community regarding drug addiction and drug related diseases and to network with other local community groups. A recent evaluation (O'Rourke 2000) found that participants generally viewed the programme in positive terms and that JADD had made a significant contribution to the quality of life and provision of opportunities for many people living within the Jobstown area. No statistics or information on specific training is available.

Cabra Resource Centre

This project established in September 1999 was set up as a 'drop in' centre for individuals and families within the community concerned about alcohol and substance abuse issues. The centre provides brief intervention counselling and an information service and is equipped with a multi-media library. It also acts as a referral agency and organises family support groups. No statistics or evaluation results are available. No information on specific training is available.

The Crinian Project

This project based in Dublin and funded by the City of Dublin Youth Services Board, was established to cater for young drug users (15-18 years) who are especially vulnerable and have few service or treatment opportunities. Participants have usually left school at a very young age and have had frequent involvement in illegal activities. The project is holistic and places emphasis not only on medical intervention but also on providing enabling-skills and drug-free alternatives to the young clients. The project has two main components a day programme and an after-hours component. The main services offered by the day programme include :

- Individual and group therapy*
- Medical services including detoxification and drug testing*
- Youthwork*
- Family support*

The after-hours aspect of the programme which is designed to complement the day programme in Crinian, involves evening activities, week-end events, literary and education support and youth work training and networking. An evaluation was carried out by Morgan 1997, however no statistics or evaluation results are available. No information on specific training is available.

9.1.5 Telephone help lines

EHB Helpline

A free telephone helpline was established by the Eastern Health Board during 1997 and is available five days per week from 10.00am to 5.00pm. It was set up to provide a confidential service offering information, support, guidance and referral for those concerned with any aspect of drug misuse. No statistics or evaluation results are available. No information on specific training is available.

Waterford Drug Helpline

This Helpline provides a telephone counselling and information service between 10am and 12am Monday to Friday and on two evenings a week from 8pm to 10pm. The helpline has ten unpaid volunteers. The service was set up to educate the general public and particularly parents and young people about drug related issues and to provide a listening service to those effected by drug use. The service aims to be easy to contact, confidential and non-judgmental. It also provides factual information about drugs and their effects and gives out details of drug related services in the region. In 1999, a total of 1270 calls were received by the helpline. The majority of these calls related to cannabis/alcohol (31.3%), ecstasy (30.9%) and amphetamines (24.2%) (Waterford Helpline, personal communication 1999). The Helpline is a member of the European Foundation of Drug Helplines (PESAT). No evaluation results or information on specific training is available.

Cork Helpline

The Southern Health Board also provides a helpline offering information on prevention and service provision. It is a charge-free service and operates weekdays from 1-2 pm. No statistics or evaluation results are available. No information on specific training is available.

9.1.6 Mass media campaigns

The Health Promotion Unit of Department of Health and Children disseminates information on drugs and their effects on an on-going basis.

HYPER

A new bi-monthly magazine 'HYPER' was launched in Spring 1999 by the project promoter – Soilse which is a rehabilitation programme in the EHB. HYPER which is an acronym for Health, Youth, Promotion, Education and Rehabilitation acts as a voice for young people affected by drugs. HYPER is funded through EHB by Youthstart and an EU Employment initiative for 18-20 year olds. It is produced by six former drug users as part of a rehabilitation project and aims to bring young

people a magazine which they can relate to and which critically addresses their lifestyles without preaching or scare-mongering. The magazine includes interviews, book and theatre reviews, cartoons and articles that challenge peoples' attitudes towards drugs, young people and health. In July 1999, HYPER won an award in the British based Total Publishing Awards competition for design innovation. The magazine was selected from over 400 entries.

9.1.7 Internet

No information available.

9. 3 Reduction of drug related harm

9.3.1 Outreach work

Each Health Board is developing its outreach capacity as part of the overall service development in the drugs area. Outreach workers provide needle exchange, support for sex workers and referrals for methadone maintenance. According to the EMCDDA Insights report, outreach workers in Ireland emphasise the importance of a community presence which enables them to 'intervene and fast-track individuals to treatment while concentrating on making contact and increasing service accessibility' p. 131 (EMCDDA 1999).

ERHA Outreach programme

This programme targets intravenous drug users, women in prostitution and gay or bisexual men. It aims to :

- *Reach IDUs who are not in touch with services and provide them with information on HIV and its prevention*
- *Encourage and facilitate referrals to drug-treatment agencies*
- *Provide information to community groups about HIV (EMCDDA 1999).*

No statistics or evaluation results are available. No information on specific training is available.

9.3.2 Low threshold services

The Mobile clinic

A Mobile Clinic was established in the Eastern Health Board in 1996. The service is low-threshold and provides initial services to the more chaotic drug user who is addicted to an opiate, is injecting and is incapable of stabilisation on methadone maintenance. A second mobile clinic was introduced in 2000, which

increased the number of areas where drug users can avail of this service. No evaluation results are available. No information on specific training is available. The Drug Misuse Research Division is currently carrying out a research study which is assessing the needs of users of this service and their experience of this and other drug treatment services.

9.3.3 Prevention of infectious diseases

Drug users who present for treatment at any of the statutory drug treatment services are routinely offered HIV/Hepatitis C testing. Needle exchanges are operational in only the Eastern Regional Health Authority which covers the greater Dublin area where the vast majority of injecting drug users reside.

According to the report of the National AIDS Strategy Committee, recent HIV statistics indicate that interventions with intravenous drug misusers are effective in reducing transmission rates among this 'at risk' group (Department of Health and Children 2000). However, there was a major increase in the numbers of drug users with HIV in 1999. The figure for 1999 was 69, compared to 26 and 21 for 1998 and 1997 respectively (Department of Health 2000).

A nationwide routine linked antenatal HIV testing programme has been established which can reduce perinatal transmission through the use of antenatal treatment of HIV positive women with anti-retroviral drugs and careful management at delivery (Department of Health 2000). No evaluation results are available. Training for midwives and others involved in the programme was provided in all health boards by a team including expert clinicians, a midwife and a social worker.

Health Promotion Unit – Merchants Quay Project

The largest needle exchange in the country is operated by a voluntary agency – Merchants Quay. The Health Promotion Unit within Merchants Quay operate the needle exchange which is aimed at drug users who inject heroin and offers a drop-in service which is open Monday to Friday, 2.00pm until 4.30pm. The Health Promotion Unit offers a range of services to its clients. It provides a range of needles and syringes, sterile water, filters, swabs, citric acid and condoms. The Unit also acts as a source of referral to other drug treatment services and offers a nursing service. This service provides clients with basic wound care, and deals with other health issues such as scabies, athletes foot and any other conditions that clients present. When appropriate, referrals are made to other services and clients may also apply for a medical card. Encouraging clients to engage in specialist contact such as having an HIV test and receiving the hepatitis B vaccination is also considered an integral part of the Health Promotion Unit. A recent evaluation (Cox and Lawless 2000), found that the Health Promotion Unit had a positive impact on clients' drug using behaviour. There was a reduction in

the frequency of injecting and the incidence of sharing and an increase in condom use reported by clients at the three month follow up visit. No evaluation results are available. No information on specific training is available.

9.4 Treatment

9.4.1 Treatments and health care at National level

The Government Strategy to Prevent Drug Misuse (National Co-ordinating Committee 1991) recognised that the treatment, care and management of drug misuse does not lend itself to a 'one solution' approach. Consequently, a variety of treatment options are provided including : counselling and support, detoxification, treatment at therapeutic communities, needle exchange, and methadone maintenance. In practice until recently there has been an emphasis on provision of methadone maintenance for opiate misusers, more recently rehabilitation measures as an aspect of treatment is increasingly being stressed.

Drug treatment services are provided through a network of treatment locations and the policy is to provide treatment locally where possible (Department of Health and Children 2000). Thus in addition, to some central treatment services, a network of addiction centres and satellite clinics have been developed – particularly in the ERHA areas. Primary provision is developing and involvement of GPs, local pharmacies etc. in local delivery is being actively encouraged. In some Health Board areas drug services are structured under health promotion or public health while in others services are provided under the psychiatric services umbrella. There is not a consistent approach across health boards.

The treatment services aimed at drug users are organised at regional level and local levels under the Health Boards and increasingly will involve more active liaison with local government structures. The main funding is made available through the Department of Health and Children to the Health Boards, and through the Health Boards to voluntary and community agencies at present. More involvement of local government structures is developing.

Financing

Two government departments fund initiatives in the drugs area – the department of Health & Children and the Department of Tourism, Sport and Recreation. The Department of Tourism, Sport and Recreation had an annual budget of IR£35 million in 2000 for the drugs area. No exact figures are available for Department of Health and Children funding which is administered through a number of different sections with the Department including: childcare, health promotion and mental health. However, an additional IR£7.75 million was made available to community drugs services by the Department of Health and Children in 2000.

In 1999, the EHB AIDS / Drug Service was allocated IR£17.5 million/Euro 22.2m including capital development costs which represents 15% of the EHB's budget for health promotion, mental health, addiction and social development (Farrell et al 2000). The ERHA budget in 2000 was over IR£ 22 million.

Statistics and Evaluation results

National Drug Treatment Reporting System Statistics

The National Drug Treatment Reporting System (NDTRS) data for 1998 (the latest year for which published data are available) indicate that there were 6043 recorded contacts with treatment services during 1998. Of these contacts, 1625 were receiving treatment for the first time. For 71% of all cases, the main drug of misuse was heroin. The vast majority of contacts (86%) were treated in the Eastern Health Board area. Two-thirds (66%) of all contacts had injected at some stage in their drug using careers. The gender breakdown of contacts indicated that 70.2% of cases were male. Almost three-fifths (58%) of those receiving treatment were under the age of 25. Two-thirds (65%) of contacts were living with their parents or other family members. Interestingly, one-fifth of all cases receiving treatment were in gainful employment an increase from 14% in 1997 (O'Brien, Moran, Kelleher & Cahill, 2000).

Review of the EHB Drugs and AIDS services

In 1999, a review of the EHB drugs and AIDS services was conducted (Farrell 2000). The purpose of the review was to :

- To appraise the current drug policies and practices within the service*
- To examine the development of the service since the last review conducted 5 years earlier*
- To comment on the EHB service response in context of trends and practices elsewhere.*

One of the indicators of drug treatment centre performance that the report examined was the results of urine tests for opiates, benzodiazepines and tricyclics among five addiction clinics across the EHB area. These tests were conducted over a four month period in 1999. The results indicated that overall, on aggregate, there was a 70% reduction in heroin use among those attending treatment. However, high rates of benzodiazepine use were found (65% positive) which suggest a major problem of polydrug use among drug users in treatment. The authors indicated that the costs of urine screening in EHB clinics are disproportionately high and needed to be reviewed. The review also found that a number of satellite clinics informally reported rates of returning to work of 40% (Farrell 2000).

The report concluded that the EHB has succeeded in achieving a major expansion in services over the last five years and that the rates of opiate use as

indicated by urine testing suggests that clinics are operating to a very high standard of performance on that particular parameter. The authors recommend that an audit of benzodiazepine prescribing processes be conducted within the service as a matter of urgency. They also argue that the needle exchange service needs to be expanded and that services should be broadened to include briefer types of intervention.

Specific Training

General practitioners – GPs, are required to undergo specific training before they are permitted to prescribe methadone since the introduction of the Methadone Prescribing Protocol in 1998. The Irish College of General Practitioners provides this training in conjunction with the relevant local health board. The training aims to provide GPs with the knowledge, skills and attitudes required to manage opiate misusers in general practice. There are two training levels that GPs can complete. The level attained will dictate the nature of the contract the GPs will have with the health board in terms of the substitution service he/she can provide within their general practice.

Level 1: This level permits GPs to prescribe methadone only for clients that have been stabilised on a methadone programme in a clinic setting. These stabilised clients are referred to the GP from the health board treatment centres. GPs in this group are limited to providing services for a maximum of 15 clients.

Level 2: This level of training permits GPs to initiate the treatment of opiate dependent persons. Doctors must have worked for a minimum of one year in a clinic based setting before they can undergo this training. A GP in this group may treat up to 35 clients in his/her own practice but if in a practice with two or more doctors may cater for a maximum of 50 clients.

In an effort to provide comprehensive national epidemiological information on treated drug misuse, the Drug Misuse Research Division make an input to this training relating to the completion of NDTRS forms. Individual training is also provided by the Drug Misuse Research Division.

9.4.2 Substitution and maintenance programmes : Lucy Dillon

Organisation and delivery of substitution drugs:

(a) Criteria of admission

During the early 1990's substitution services in Ireland were expanded and became more widely available to the opiate using population. In accessing maintenance programmes preference has always been given to pregnant women and those who have AIDS or are HIV positive. However, in 1998 the Eastern

Health Board produced an 'Inventory of Policies' which lays down criteria for admission to substitution programmes. These are as follows:

- Clients must meet physical, emotional and behavioural criteria for addiction as set down by the International Classification of Diseases Version 10 [ICD-10]
- Clients must be 18 years of age. Those between the ages of 18 and 20 require a more extensive investigation before being commenced on methadone
- Clients under the age of 18 will need their parents to attend and give parental consent. There should be a history of at least one failed detoxification, usually two or three preferably at inpatient level. However, where patients have a very long history that can be verified, this condition may be waived
- For admission to a maintenance programme a client must have an extensive one-year history of intravenous drug use. For interim programmes a client must have been using opiates for a minimum of two years and/or injecting for one year
- Clients must have gone through at least one previous detoxification attempt.
- Special circumstances may dictate being accepted on a programme without fulfilling all the above criteria. Such circumstances include being HIV positive, being pregnant and being a partner of a client already on a programme.

Prior to the introduction of these guidelines, the criteria of admission onto maintenance programmes were generally left to the discretion of an individual GP or particular clinic. As such, there may have been extensive variation between programmes in terms of the criteria used for admission.

(b) Mode of prescription

Legal Basis for Substitution

Prior to October 1998 there was no policy in relation to GPs prescribing methadone. There is no data available on the extent to which GPs prescribed methadone up until this point, as the provision of such a service was up to the discretion of individual GPs. However, in the early 1990s there was a move away from the centralised specialist model toward a more decentralised model of service provision. This called for the involvement of community based GPs and pharmacists in the prescribing and dispensing of methadone. Although some individual GPs were already involved in providing this service, the aim was to establish a structured and co-ordinated approach to the provision of services. An Expert Group was set up to develop a suitable treatment protocol. In March 1993, the Protocol for the Prescribing of Methadone was issued which set out guidelines for GPs prescribing methadone within the general practice setting, and for pharmacists in their dispensing of methadone. Guidelines set out in a review of this protocol produced in 1997 were implemented in October 1998. Consequently, the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations were published in 1998.

The guidelines aim to create a more controlled environment for the prescribing and dispensing of methadone. Under the Regulations the prescribing medical practitioner must register each client in receipt of a methadone prescription on the Central Treatment List. The guidelines aim to restrict the number of clients for whom individual GPs can prescribe methadone. While there is no specific licence required by GPs in Ireland to provide substitution programmes, they are required to undergo training and must be approved by the relevant health board. Methadone itself is a licensed prescription drug controlled under Schedule 2 of the Misuse of Drugs Regulations, 1988. Methadone is currently prescribed in two service settings: clinic setting and GP setting. Furthermore, it is also dispensed from community pharmacies.

Clinic Setting

Clinics have been developed specifically to meet the needs of drug users. Expansion in the clinic services has been overwhelmingly in the area of substitution programmes, including methadone detoxification, stabilisation and maintenance. The number of clinic locations where methadone is prescribed has grown from two in 1991 to four in 1994, to 45 in 1999 and 53 in 2000. Forty-nine of the fifty-three clinics are based in the Eastern Regional Health Authority Area where the large majority of opiate users reside.

Clinics fall in to one of two categories. First is the category referred to as 'addiction centres' where a range of services are available to clients, including substitution programmes. The majority of the clients attending these clinics are dispensed their methadone on-site on a daily basis, this means they consume the methadone under the supervision of a member of staff. Supervised urine samples are taken on a regular basis. When clients have demonstrated a certain level of stability by providing opiate-negative samples over a period of time, they may be dispensed 'take home' doses. This means less frequent attendance at the clinic is required.

The second category of clinic is referred to as 'satellite clinics'. These are clinics based in communities identified as having a significant opiate using population. These clinics provide methadone prescribing services, although it is not dispensed on site. Rather, clients attend a designated community pharmacy where their methadone is dispensed.

General Practice Setting

As mentioned above, in 1993 a protocol was published for the prescribing of methadone in the GP setting. The basic premise outlined in the 1993 Protocol is that GPs should take on responsibility for the care of opiate dependent people once they have been stabilised in either an addiction centre or a satellite clinic. GPs and clients should then have the continued support of that centre. A protocol review committee was established which produced a report in 1997, the

recommendations of which were implemented in October 1998. The main changes this had on the organisation and delivery of methadone services in the GP context were:

- GPs had to register with the health board to enable them to prescribe methadone*
- GPs were restricted in the number of drug users they could treat, depending on their level of training*
- Only GPs having undergone specialised training could initiate the prescription of methadone in the treatment of drug addiction. Other GPs could only treat those already stabilised in a clinic setting*
- GPs were no longer allowed to prescribe methadone to patients in a private capacity but had to provide the service free of charge to the patient*
- All patients in receipt of a methadone prescription had to be registered on a Central Methadone Treatment List.*

As with the number of clinics providing substitution services, the number of GPs offering the service has increased dramatically over recent years. In 1996 there were 58 GPs registered as prescribing methadone in their practice setting, this grew to 97 in 1998, 143 in 1999 and in 2000 has grown to 158.

Community Pharmacists

As substitution programmes have become more decentralised the role of the community pharmacist has become increasingly important. Pharmacies are responsible for dispensing methadone to clients attending a GP based substitution programme and those attending satellite clinics. Each client is assigned to a particular pharmacy in the local community, from which his or her methadone will be dispensed. Pharmacists are involved in dispensing take home doses and also provide a supervised administration service. The Pharmaceutical Association of Ireland recommends that pharmacists agree a written contract with clients upon initiating these services. Contracts detail the pharmacy service and the expected standards of behaviour of clients. The number of pharmacies involved in dispensing methadone has increased significantly over recent years. As of 2000 there were 207 pharmacists involved in dispensing methadone, one hundred and fifty four of these were based in the Eastern Regional Health Authority area (personal contact, Pharmaceutical Society of Ireland).

Specialised Prescription Forms

It is required that methadone be prescribed using specialised prescription forms. These prescription forms must be correctly written and allow for a single supply or supply on instalment. The prescription form must also indicate whether or not the administration of the dose should be supervised by the pharmacist (Department of Health 1997).

(c) *Objective (gradual detoxification, maintenance)*

The objectives of substitution programmes vary depending on the type of programme. While the ultimate aim of the services is to facilitate the individual to return to a drug free lifestyle, a variety of programmes are available. While some programmes aim to detoxify the individual on a short-term programme others offer a longer term maintenance which is not subject to a specific time limit.

(d) *Substitution drug/s, mode of application*

The only substitution drug currently prescribed in Ireland is oral methadone. Prior to 1996 the only form of methadone available in Ireland was Physeptone Linctus (2mg methadone per 5mls of syrup). As part of a move in the reorganisation of the methadone treatment services, the Health Boards decided to transfer patients on to methadone mixture (5mg methadone per 5mls syrup). This change was first implemented in treatment clinics and then in GP surgeries. This methadone mixture is the only form currently available from treatment services.

The Pharmaceutical Society of Ireland has proposed that the use of non-opioid alternatives to methadone for the management of addiction, such as Lofexidine, be considered and this is currently being reviewed. Research projects under the management of the consultant psychiatrist with responsibility for drug misuse are also currently investigating the effectiveness of Loxexidine, LAAM and Buprenorphine.

(e) *Psycho-social counselling (requirements and practice)*

Counselling is available on-site to those attending a clinic-based programme. Interim programmes have counsellors available to clients on an ad hoc basis. Access to counselling is provided where there are complex/acute issues involved. Clients of maintenance programmes are allocated a full time counsellor. While participation is recommended within the programme, it is ultimately voluntary. In the GP setting clients can be referred to local counsellors if so required. Attendance is also voluntary. There is no data available on the level of uptake of counselling services or the number of visits made per client from either treatment setting.

(f) *Drug testing*

Both clinic and GP based programmes require clients to give regular supervised urine samples that are tested for the presence of prohibited substances. In the clinic settings, urine samples are taken on a twice-weekly basis during stabilisation, and on at least a weekly basis once clients are stabilised. These samples are all screened for opiates and methadone. On a monthly basis all clients are screened for other substances such as benzodiazepines and cocaine.

Where clients are identified as having a specific 'problem' with such substances they are screened for them on at least a weekly basis. Where clients are transferred to a GP based programme, urine screening is organised between the Health Board and the GP, and carried out on a weekly basis. All samples are currently sent to the Drug Treatment Centre for analysis.

(g) Diversion of substitution drugs

No research has been carried out to date in Ireland looking specifically at the extent to which substitution drugs are diverted. However, the National Drug Treatment Reporting System data show that of those who presented to drug treatment services with problem drug use during 1998 (N=5076), 6.3% reported 'street methadone' as their main drug of misuse. This suggests that at the time, methadone continued to be diverted from the treatment service environment. However, it will be necessary to examine these figures as they become available to assess the impact of the tighter regulations on methadone prescribing on the diversion of methadone to the street market.

(h) Statistics (measure point)

At the end of July 2000 there were 4,851 clients receiving substitution treatment in Ireland. Clients of both GP and clinic based programmes are all registered on a Central Treatment List. As mentioned in previous sections, opiate use in Ireland is overwhelmingly based in the Eastern Regional Health Authority Area, therefore most substitution programme clients are resident there. As of July 2000 only 90 of a total of 4,851 clients registered on the Central Treatment List were receiving substitution services outside the Eastern Regional Health Authority area. Data gathered through the Central Treatment List is confidential and is not available for epidemiological analysis.

(i) Specific research results

Most research carried out in Ireland with clients of substitution programmes has focused on their identity as injecting drug users rather than their experiences of substitution programmes. In addition this has been limited to sample populations from one particular clinic (Smyth et al. 1998; Smyth et al. 1995; Dorman et al. 1997; Williams et al. 1997). Little research has been done looking at substitution programmes per se.

A nation-wide general population survey on 'Drug-Related Knowledge, Attitudes and Beliefs in Ireland' (Bryan et al. 2000) has been carried out by the Drug Misuse Research Division of the Health Research Board. In this study one thousand members of the public were asked about a range of drug-related issues, including drug treatment services. In relation to substitution services specifically, respondents were asked to what extent they agreed with the following statement:

'Medically prescribed heroin substitutes [such as Methadone/physeptone] should be available to drug addicts.'

Only 16.1% disagreed with this statement while 63.5% agreed and 20.3% responded 'don't know'. These views appear to contradict the negative attitudes expressed by communities in relation to the establishment of treatment centres in their localities.

Evaluation results

No detailed evaluation of substitution service provision in Ireland has been carried out to date.

9.5 After-care and re-integration : Eimear Farrell

There has been an increased focus on rehabilitation in recent years as indicated by recent speeches of the Minister of State with special responsibility for the drugs area, the service plans of ERHA and the development of a rehabilitation/re-integration blueprint. However, as of yet, there are relatively few rehabilitation programmes in place. Both statutory and community agencies provide these services. Below are some examples of the types of rehabilitation programmes available.

St. Francis Farm

Merchants Quay, a voluntary drug treatment project based in Dublin has established an innovative drug free therapeutic training facility known as Francis Farm in a rural area in the south-east of Ireland. The training facility offers a one-year programme for former drug users, which involves both vocational and educational training in a farm environment. Participants learn a wide range of skills including animal care, horticultural techniques, catering and food preparation, building and joinery, machine maintenance and literacy/numeracy skills. Organic farming methods are used on the farm to mirror the chemical free status of participants. The programme enables those with a low skill level to discover new areas of ability that will help them to gain access to more formal training on completion of the programme. No statistics or evaluation results are available. No information on specific training is available.

Tallaght Rehabilitation Project

Tallaght Rehabilitation Project was initiated in early 1997 and began to deliver services to drug users in the Tallaght area, one of the major Dublin suburbs, in February 2000. The service provides education and training to former drug users and drug users who have stabilised on methadone maintenance. It is run by a management team of statutory and community representatives. The aim of the

project is to facilitate drug users to re-integrate into their communities and into mainstream employment, education and training. Participants attend the project for four hours a day. This is broken down into three hours of education and training and one hour of social interaction and group work. Currently, 14 participants, nine women and five men are taking part in the programme. No evaluation results are available. No information on specific training is available.

Soilse

Soilse, set up by Eastern Health Board in 1995, is a dedicated drug rehabilitation programme specialising in insertion to employment, vocational training and education. Soilse aims to overcome the limitations of a psycho-therapeutic approach to addiction by building goals and supporting participants in their desire to re-socialise themselves personally, economically and culturally. Soilse also seeks to re-integrate former drug users into society through restoring independence, self esteem and self direction. The programme is a non-residential day drug rehabilitation model, balancing group therapy and counselling (resistance training and normative education) with creativity and soft vocation skills. An evaluation of the project has indicated that that the programme has been successful in enhancing participants self-esteem and in facilitating their entry to employment and training. No statistics are available. No information on specific training is available.

9.5.2 Employment

FÁS – the state training agency have forged links with the LDTFs and many participants taking part in rehabilitation programmes are doing so under the Community Employment Scheme which aims to facilitate the long-term unemployed in returning to work. FÁS are also making a substantial number of training slots available for drug addicts in treatment (Farrell 2000). No statistics or evaluation results are available. No information on specific training is available.

9.5.3 Housing

No specialised housing projects have been initiated in Ireland for drug users.

9.6 Interventions in the Criminal Justice System : Lucy Dillon

(a) Interventions

Medical (detoxification, drug substitution)

In Ireland any individual held in custody has the right to request to see a general practitioner (Criminal Justice Act). Where a drug user wishes, he/she may

request to see a general practitioner who will tend to them while they are being held in custody and assess whether to provide the individual with medication, e.g. methadone, to alleviate withdrawal symptoms. However, data is not currently collected on either the number of people held in custody who avail of this service or the proportion who do so as a consequence of their drug use.

Upon imprisonment there is a standard thirteen-day methadone detoxification programme offered to prisoners who are found to test positive for opiates. This service however is not available in all prisons around the country and tends to be based in the Dublin prisons. In what has been the main committal prison in Ireland up until recently (i.e. Mountjoy Prison, Dublin), there were an estimated 1,200-1,500 cases of prisoners receiving methadone detoxification per year (Department of Justice, Equality and Law Reform, 1999). Prisoners who may have been stable on a methadone maintenance programme in the community are generally detoxified upon incarceration.

The following is the detoxification regime followed in Mountjoy Prison, Dublin. This is a methadone based detoxification programme, in which Melleril¹ (25mgs) is also offered for the first seven nights during detoxification. In the context of Mountjoy prison this programme has been described as being provided in an “essentially unstructured and unsupervised fashion, with no follow-up or medium to long term planning” (Department of Justice, Equality and Law Reform 1999). The programme is the same for each prisoner, irrespective of the quantity of opiates being used prior to imprisonment. The doses involved are as follows:

Day 1-2 25mls methadone mixture (green colour)

Day 3-4 20mls methadone mixture (green colour)

Day 5-8 15mls methadone mixture (green colour)

Day 9-11 10mls methadone mixture (green colour)

Day 12-13 5mls methadone mixture (green colour)

Melleril 25mgs each night on day 1-7 of this programme.

The provision of methadone maintenance within the Irish prison system remains limited. Methadone maintenance is only available to prisoners who are HIV positive or who have AIDS and, to a limited extent, to those who are on a maintenance programme prior to imprisonment. Methadone maintenance only commenced in Irish prisons in the case where a prisoner is HIV+. In a limited number of prisons, including the country's main male juvenile prison, a methadone maintenance programme is available to those prisoners who are coming from the community and are already on a methadone maintenance programme. This is a recent development in service provision.

¹ Melleril contains thioridazine which belongs to the phenothiazine class of drugs. Among other uses, it is used to relieve tension and anxiety.

Drug-free programmes

The Probation and Welfare Service provides a Drug Awareness Programme in a number of Dublin based prisons. This is a four-week programme consisting of one session per week. The principal aim is to educate participants about their drug use and the associated risks. It is aimed at all prisoners with a history of drug use, including those who have ceased their drug use and those who are continuing to use within the prison setting. The programme is run regularly in a couple of prisons but staffing shortages prevent it from being a more widespread service.

A seven-week 'Drug Detoxification and Rehabilitation Programme' is run by probation and welfare officers, and is based in the Medical Unit of Mountjoy prison. The programme caters for nine male prisoners at a time. There is no equivalent service available to female prisoners. To access the programme prisoners are interviewed by probation and welfare officers and assessed for suitability. Only prisoners with less than 26 months to serve or with a court sentence review date less than 26 months away can apply for the programme. Participation entails an initial methadone detoxification followed by an intensive rehabilitation programme. A multi-disciplinary team that includes both medical staff and counsellors from outside agencies delivers this programme. Participants who remain drug free during the seven-week period are then transferred to a designated drug free unit (the Training Unit). While workers from a therapeutic community are involved in service provision for this particular programme, there is no therapeutic community type programme available to drug users in the Irish prison system. A similar programme with more of a focus on factors associated with imminent release into the community is run over an eleven week period. This is also based in Mountjoy Prison Dublin and will be discussed in the 'Release' section (below).

Self-help groups

Self-help groups within the Irish criminal justice system are based within the prison setting. The only structured self help group available to prisoners which specifically addresses the issue of drug use is Narcotics Anonymous (NA).

HIV/Hepatitis prevention (needles and syringe exchange)

Needle and syringe exchanges are not provided to drug users in the Irish prison system. Furthermore, there is no structured access to cleaning materials for injecting equipment.

As mentioned above the Probation and Welfare Service in Mountjoy prison Dublin have developed a Drug Awareness Programme which is also run to some extent in other prisons. This is a four-week programme consisting of one session

per week. The principal aim is to educate participants about their drug use and the associated risks. It is aimed at all prisoners with a history of drug use, including those who have ceased their drug use and those who are continuing to use within the prison setting. Included in this programme is a session on HIV and Hepatitis.

(b) Drug testing

In the community, drug testing (urinalysis) is sometimes used by probation and welfare officers as a condition of an offender's Supervision Order.

Routine randomised drug testing is only carried out within the prison system in the designated drug free area of the Training Unit in Mountjoy Prison. A drug free environment is ensured by the requirement for all prisoners, irrespective of whether they have a drug using history or not, to undergo random urinalysis. Where a prisoner tests positive for a prohibited substance, he is moved either to another prison or another area of Mountjoy.

Drug testing is also used to monitor those prisoners who are receiving methadone on a maintenance basis in the prison setting.

(c) Release: referral to treatment, aftercare, probation

In Ireland there is no formal referral scheme for drug using prisoners to treatment upon release. The need to develop a structured through-care programme from the prison system to the community has been identified within the Irish criminal justice system (Irish Prisons Service 2000). The Probation and Welfare Service of the Department of Justice, Equality and Law Reform carry out group work programmes in the prison setting. These aim to promote desired behavioural changes in terms of risk behaviour and drug addiction, and to help prisoners cope with imprisonment and to prepare them for life demands following release from prison.

There are also a couple of specific projects underway which are targeted specifically at dealing with the issues surrounding release:

As mentioned above, the Probation and Welfare Service of Mountjoy Prison run an eleven week drug rehabilitation programme that focuses on factors associated with imminent release into the community. The programme facilitates prisoners in developing a Community Release Plan through contact with his probation and welfare officer. After the initial eleven week period prisoners are released subject to Temporary Release Rules. Prisoners then contact their probation and welfare officer and link in with therapeutic, education, training and employment contacts in the community.

There is also a rehabilitation programme for ex-prisoners based in Cork (southern Ireland), that has as its aim the integration of ex-prisoners back into mainstream society and stop them re-offending. This is a collaborative project managed by a partnership of voluntary and statutory bodies, part funded by the Cork Drugs Task Force. Key roles in the development of the project have been played by: the Probation and Welfare Service of the Department of Justice, Equality and Law Reform, the Cork Prison's Governor, the prison staff and the Education Department in the prison. The project serves prison inmates, ex-prisoners, those who are on probation and family members of prisoners. The project provides a counselling and referral service to clients referred by the Probation and Welfare Service. In addition the project provides a counselling service within the prison and an 'Addiction Education and Awareness Programme'. Since it started, the project's counsellor has had some form of contact with 181 people.

The CONNECT project was established in Mountjoy under the European DESMOS project which is supported by the European Social Fund under the Integra Employment Initiative. The main objective of its work is 'to encourage the (re) integration of offenders in society through employment as a support.' Each country has developed its own national programme which has as its base the guidelines on employment recommended by the Council of Europe, which have at its core four aims:

- Improving employability*
- Developing entrepreneurship*
- Encouraging adaptability of businesses and their employees*
- Strengthening the policies of equal opportunities for women and men.*

In Mountjoy, the CONNECT project is an action-research project led by the Department of Justice Equality and Law Reform and run by the National Training and Development Institute. Initially the project carried out research to identify the education and training gaps in programme provision in Mountjoy Prison and the Training Unit. In response, the project has developed and implemented pilot strategies and systems to fill the gaps identified and improve the employability of offenders while in custody. Included in the pre-vocational training is training in job seeking skills and work-related social skills. The process at the centre of the project is described as the 'transition from custody, through training, on to reintegration in the community and more specifically, on to labour market participation'. Each course caters for up to fourteen male prisoners.

(d) Statistics and evaluation results

There has been little evaluation carried out of programmes aimed at drug users in the Irish criminal justice system. Crowley (1999) provided a medical review of the seven-week Drug Detoxification and Rehabilitation Programme in Mountjoy prison, Dublin. Up to February 1999, 187 prisoners had entered the programme, 173 completed the detox and 14 failed to complete the detox. While this implies a

93% success rate, Crowley (1999) highlights the need for the success of this intervention to be determined by the 6 and 12 month relapse figures. Overall it was found that there was a twelve monthly relapse rate of 78%. Crowley argues that while this may appear high, it compares favourably to outcome rates of other inpatient detoxification programmes.

(e) *Specific training*

There is little specific training of those working within the Irish criminal justice system in relation to drug use and the specific needs of drug users.

As part of their training, members of the Irish police force (An Garda Síochána) receive instruction in the area of drug misuse. The programme includes training in:

- *the enforcement of drug-related laws*
- *the procedures for dealing with drug cases*
- *health and safety issues.*

As part of its proposals for the staff development the Steering Group on Prison Based Drug Treatment Services (Irish Prisons Service 2000), it is proposed that a special Prisons Service Training Officer be appointed. It is proposed that this Training Officer would work in tandem with the Area Health Authority's training department of the Drugs/AIDS services. The Officer would have responsibility for implementing a full training package for all staff within the prison who are working with drug users. The proposed training would consist of two levels. The first level would cover general education, basic skills training and awareness training of drug problems for all prison staff in relevant institutions. The second level would be more specific training for a core group of staff who would be working directly with drug users, within prison treatment units.

There is an on-going review of the prison services which includes an evaluation of the prison drug service.

The Probation and Welfare Service have funded two places in one of the drug treatment clinics – Ashling, thus there are 2 treatment places available to which the probation and welfare service can refer people.

The Bridge Project : Eimear Farrell

The Bridge Project is a community-based programme for young adult offenders that provides an alternative to custody. It is supported by the Probation and Welfare Service. It aims to prevent re-offending by young adult offenders (aged between 17 and 26) who would otherwise receive substantial custodial sentences. The programme addresses the key factors that contribute to and are associated with criminal behaviour such as drug addiction. The programme consists of three phases.

Phase 1: This phase involves a detailed assessment of each participant to determine his/her strengths and weaknesses and prepares participants for the second stage of the project which involves group work. During this phase, addictions and other personal and social problems are identified.

Phase 2: The second phase consists of a 17 week intensive group-based module which focuses on participants offending behaviour and how it has affected them, their families and the victims. Contributing factors which can influence offending behaviour such as alcohol, drug and gambling addictions, family relationship problems, violence and anger management are also addressed. During this phase, education and training and work needs of participants are assessed.

Phase 3: In this phase, participants pursue personal goals in education, training and employment. This phase continues until participants' court orders are completed.

An evaluation of the Bridge Project (*Kelleher Associates 1998*) has shown that participants respond positively to the programme. *No statistics are available. No information on specific training is available.*

Cork LDTF – Rehabilitation Programme for Ex-Prisoners

This project based in Cork, received funding to set up a rehabilitation programme with the aim of integrating ex-prisoners back into mainstream society and stop them re-offending.

The project is managed by a partnership of voluntary and statutory bodies but has a specific management committee of four. The Probation Service of the Department of Justice Equality and Law Reform has along with the Governor his staff and the Head Teacher and the Education Department in the prison been the primary animators in the development of this project. The project serves the inmates of the prison who prior to detention resided in the Cork Drugs Task Force area but also works with family members of prisoners and with ex-prisoners and those who are on probation. An addiction counsellor has been employed by the project to work with the above target group.

The project provides a counselling and referral service to clients referred by the Probation and Welfare Service. The project also provides an individual counselling service in Cork Prison and an Addiction Education and Awareness Programme. The worker runs an Alcohol Management Course with the Intensive Probation Scheme and also link in with the Auto Crime Diversion Unit. A working alliance has been established with a number of related groups. Since the project's inception, 181 people have had some form of contact with the counsellor. In addition to this number there is a current waiting list of fifteen.

9.7 Specific targets and settings

Gender-specific issues

SAOL

The SAOL programme is an inner city rehabilitation and training project for a small group of women in recovery or stabilised on methadone. It offers women a chance to acquire a range of skills including literacy and numeracy and other social skills in order to give them a better opportunity to return to normal living. The project operates on the basis of social justice, adult education and community development principles. An evaluation of the project found that women who participate in the programme report increased stability in their lives, increased levels of self-esteem and gains in terms of educational and vocational development (SAOL Project, 1996). No statistics or information on specific training are available.

Women's Health Project

This project was established in 1991 to target women working in prostitution in Baggot St. Clinic of the EHB. The overall aims of the project are to prevent HIV and improve the general health and well being of the women attending the project. There are two main aspects of this service – 1) a drop in medical/counselling service in an informal setting, which aims to promote women's health in a confidential way in an informal setting and 2) an outreach service. The project provides advice on safer sex and injecting, needle exchange and offers a wide range of health services including cervical smears, STD screening, contraception and HIV and Hepatitis testing and referral to other services (O' Neill & O' Connor 1999). The project operates on a peer-support basis where women involved in prostitution are involved in contacting other female sex workers (EMCDDA 1999). Since May 1999, a harm reduction service consisting of a low dose of methadone and needle exchange has been provided on a nightly basis from the mobile clinic unit that operates daily throughout the city. A welfare service is also available once a month which provides advice on welfare rights such as entitlements and housing. No statistics or evaluation results are available. No information on specific training is available.

Star Women's Rehabilitation Project

This project established in 1998, provides a 50 week adult education and training course for 15 women drug users who have stabilised on methadone maintenance. It operates in the Ballymun area of Dublin city. The programme consists of 6 week modules covering a variety of issues including communication, computers, team building, parenting, basic English and art drama and drug issues. Of the 1999 programme cohort, 9 of the 15 initial

participants completed the programme. Of the six that did not complete the programme, four left to pursue further training or other positions. At the end of the programme, nine of the fifteen initial cohort were either in training or community employment, one was employed in the industrial sector, four were actively seeking employment and two were not seeking work (Ballymun Local Drug Task Force, personal communication 2000). During the course of the year, many of the participants attained accredited training qualifications in areas such as word processing, addiction studies, childcare and youth studies. No evaluation results or information on specific training are available.

Children of drug users

Support is provided in some local areas by way of crèche, play-school and after-school facilities for the children of drug users receiving treatment. However, a study by Moran (1999) indicates that current levels of crèche provision are inadequate. The study found that only 20% of drug treatment centres in the Dublin area currently provide crèche facilities and that existing crèche facilities are insufficient. The study found that lack of access to crèche facilities served as a barrier to treatment uptake.

Lorien Project

(See Section 9.1.1 for details).

Parents of drug users

Family Communication and Self-Esteem programme

(See Section 9.1.1 for details).

Fás le Chéile

(See Section 9.1.1 for details).

Kilkenny Drugs Initiative (KDI) Family Support Group

This group, based in Kilkenny city in the south-east of Ireland, was set up for parents and partners of substance misusers in Kilkenny city and county. The group meets once a week for two hours and offers an opportunity for people to come together to chat, share information and talk about their experiences. It also offers the opportunity for personal healing through aromatherapy, meditation, and the chance to engage in substance misuse education programmes. No statistics or evaluation results are available. No information on specific training is available.

Drug use at the workplace

No information available.

Ethnic minorities

Cork LDTF – Travellers Visibility Group

Funding was granted to conduct research on the experiences and attitudes of young travellers and their families in relation to drug misuse. The task force is developing focus groups amongst the young people and through these groups they plan to assess drug experiences amongst the Traveller community.

The issue of drug use among ethnic minorities including an indigenous Irish ethnic group known as 'travellers' is an emerging issue which requires further attention.

Self-help groups

A variety of self-help groups are available through the drug treatment centres. There are also a number of community based self help groups including Narcotics Anonymous which is based on the 12 step AA philosophy and Nar-Anon a support group for the families and friends of drug users based on similar principles. No statistics or evaluation results are available. No information on specific training is available.

Alternatives to prison and prosecution: Lucy Dillon

In Ireland, where drugs are involved in an offence, the police have no discretionary powers to issue a caution [informal or formal] nor to impose an on-the-spot fine. Therefore, officially, charges will be brought against any individual found to have committed an offence against the Misuse of Drugs Act. An exception is made in the case of a juvenile offender (under 18 years old) found in possession of a small amount of drugs, where drug trafficking is not an issue. In such a case, the Juvenile Diversion Programme is brought to bear. The Garda Juvenile Diversion Programme was introduced in 1963 with the aim to divert juvenile offenders from criminal activity. The Programme allows that if certain criteria are met, a juvenile offender may be cautioned as an alternative to being prosecuted. The programme operates on the basis of the common law principle of police discretion (An Garda Síochána 1999). While this programme is specifically aimed at juvenile offenders committing first offences, it can be adapted/extended to include juveniles committing subsequent offences. A juvenile offender who is eligible for inclusion in the programme is dealt with by way of a caution, as opposed to being prosecuted for a criminal offence. Cautions may be either formal or informal. A Juvenile Liaison Officer [JLO]

becomes involved with the offender and the family. While an informal caution may be given by the JLO, a formal caution must be given by the Garda Superintendent of the district where the offender lives. There is no provision for a similar system of cautioning for adults.

In terms of alternatives to prison there is a range of non-custodial options available to sentence those who plead guilty or are found guilty through the courts. The decision of the court in relation to the imposition of a custodial or non-custodial sentence may be influenced by a Pre-Sanction Report where available. This report is compiled by the Probation and Welfare Services and includes information on factors such as addiction that may have contributed to the individual's offending. Pre-Sanction Reports are often not available, however a judge may request that one be provided. The non-custodial options available in the Irish criminal justice system were overviewed in a report on the Irish Probation and Welfare Services (Expert Group on The Probation and Welfare Services 1999) and include :

- A suspended sentence*
- Supervision during deferment of penalty*/ Intensive Supervised Probation: This facility was designed to increase restraints on offenders in the community. Offenders are required to report for frequent urine testing. The type and levels of demand placed on offenders differ enormously by jurisdiction
- A Community Service Order: Community Service Order requires offenders to perform unpaid work for between 40 and 240 hours. There is a perceived lack of suitability of community service for offenders with addictions (Expert Group on The Probation and Welfare Services 1999). This can be due to the Probation Service's inability to provide occupational insurance in the event of an accident due to known disability in the offender i.e. addiction
- A fine: A fine has statutory limits, fixed for a particular offence. The money goes to Central Funds and if unpaid can be enforced by committal to prison
- A Compensation Order: A Compensation Order has a specific statutory format as laid out in the Criminal Justice Act, 1993 and is related to the wrong done. The money goes to the victim as opposed to Central Funds
- A fine and Compensation Order
- Release under the Probation of Offenders Act, 1907: In this instance a decision is made not to proceed to convict
- Probation Order (Probation of Offenders Act, 1907): The purpose of a probation order is to secure the rehabilitation of the offender, to protect the public and to prevent the offender from committing further offences. This is used for drug users by imposing conditions. Conditions may include attendance for treatment and the provision of urine for analysis. This is the preferred procedure in the District Court when dealing with drug users
- Order of Recognisance (Misuse of Drugs Act, 1977, Section 28 as amended by the Misuse of Drugs Act, 1984): This is an order requiring an offender to

* Both these options have no statutory basis but are widely used by the Courts

undergo treatment for his/her drug condition in a residential centre or in the community.

The 'Order of Recognisance' would appear to be an important non-custodial option for drug users who offend in Ireland. However, in practice this Order is not generally used by the courts. The necessary rules and regulations have not been made. Furthermore, the provision of a statutory place of treatment has always been problematic. The Expert Group on the Probation and Welfare Services has recommended that the necessary Courts Rules and Regulations be updated by the various Court Rules Committees to facilitate wider use of the 'Order of Recognisance' (Expert Group on the Probation and Welfare Services 1999).

Furthermore, it is planned that a Drug Courts system will be introduced in Ireland on a trial basis early in the year 2000. 'The Working Group on a Courts Commission' was established by the Minister for Justice, Equality and Law Reform to advise on the development of such a Drug Courts System. As mentioned above, the legislative framework required for such a system is already in place under the Misuse of Drugs Act, 1977 as amended by the Misuse of Drugs Act, 1984.

'Power of court to remand person convicted of offence to which section 7 applies and to obtain a report and in certain cases to arrange for the medical or other treatment or for the care of such person.'

[Section 8, Misuse of Drugs Act, 1984]

While this legislative framework exists, little use of it has been made in relation to a court arranging for the treatment of an individual. The Working Group's report however describes what it sees as a 'quasi-drug courts system' in operation in some courts. In these instances a court may adjourn a case for a time, usually a year, during which time the accused undergoes treatment while being monitored by the Probation and Welfare Services. The accused enters into a bond that requires him/her to follow the direction of the Probation and Welfare Services over a certain period of time, usually at least one year. Where this bond is broken, for example if the accused gives a urine sample that tests positive for opiates, the Probation and Welfare Service and the Gardai can bring offenders back to the court. The limitations to this process have been highlighted by the Working Group. These include a lack of resources in the Probation Service.

In a second example, the report describes a sentencing structure adopted by one particular judge residing in the Circuit Court. Upon a guilty plea the defendant is either remanded on continuing bail or in custody. A Probation and Welfare Report is then requested and the defendant is given the opportunity to address his/her addiction by attending treatment and undergoing urinalysis. When the defendant returns to court for sentencing the Probation and Welfare Report is taken into account (Working Group on a Courts Commission 1998).

Thus, while a 'quasi-drug-court' system may be in place in Ireland, this does not function in a unified or structured manner, and does not have adequate infrastructure. At the time of writing the application of such diversion activities depend on individual judges and the availability of relevant support. The implications of such activities therefore occurs in an ad hoc manner. A structured drug court will be initiated on a pilot basis later in the year 2000 under the jurisdiction of the District Court. This pilot programme will be subject to an independent evaluation.

10. Quality Assurance

10.1 Quality assurance procedures

As outlined in 12.3 below, a culture of evaluation is developing in the drugs area and is an integral aspect of programme development in some existing programmes. For example, guidelines have been developed for the conduct of evaluations in the context of the LDTFs [see 12.3].

Evaluation of Local Drug Task Force Funded Projects

Over 200 projects were funded through the Local Drug Task Forces during 1999 and 2000. During April and May 2000, 133 of these projects were evaluated. The evaluations were process orientated and centred on the development of objectives and setting up of appropriate structures and processes to support the achievement of these objectives rather than outcomes.

Of the projects evaluation, half were in the field of education and prevention, about a third (36%) were treatment and rehabilitation projects, and the remainder were in a combination of education/prevention and treatment/rehabilitation (7%), research and information (3%) and supply control (3%). Most of the projects were based in either the voluntary/community sector (58%) or were a partnership of voluntary and statutory agencies (22%), 6% were statutory agency projects and the remaining 14% were classified as 'other' (National Drug Strategy Team, personal communication). On the basis of the evaluation reports produced, the National Drug Strategy decided that 122 of the 133 projects would be mainstreamed. This effectively means that these projects will receive statutory funding on an on-going basis in line with agreed procedures. A composite evaluation report is currently being compiled, however, it was not available at the time of writing.

10.2 Treatment and Prevention Evaluation

There is little evaluation carried out in the treatment services but this is changing with a move towards evidence-based health care delivery.

Review of EHB Drugs and AIDS Service

A review of the Eastern Health Board's Drugs and AIDS services was conducted during 1999 (Farrell et al. 2000). The review was designed to examine the service development over the 5 years since the last review was undertaken, to assess the current service provision and service mix and to make recommendations about policy development and the evolution of policies in the context of services and practices elsewhere. The report concluded that the Eastern Health Board has achieved a major expansion in drug services over the last five years and has developed innovative services. A number of recommendations were made in the report. It was suggested that an audit of benzodiazepine use should be conducted and that the current needle exchange facilities be expanded. The need to broaden the services available and consider briefer types of intervention was also recommended (See Section 9.4.1 for further details of the evaluation).

10.3 Research

A National Advisory Committee on Drugs comprising of experts from the research, voluntary, community and statutory sectors was established during 2000 to co-ordinate and commission research on drug problems. This advisory group have identified a prioritised three year research programme.

The Drug Misuse Research Division has an active research programme and currently 8 projects are underway [see www.hrb.ie].

An Addiction Research Centre has recently been established in Trinity College Dublin. This centre will be involved in research into drug addiction in the coming years.

10.4 Training for professionals

There has been a major proliferation in the number of training courses in the drugs area in Ireland in recent years [see *Department of Tourism, Sport and Recreation 1999. Directory of Training Courses in Drug Misuse*]. The growth in provision is partly in response to a growing demand for trained workers with expertise in the drugs area, e.g. community and voluntary sectors, inter alia.

In August 1999, the Department of Tourism, Sport and Recreation commissioned a study to compile a directory of existing courses and to identify gaps and overlaps. The study identified a wide variety of training courses, ranging from single sessions to courses lasting between one and three years. The depth of coverage of the issues varies considerably, according to the length of the course and the level at which it is aimed. There are also variations in the training methods and in the underlying principles and approaches to the issues of drug misuse. The problem of drug misuse provokes different feelings, attitudes and

beliefs, and these are reflected to some extent in the training courses listed in the directory. Some courses provide broad coverage of a variety of viewpoints, while others are clearly based in the context of a particular perspective.

While there is a wide range of courses available, not all of these are available throughout the country. In general, the Dublin area is best provided for, while the range of training available elsewhere is more limited, although there are indications that this is beginning to change.

The courses listed in the directory are divided into six categories, according to course length and purpose. The categories used are as follows:

- A) Short courses aimed at providing basic information and/or raising awareness of drug misuse among the general public
- B) Short courses aimed at providing information, raising awareness and developing skills among those whose paid or voluntary work brings them into contact with drug misuse
- C) Longer courses aimed at providing information, raising awareness and developing skills among those whose paid or voluntary work brings them in contact with drug misuse
- D) Courses leading to professional qualifications in the field of drug misuse
- E) In-service training for professionals and other vocational groups working in the field of drug misuse or related areas
- F) Courses in drug misuse aimed at young people.

The directory is very extensive (though it claims not to be exhaustive) and includes almost 40 courses. Therefore, in this section, only a selection of these courses is described. *As the purpose of this section is to describe the types of courses that are available for professionals*, the courses described here are examples of the type of courses offered under categories C and D listed above which covers courses for both community members and voluntary workers and courses that result in professional qualifications. Within these categories, the courses were chosen to represent examples of the type of programmes offered by the three main education providers in this area, namely, community organisations, voluntary agencies and the third level education sector. *No statistics or evaluation results are available for any of the programmes presented here.*

Examples of Category C Courses

DICE – Drugs Information and Community Education

This course is provided jointly by two community development projects based in one Dublin suburb – namely the Project West Community Development Project (CDP) and Finglas South CDP. The course was developed as a local response to drug addiction and leads to the award of a National University of Ireland (NUI) certificate. The programme, which is 100 hours in duration, is designed for

community members. It is designed to allow participants develop an awareness and understanding of addiction and how it can impact on the community.

Urrus/Ballymun Youth Action Project

The Ballymun Youth Action Project, the first community response to drug misuse in Ireland, was set up in 1981. Urrus was established in 1996 to deal with all aspects of training within the Ballymun Youth Action project. Urrus runs two courses in the drugs area: a community addiction studies course and a course that provides further training in community drugs work.

The community addiction studies course : This course consists of five units (drugs and their effects; the process of addiction; intervention strategies; community responses; and personal development) and is 100 hours in duration. It aims to provide participants with knowledge about different drugs and their effects, to raise awareness of the dynamics of addiction, to challenge attitudes towards drugs, addiction and communities affected by addiction. It also examines community responses to drugs using the Ballymun Youth Action Project as an example. It is open to anyone with an interest in the drugs field including; professionals, community and voluntary workers, community members, young people, stabilised drug users and people in recovery. It is counted as one module of a National Council for Vocational Assessment (NCVA) level 2 qualification.

Further Training in Community Drugs Work : This course is aimed at local people who have completed the Community Addiction Studies course. It is designed to provide participants with the skills to deliver drug awareness programmes in their own communities. It is counted as two modules of a National Council for Vocational Assessment (NCVA) level 2 qualification.

IACC Training

The Irish Association of Addiction Counsellors has secured funding to provide additional training in drug misuse treatment to ensure high standards are maintained in the area.

Merchants Quay Project Drugs/HIV Service

The Merchants Quay project provides a number of courses in drugs and addiction education including the following:

- Foundation level course in drug use and addiction

This course serves as an introduction to the broad issues associated with drug use and addiction. It is designed to prepare participants to interact with drug users and the issues that they face.

- Motivational interviewing and brief counselling skills course

This intensive three-day course is aimed at people working with drug users. It is designed to teach participants motivational interviewing and brief counselling/intervention skills.

- Certificate in drug counselling and intervention skills

This one-year part-time course validated by the University College Dublin aims to provide participants with the skills to respond more effectively to the issue of drug misuse. The course consists of three modules: theories and models of; 1) addiction, 2) intervention and brief therapy skills for working with drug users and 3) policy and prevention. It is targeted at both paid and voluntary workers who work in the area of drug misuse.

Examples Of Category D Courses

National Diploma/Degree in Community Drug Prevention Studies

The Waterford Institute of Technology, located in the South east of Ireland, provides an introductory certificate, a diploma and a degree course in community drug prevention. All courses are offered on a part-time basis. The aim of the courses is to provide accredited third level education that will qualify candidates to work in the area of community drug prevention. The courses were developed in conjunction with the South Eastern Health Board in response to a need for skilled drug workers in the region.

National University of Ireland (N. U. I.) - Certificate in Addiction Studies

This course run by the Centre for Adult Education, N U I Maynooth, is aimed at voluntary and community workers with experience or interest in the drugs area. It is designed to provide participants with the knowledge and skills necessary to respond positively to addiction related issues. It focuses on current debates on addiction and uses teaching methods based on the principles of adult education. In 1999/2000, the course is also being provided at a number of locations in the Dublin area and to Eastern Health Board staff. The course is also being offered in Clonmel (South Eastern Health Board).

Trinity College Dublin - TCD

The Department of Social Studies, in Trinity College, provides both a Diploma in Addiction Studies and an M.Sc. in Drug and Alcohol Policy.

Diploma in Addiction Studies - TCD

This one-year full-time course is aimed at people with experience in the drugs field. It is designed to allow participants to familiarise themselves with the various treatment modalities and to develop an understanding of evaluative research. It examines the theoretical and practical aspects of problem drug and alcohol use and analyses public policy in relation to alcohol and drug problems. Participants are also trained to be proficient in the use of at least one of the major counselling approaches.

M.Sc. in Drug and Alcohol Policy - TCD

This part-time course conducted over a two-year period is aimed at those holding management or policy-making positions in the alcohol and drugs field. It is designed to allow students to develop a broad critical understanding of how society attempts to prevent or respond to problems associated with the use of illicit and licit drugs. The course consists of six modules; 1) alcohol and drugs – use and problem use, 2) national and international policy, 3) research and evaluation, 4) research seminars, 5) therapeutic interventions into problem alcohol/drug use and 6) service management.

11. Conclusions: future trends

A partnership approach has been adopted in the drugs area in Ireland with voluntary, statutory and community sectors working together to tackle the drug problem. This approach is reflected in the Local Drugs Task Force (LDTF) structures and in the models of work adopted by the Health Boards. This model appears to be working well and is likely to continue in the future.

Community based projects based in the areas designated to have the most serious drug problems, have in recent years, been securing funding through the Local Drugs Task Force structures. This trend is also likely to continue, as is the recent approach of mainstreaming projects funded through the LDTFs following evaluation.

The increase in the funding allocation for the Young People's Facilities and Services Fund (YPFSF) should result in a proliferation of projects aimed at young people in disadvantaged areas over the coming years.

Two other major additional developments during 2000 are likely to have a major influence in the drugs area; 1) The Review of the National Drug Strategy and 2) the establishment of a National Advisory Committee on Drugs.

The findings of the National Drug Strategy Review will have a major impact in shaping Irish drug policy in the coming years. The National Advisory Committee

on Drugs will, inter alia, provide support for research which will help inform policy in Ireland over the coming years.

There also appears to be an increased focus on rehabilitation in the drug services and on increasing the options available to drug users in treatment, particularly in relation to providing alternatives to methadone, which is likely to continue for the foreseeable future.

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PART 4

KEY ISSUES

12. Drug Strategies in European Union Member States : Rosalyn Moran

12.1 National policies and strategies

Since 1996, the Irish Government's drugs strategy has been underpinned by the findings, recommendations and policies established by the two reports of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.

De facto, national policies and strategies in recent years have been undergoing considerable changes which involve an integrated, inter-agency response to the drugs problem with involvement of local communities in policy making and implementation [e.g. Integrated Services Process, Local Drug Task Forces etc.]. More recently, greater regionalisation in the implementation of initiatives in the drugs area is taking place within the framework of the new National Development Plan 2000-2006 and related social partnership arrangements, which, inter alia, prioritise social inclusion as an objective of national development. These and related developments are likely to be reflected and, if so, formalised in the major review of the National Drugs Strategy which is currently underway and which is due for completion before the end of 2000 [see below].

At the micro level, a major objective of drug policy in Ireland is to maintain people in, and restore misusers to, a drug free lifestyle. In practice, it is acknowledged that this is not an option for a number of citizens in the short term. Accordingly, a pragmatic approach is taken and the importance of the minimisation of risk i.e. harm reduction is stressed in treatment and in a number of education and rehabilitation programmes. The emphasis on harm reduction has grown with the concern relating to the public health implications of the growth in AIDS/HIV and hepatitis B and C infections.

The overall aim of the Irish Government's Drug Strategy is to provide an effective, integrated response to the problems posed by drug abuse and to work in partnership with the communities most effected by the drugs problem in tackling the issues raised.

Arising from this, the *key objectives* of Government policy are to :

- reduce the number of people turning to drugs in the first instance through comprehensive education and prevention programmes
- provide appropriate treatment and aftercare for those who are dependent on drugs

- have appropriate mechanisms at national and local level aimed at reducing the supply of illicit drugs and
- ensure that an appropriate level of accurate and timely information is available to inform the response to the problem.

In line with these overall aims and objectives, *four basic principles* underpin the Government's strategy :

- it is recognised that an effective strategy must encompass a range of responses which not only addresses its consequences, but also attacks its causes
- the response to the drug problem must take account of the different levels of drug misuse, which are being experienced around the country. While illicit drug use is a nation-wide phenomenon, [particularly the use of drugs such as cannabis and ecstasy], heroin abuse – in view of its public health implications and close association with crime – is currently seen as the most pressing aspect of the problem. A more targeted response is required, therefore, in the areas experiencing the highest levels of heroin abuse
- the need for all agencies which have a role in responding to the drug problem to work together so as to ensure that their individual contributions form part of an overall coherent approach. There is a need to ensure that all programmes and services which respond to the drug problem are delivered in a coherent, integrated manner
- the need to tap the depth of experience and knowledge which community groups and voluntary organisations can bring to a response to the drug problem. It is recognised that there is considerable knowledge and experience among communities in the areas experiencing the highest levels of use. These communities, therefore, must have an opportunity to participate in the design and delivery of the response to the problem in their areas [Flood, 1999].

An interesting aspect of the Irish Government's drugs strategy is a resourcing of the development of sporting and recreational activities for young people at risk with a view to promoting more healthy and productive behaviour.

As outlined in Part 1, Ireland's drug policy is most appropriately viewed within the framework of the Government's response to social exclusion. A nexus of agreements between the Government and the social partners has resulted in social inclusion becoming a major aspect of the Irish National Development Plan 2000-2006. Under this seven year Plan spending earmarked for social inclusion amounts to Ir£19,077.7 million i.e. Euro 24,223.7m. The Plan involves greater devolution to the regional and local levels, with the South-East region and Border-Midland West regions receiving respectively allocations of Ir£112 and Ir£10 million [Euro 142.2m & 12.7m] specifically to combat drug abuse.

The recently established County and City Development Boards – CDBs whose primary function will be to draw up a comprehensive Strategy for Economic, Social and Cultural Development [by Jan 2002] have a key role in co-ordinating

local delivery of social inclusion measures. The CDB's will operate on the partnership principle with the Regional Assemblies and under the local government umbrella with membership drawn from local development organisations, social partners, local representation of State agencies and local government itself [NDP – National Development Plan 2000]. A Director of Community and Enterprise has been appointed by each CDB. All the relevant programmes and projects, and their delivery mechanisms, covered by the NDP will be expected to accord with this framework.

The Government's social inclusion strategy involves a range of responses, which addresses the causes and consequences of drug misuse. The Government's response can be characterised as supporting **general initiatives** to tackle social exclusion and **specific initiatives** within the social inclusion framework but more specifically targeted at drug related problems. The general initiatives are targeted at issues seen as contributing to the drugs problem [e.g. unemployment, social deprivation] [see DMRD (1999), National Report on Drug Issues 1999, Ireland; internal report]. Such programmes provide scope for agencies and communities affected by the drugs problem, to avail of financial and other resources to tackle the broader problems associated with drug misuse in their communities.

The Government's specific response to tackling the drugs problem is focused around two major initiatives - the Local Drug Task Forces and Young People's Facilities and Services Fund [see 12.2 below]. Both initiatives have been largely focused on urban areas where the drug problem is most acute. These initiatives will be described in section 12.2 below.

*In addition to these two major initiatives which are largely focused in urban areas, Government strategy has begun to address the drug problem on a nation-wide basis in particular the use of recreational drugs, such as cannabis and ecstasy, particularly among young people. **Regional Drugs Co-ordinators** have been appointed to assist the Regional Health Boards in developing appropriate programmes and services, mostly in relation to drug awareness, education and prevention. A number of the Health Boards have set up Regional Co-ordinating Committees in their areas, which work in partnership with other relevant agencies in developing a co-ordinated response to the drug problem, having regard to the needs of their particular regions.*

The **status of the national strategy on drugs** in Ireland is characterised by change and development at this time. The Government [informed by experience with the implementation of the various policy initiatives at local level and by international experience] have identified a need to examine the existing strategy and initiatives. Two major initiatives have been put in place in this context. A comprehensive review of the National Drugs Strategy is underway and is due to report before the end of 2000, and a National Advisory Committee on Drugs has been established.

Review of the National Drugs Strategy

A comprehensive review of the National Drugs Strategy was initiated by the Department of Tourism, Sport and Recreation in April 2000. A sub-group of the Inter-Departmental Group on Drugs, which includes representatives of the State Agencies and the National Drugs Strategy Team, are overseeing the management of the review. They were assisted by independent consultants. It is intended that the review will be completed and the new strategy in place before the end of the year.

The objective of the review is to identify any gaps or deficiencies in the existing strategy and to develop revised strategies and, if necessary new arrangements through which to deliver them. The review will identify the latest available data on the extent and nature of drug misuse in the country as a whole and it will also attempt to identify any emerging trends and pinpoint the areas with the greatest levels of drug misuse. To be as comprehensive as possible, the review will also be looking at international trends, developments and best practice models [DofTSR, Internal doc., No. 2].

The review has involved extensive consultations through invited submissions [over 190 received], discussions with key players in the State, voluntary and community sectors and through a series of 8 public regional consultative fora [attendance 600 approx.] held throughout the country during June 2000. Over 30 agencies and organisations were invited to make detailed presentations to further assist in the identification of any gaps or deficiencies in the current strategy. These consultations will be underpinned with extensive research of international examples of best practice, a review of various relevant evaluation reports and other literature.

The Drug Misuse Research Division made a detailed written submission and were one of the groups invited to make a presentation at the oral hearings.

While the results of the review will not be published until the end of 2000/early 2001, on the basis of the Drug Misuse Research Division's attendance at the Public Fora held nationwide, and documents to hand [DofTSR, Internal Document] the emerging issues include :

- the need for co-ordination between the various "players" – statutory and voluntary/community – dealing with the drug problem on the ground (especially in non-task force areas)*
- the need to make substance misuse programmes compulsory in all schools, particularly in Local Drug Task Force areas to heighten awareness*
- the need for a continuum of care for drug users and for more "half-way" houses for recovering drug users to ease the transition back to "normal" life*
- the need for an awareness programme for parents to educate them on issues around drug misuse and the various services that are available*

- the inclusion of alcohol in any new strategy – for many areas, under-age drinking is seen as a big problem and a “gateway” drug
- the need for a major media campaign highlighting the dangers of drug use
- the need for increased treatment facilities
- the need for improved community policing particularly in areas of high drug misuse
- the need for research findings into all aspects of drug misuse.

In addition, an address by the Minister of State for Local Development and with special responsibility for the National Drugs Strategy, Mr. Eoin Ryan T.D. at the European Cities Against Drugs [ECAD] conference on 28th April 2000 where he outlined some of his policy priorities for tackling the drugs problem over the coming years, is indicative of future directions -

1. Continuation of support for the Local Drugs Task Forces as a mechanism for responding to the drug problem at local level.
2. Given the success of the Task Forces, it intended that the partnership principles enshrined in them are expanded to the rest of the country.
3. Programmes to move people who are in treatment towards full rehabilitation and re-integration into society will be supported. Such programmes will address the education and training needs of drug users, to equip them with the skills to access employment.

National Advisory Committee on Drugs

An Interim Advisory Committee on Drugs was established by the Cabinet Committee on Social Inclusion in recognition of the importance of having authoritative information and research findings available as a guide to policy. The Group was chaired by the then Minister of State with special responsibility for National Drugs Strategy, Chris Flood T.D.. The Group reported in February 2000 and, inter alia, made a number of recommendations regarding a structure and composition for a National Advisory Committee and recommendations for a three year programme of research and evaluation on the extent, nature, causes and effects of drug misuse in Ireland.

The resultant National Advisory Committee on Drugs, NAC - was established in July 2000. The Committee is being established on a non-statutory basis for 3 years and will have responsibility for research and information on drug misuse in Ireland and for a 3 year prioritised work programme of research and evaluation.

The functions of the Committee are as follows :

- to advise the Cabinet Committee on Social Inclusion and through it, the Government - based on the Committee's analysis and interpretation of research findings and information available to it - in relation to the prevalence, prevention, treatment and consequences of problem drug use in Ireland

- *to review current information sets and research capacity in relation to the prevalence, prevention, treatment and consequences of problem drug use in Ireland and to make recommendations, as appropriate, on how deficits should be addressed including how to maximise the use of information available from the community and voluntary sector*
- *to oversee the delivery of a three year prioritised programme of research and evaluation as recommended by the Interim Advisory Committee to meet the gaps and priority needs identified by;*
 - ◆ *using the capacity of relevant agencies engaged in information gathering and research, both statutory and non-statutory to deliver on elements of the programme*
 - ◆ *liaising with these agencies with a view to maximising the resources allocated to delivering the programme and avoiding duplication*
 - ◆ *co-ordinating and advising on research projects in the light of the prioritised programme;*
 - ◆ *commissioning research projects, which cannot be met through existing capacity*
- *to commission additional research at the request of the Government into drug issues of relevance to policy*
- *to work closely with the Drug Misuse Research Division of the Health Research Board on the establishment of a national information/research database (in relation to the prevalence, prevention, treatment and consequences of problem drug use) which is easily accessible*
- *to advise relevant agencies with a remit to promote greater public awareness of the issues arising in relation to problem drug use and to promote and encourage debate through the dissemination of its research findings.*

The first meeting of the Committee took place in late September 2000. The head of the Irish Focal Point has been nominated to serve on the Committee.

On foot of the report of the Interim Committee, the Drug Misuse Research Division of the Health Research Board - HRB, has been nominated to establish a National Documentation Centre. The Government has designated the HRB as a central point to which all information on drug use in Ireland should be channelled. [Press release : Minister of State, Eoin Ryan establishes NAC on Drugs, July 2000]. The Documentation Centre will include a drop-in access point or library facility focusing on grey literature in the drugs area, development of an electronic library and in collaboration with the EMCDDA a virtual library which will provide access to a pan-European information network on drugs. In the long term it is envisioned that this resource will be entirely electronically based. Related added value activities envisioned include regular publication of a Register of Research on Drug Misuse in Ireland and Annotated Bibliographies on Drug Misuse in Ireland. An information and dissemination function will be an integral part of the Centre.

An overview of the Three Year Work Programme of the National Advisory Committee on Drugs is presented in Box 12.1 [see next page].

Box 12.1 : Three Year Work Programme of National Advisory Committee

Inventory of Research and Information :

- to compile a comprehensive inventory of existing research and information sets relating to the prevalence, prevention, treatment/rehabilitation and consequences of problem drug use in Ireland.

Improved co-ordination of research and data collection :

- to open communication channels with key agencies to ensure that the NAC is kept informed of any new research being undertaken or new data being collected
- to establish a research network which will ensure better co-ordination and integration of research projects among relevant agencies and maximise resources in the context of the NAC's programme of research.

Prevalence :

- to determine the size and nature of the drug problem in Ireland
- to determine the extent and nature of opiate use, poly-drug use and patterns of problem drug use (experimental, occasional, regular non-medical use) particularly among young people under 25
- to identify emerging trends and geographical spread
- to determine the extent and nature of problem use of prescription drugs
- to determine the prevalence of problem drug users not in contact with treatment services.

Prevention :

- to examine the effectiveness in terms of impact and outcomes of existing prevention models and programmes, with particular regard to evaluation instruments developed at European level
- to undertake comparative studies of different models with particular reference to those in operation in Task Force areas
- to determine transferability of models among different target groups.

Treatment/Rehabilitation :

- to examine the effectiveness in terms of impact and outcomes of existing treatment and rehabilitation models and programmes
- to undertake longitudinal studies of the effectiveness of existing treatment and rehabilitation models
- to examine the context in which relapse occurs
- to examine the impact of the treatment setting.

Consequences :

- to examine the cost to society of the drug problem in terms of :
 - . drug related deaths
 - .the impact of drugs on the family and communities
 - .the relationship between drugs and crime
 - .the methods for tackling social nuisance related to drug misuse.

12.2 Application of national strategies and policies

The ongoing review of the National Drugs Strategy underway may result in changes to the existing and emerging mechanisms outlined below. The existing institutional mechanisms involved in ensuring the implementation of the National Drug Strategy, not surprisingly, overlap with the mechanisms in place to combat social exclusion in general. Foremost here is the **Cabinet Committee on Social Inclusion** – which gives political direction to the Government's social inclusion policies including the national drugs strategy. This Committee receives input from the **Inter-Departmental Group on National Drugs Strategy** and the National Drugs Strategy Team. The relevant Government Departments and agencies are represented in these groups. In addition, two representatives, one from each of the community and voluntary sectors, are represented on the **National Drugs Strategy Team** which plays a central role in overseeing the implementation of the Government's Drug Strategy and at the operational level the work of the Local Drugs Task Force, inter alia. The Team was established on the principles outlined in the Strategic Management Initiative for addressing issues which cut across the remit of a number of Government Departments and Agencies. **The Drugs Co-ordinating Committees of the Regional Health Boards** operate at the regional level. The **Local Drugs Task Forces** – 12 in Dublin, 1 in Cork and 1 in Bray - provide a strategic locally-based response by the statutory, community and voluntary sectors to the drug problem in the areas worse effected. The **National Assessment Committee and Development Groups** established under the **YPFSF** are also involved at the implementation level [see below].

Preliminary arrangements have been put in place to give expression to the recent developments towards greater devolution to the regional level under the National Development Plan 2000-2006 inter alia. Accordingly, the LDTFs and Area Based Partnership Companies are due to work with the Directors of Community and Enterprise and the City/County Development Boards - CDBs, when drawing up their integrated local action plans. Arrangements for co-ordination of planning and delivery of services are to be agreed with the CDBs.

Local Drugs Task Force – LDTFs

Purpose : The Local Drugs Task Forces were established in 1997 with a three fold purpose - to ensure effective co-ordination of drug programmes and services at local level; to involve communities in the development and delivery of locally based strategies to reduce the demand for drugs and to focus actions on tackling the problem in the communities where it is at its most severe. It was hoped that the establishment of the Task Forces would also help offset the feelings of marginalisation and abandonment being felt by these communities.

*Functions : Fourteen LDTFs² have been established in areas experiencing the highest levels of drug misuse and, in particular, where heroin misuse is most prevalent. In line with the aims of the Government strategy outlined above, the LDTFs were mandated to prepare and oversee the implementation of **action plans** which co-ordinate all relevant drug programmes in their areas and to address any gaps in service. Over 200 separate measures, mainly **community based initiatives**, were initially funded to complement and add value to existing services and programmes under the themes of education, prevention, treatment, aftercare, rehabilitation and reducing supply [DofTSR (1999). A Handbook - Local Drugs Task Forces – A local response to the drug problem, Dublin].*

Composition : The Task Forces comprise representatives from statutory bodies such as the Health Boards, Garda Síochána, Local Authorities, FAS (training and employment agency), the Vocational Education Committees, Probation and Welfare Service, Departments of Education and Science and Social Community and Family Affairs [under discussion at moment]* as well as from voluntary and community groups. It is expected that representatives at a senior level from these agencies be nominated to the Local Drug Task Forces – i.e. people who are in a position to influence policy. In addition, organisations are required to view staff participation in Task Force activities as core duties and to allocate the time necessary for meaningful participation.*

The formal composition of the Task Forces allows for broad representation and, in addition, allows for representation of vocational groups/agencies through the sub-committees and working groups of the Task Forces. Drug users can achieve representation through the use of drug user fora. Some of these latter groups are campaigning for more direct involvement. Task Forces are required to ensure that appropriate procedures are in place to assist them with the regular review of representation [see DofTSR (1999), LDTF Handbook, p16]. At this stage of the development of LDTFs, formal and informal activists are calling for greater networking and sharing of experiences between Task Forces.

Structure and Functioning : When the Task Forces were being established, an independent chairperson was nominated to each Task Force by the Area Partnership in whose area the Task Force operates. The Area Partnerships were set up in 38 disadvantaged areas around the country [including all the LDTF areas] under the Operational Programme for Local Urban and Rural Development 1994-1999, to address the issue of long term unemployment, particularly in the context of social inclusion. Subsequent chairperson vacancies are filled through nomination by the Partnership, in consultation with the Task

² The LDTF areas are: Ballyfermot, Ballymun, Blanchardstown, the Canal Communities, Clondalkin, Dublin North Inner City; Dublin South Inner City, Dublin 12, Dun Laoghaire/Rathdown, Finglas-Cabra, North Cork City, North East Dublin and Tallaght. Bray has recently been designated as an LDTF area.

- Not initially part of the LDTFs but added/being added, in view of the key role which initiatives operating under their aegis play in responding to drug misuse.

Force and the National Drug Strategy Team. The Area Partnerships also channel funding to certain projects and administer the Task Force administrative budgets [see DoF TSR (1999). Handbook, p.30].

Supports : A range of supports have been put in place to assist the Local Drug Task Forces in their work. Each Task Force has a full-time co-ordinator funded by the relevant Health Board. The Community Sector is supported by Dublin Citywide Drugs Crisis Campaign which acts as an umbrella group for the community sector, trade unions and voluntary groups tackling the drugs problem. Citywide facilitates training and regular meetings of the Task Force community representatives. A similar support structure for the voluntary sector is under consideration. Each LDTF has been requested to identify their training needs.

Phases and Funding : Phase 1 of Local Drug Task Force Operation – From January 1997 to October 1998 : The Task Forces prepared action plans for their areas and Ir£10 million/Euro 12.7m, was set aside to finance such plans. This money funded over 200 separate projects - mostly community based and designed to complement and add value to the drug programmes and services already being provided or planned by the State Agencies. Although projects were initially funded on a one year basis, they subsequently received interim funding, pending their formal evaluation and a decision in relation to their 'mainstreaming' [see below].

An evaluation of the Local Drug Task Forces was concluded in October 1998 which focused on the processes and structures associated with the initiative. The evaluation found that the Local Drug Task Forces had 'achieved a considerable degree of success in the short term since they were established and that their very existence had provided a strong focus for tackling drug issues in the target areas, often reducing the feeling of isolation felt by local communities and preventing a potentially critical situation from developing further' [PA Consulting Group 1998].

Phase 2 of Local Drug Task Force Operation - From October 1998 to date i.e. October, 2000 : The National Drugs Strategy Team subsequently undertook a detailed review of the operation of the Local Drugs Task Forces – taking account of the findings and recommendations of the independent evaluator. In July 1999, the Cabinet Committee on Social Inclusion agreed arrangements for the continued operation of the Local Drugs Task Forces based on the recommendations brought forward by the National Drug Strategy Team, on foot of this review.

These arrangements included the continuation of the Local Drug Task Forces for at least a further two years, new terms of reference and the addition of elected public representatives and representatives from the Departments of Education & Science and Social, Community & Family Affairs [under discussion at moment] to the membership of the Task Forces, [in view of the key part which initiatives

operating under the aegis of these Departments play in the response to the drug problem]. They also included the putting in place of an evaluation framework which would allow the LDTF initiative to be measured in terms of outcomes and impacts [see details in Box 12.2 below]. A Handbook - Local Drugs Task Forces – A local response to the drug problem, outlining the revised arrangements for the operation of the Task Forces was published by DoF TSR in late 1999 [referred to in text as DoF TSR (1999) Handbook.]

Box 12.2

Arrangements Adopted by the Cabinet Committee on Social Inclusion for the Continued Operation of the Local Drug Task Forces – July 1999

- *New Terms of Reference for the Local Drugs Task Force have been developed. Thus LDTF are to :*
- *oversee and monitor the implementation of projects already approved under their existing action plans*
- *ensure the evaluation of current projects, with a view to their mainstreaming by the relevant statutory agencies*
- *in accordance with agreed guidelines, prepare updated action plans which:*
- *update the area profile and take into account changes in the drug problem since preparation of the original plan and*
- *ensure that emerging strategic issues are identified and propose policies (actions) to address such issues*
- *oversee the implementation of the local drugs strategy, in consultation with appropriate voluntary and statutory agencies and community/resident groups*
- *ensure appropriate representation by the voluntary and community sectors on the LDTF*
- *identify any barriers to the efficient working of the LDTF*
- *develop networking arrangements for the exchange of information and experience with other LDTFs and the dissemination of best practice*
- *identify the training needs of LDTF members and take the necessary steps to ensure those needs are met through appropriate courses, training programmes etc.*
- *take account of and contribute to other initiatives aimed at tackling social disadvantage under the aegis of the Cabinet Committee on Social Inclusion, including the Integrated Services Process, the Young Peoples' Facilities and Services Fund, the Local Development Programme, the Community Development Programme, etc.*
- *provide such information, reports and proposals to the NDST, as may be requested from time to time.*
- *Membership of the Local Drugs Task Force to be expanded to include representatives from the Department of Education and Science and Department of Social Community and Family Affairs and it is recommended that locally elected public representatives be given the option of becoming members.*
- *Each Local Drug Task Force to be asked to prepare updated action plans, following specified guidelines which stressed the need for a more strategic approach. The updated action plans are to be structured in 3 parts, as follows – review of progress in implementing the existing action plans; development of a revised strategy and development and prioritisation of specific proposals to give effect to the revised strategy. The guidelines provided were very detailed and further guidance in the form of information sessions was made available to Local Drug Task Forces particularly with reference to compiling and disseminating examples of best practice under the various themes to be addressed in the plans.*
- *Designation of Local Drug Task Force Areas – it was recommended that the focus should be on those areas, where the drug problem is most acute. The criteria to be used in determining such areas should be drug treatment data from the Health Services; Garda crime statistics;*

data relating to school attendance/drop out and other relevant data on the levels of social and economic disadvantage in the area. Using these criteria it was recommended that Bray to added to the designated Task Force areas.

In agreeing these arrangements, the Cabinet Committee also allocated a further £15 million/Euro 19.05m to the initiative over the period 2000 – 2001. This funding will enable the Task Forces to update their plans, as well as address issues which need to be tackled on a cross-Task Force basis. As indicated above, the National Drugs Strategy Team have issued detailed guidelines to assist the Task Forces in updating their plans.

Under the revised Drugs Strategy in the National Development Plan, the allocations to combat drug abuse specifically through the LDTFs³ will be £122 million Irish pounds/Euro155m over the seven year period of the Plan. The allocation under the Regional Programmes will be Ir£112 million/Euro142.2m, for the SE Region and Ir£10 million/Euro12.7m for the BMW Region. [DofTSR, Internal Doc. 10].

Achievements of LDTF

The LDTFs are an innovative response to a serious drug problem which manifested itself most acutely in a number of deprived communities. Amongst the achievements of the initiative has been the active and constructive community response in areas where resources were few and the establishment of a broad range of initiatives in the areas of treatment, rehabilitation, education, prevention etc. which address local needs.

Mainstreaming of Local Drug Task Force projects has been instituted in order to ensure the continuity of projects which are meeting their aims and objectives. The National Drug Strategy Team has prepared a set of protocols to govern the mainstreaming of such projects. Fundamental to mainstreaming in this context, is the transfer of budgetary responsibility from Government departments to agencies / project promoters for specific pieces of work. The exchange to be consolidated as a formal contract /agreement witnessed by the Local Drug Task Force. Standards acceptable for Exchequer accounting purposes will apply. These protocols will provide a platform on which project promoters and statutory agencies can enter into an arrangement for the continuous operation of projects on a mutually acceptable basis.

One hundred and forty Task Force projects were evaluated April-June, 2000 and 1224 of them were subsequently mainstreamed involving a number of Government departments. PR Consultancy has coordinated a composite report on the evaluation. Mainstreaming will ensure ongoing funding. The process copperfastens the role played by community and voluntary organisations in responding to drug misuse at a local level.

³ DofTSR vote

⁴ This includes the merging of a number of projects on foot of recommendations from the evaluators.

Documentation provided by the DoTTSR indicate the following as amongst the achievements of the LDTFs - 800 stabilised drug users are participating in specially designed Community Employment projects developed by the Task Forces, in conjunction with FAS, the national training agency. These projects, supplemented with treatment and counselling, will assist drug users to improve their employment potential [DoTTSR, Internal Document, No.1]. The Task Forces have also been involved in creating greater awareness about the issues around drug misuse. Nearly 350 schools have undergone drug awareness programmes in Task Force areas, with around 6,000 school children participating in these programmes. In addition, 350 teachers have received training; over 300 youth groups have run drug prevention initiatives; while training programmes have also been delivered to 1,300 community workers, 1,200 parents and 1,300 young people outside the school setting. These programmes are aimed not only at creating greater awareness of the dangers of drug misuse among young people, but also at educating communities about the needs of drug users, so that they are in a better position to respond to these needs [personal communication, DoTTSR]. Evaluation of the LDTFs will be ongoing.

The Young People's Facilities and Services Fund – YPFSS

An innovative and interesting feature of policy in the drugs area in Ireland is a focus on the potential of sport and recreation to engage young people constructively and thereby discourage or divert them from involvement in drugs and unhealthy life choices.

Under an initiative separate but complementary to the Task Force initiative, the Government set up the Young People's Facilities and Services Fund (YPFSS). The aim was to develop 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 three-year Fund aims to attract young people in those areas – at risk of becoming involved in problem drug use – into more healthy and productive pursuits. The target group for this Fund is youth aged 10 to 21 years who traditionally have found themselves outside the scope of mainstream youth activities because of their family background, their involvement in crime or drug misuse or their lack of education.

The primary focus of the YPFSS is on the LDTF areas and 6 urban areas of Galway, Limerick, South Cork City, Waterford, Bray and Carlow, where a serious drug problem exists or has the potential to develop.

A National Assessment Committee was established under the Young People's Facilities and Services Fund, to prepare guidelines for the development of integrated plans in the target areas for the Fund; to assess the plans and to make recommendations on funding to the Cabinet Committee on Social Inclusion. The Committee oversees the implementation of the Fund. Membership of the Committee comprises civil servants, representatives of state agencies and

representatives of the community and voluntary sector, and the National Drugs Strategy Team.

Development Groups in the 13 Task Force areas and 6 Urban Areas outside the Task Force areas were established to develop plans and strategies for the YPFSF and to oversee their implementation in conjunction with the relevant VEC and Local Authority. In the LDTF areas, the Development Groups comprise one representative each from the LDTF, the VEC and the relevant local authority. In the targeted urban areas, the local VEC has responsibility for the development and delivery of the strategies in conjunction with relevant state agencies and the community & voluntary sectors.

To ensure complementarity with the LDTFs plans for the area, the LDTFs nominated a representative to the Development Groups [who generally act as chairperson]. The YPFSF plans and implementation process reports are passed to the LDTFs for their information and views before submission to the NAC - National Assessment Committee [which evaluated them and recommended funding to support their implementation]. The Development Groups are responsible for overseeing the effective implementation of the plans.

Under the devolution of structures outlined above, the LDTFs and Area Based Partnership Companies are due to work with the Directors of Community and Enterprise and the City/County Development Boards –CDBs, when drawing up their integrated local action plans. Arrangements for co-ordination of planning and delivery of services are to be agreed with the CDBs. It is likely that the YPFSF will adopt similar procedures when their next funding is due i.e. 2002.

YPFSF outside the LDTF Areas : Recognising that the issue of problem drug use is not confined to the urban areas, YPFSF funding has been allocated to a number of nation-wide initiatives to inform and raise awareness of the dangers of problem drug use, particularly through peer education, as can be seen below. Up to Ir£7.2m/Euro 9.14m has been allocated under the YPFSF for the “Springboard Initiative” [see below] which will see the establishment of 14 family support projects aimed at children at risk in disadvantaged areas around the country.

YPFSF Budget⁵ : The Young People's Facilities and Services Fund was established in 1998 with a Ir£30 million/Euro 38.1m allocation over 3 years. This has since been increased to Ir£37.4⁶ million/Euro 47.5m. Of this amount, Ir£27.4 million/Euro 34.8m has been approved for support of over 295 projects in the LDTF areas. The remaining Ir£10 million/Euro 12.7m [approx.] has been allocated as follows :

⁵ Acknowledgements – Kathleen Stack, DofTSR and S. Falvey, DofE&S for supplying budgetary information.

⁶ This funding is separate to LDTF and is in Department of Education and Science vote

- Ir£7.2m/Euro 9.14m over 3 years 1998-2000 has been allocated to the Springboard Initiative, which is administered by the Department of Health and Children. Springboard funds 15 family support projects. The projects work intensively with mainly 7-12 year olds (who are at risk of going into care or getting into trouble) and their families
- Ir£2.3m/Euro 2.9m was allocated to other urban areas outside the Task Force Areas for prevention work e.g. Waterford, Galway, South Cork City, Limerick, Bray and Carlow
- Ir£0.5m/Euro 635,000 goes to voluntary organisations who have the capacity to deliver drug prevention programmes at national or regional level; this is a new initiative in 1999.

In terms of the new structures set up under the National Development Plan, the breakdown of this money is as follows :

South and Eastern Region:	Ir£29.756m/Euro 37.782m
Border Midlands and Western Region:	Ir£ 0.450m/Euro .571m
Dept. of Health and Children:	Ir£ 7.200m/Euro 9.142m
Total:	Ir£ 37.406m/Euro 47,496m

The type of projects and initiatives approved as part of the plans and strategies submitted to date include :

- capital projects such as building, renovating or fitting out **community centres, youth facilities and sports clubs** so as to provide suitable accommodation for programmes and services geared for the most "at risk" young people in an area. Access for the target group is an essential condition of funding for capital projects
- a number of **purpose-built youth centres** which will provide a focal point for youth activities in an area, particularly those areas such as Tallaght, Ballymun, Clondalkin and Blanchardstown where there is a dearth of dedicated youth facilities
- the appointment of **youth and outreach workers** to work on the ground with the target group offering developmental activities and educational programmes for young people who have traditionally found themselves outside the scope of mainstream youth work due to family background, involvement with crime or drug misuse or lack of education
- the appointment of **sports workers** to encourage greater involvement of the target group in sports and recreational activities
- a wide variety of **community-based prevention/education programmes**, including Early School Leaving Programmes, Sports and Recreational Activities, Family Support Programmes, Art, Drama and Music Programmes, Counselling and Transport Services

- **targeted interventions** for particular groups such as youth work projects for young travellers
- the appointment of **national drugs education and training officers** for youth organisations catering for the target group who will deliver programmes throughout the organisation
- a provision to meet the **training** needs arising from the Fund, particularly in the area of drugs training for youth workers.

Innovative Conditions, which can serve as a model for such projects, have been applied to the draw down of funds under the YPFSF. These measures ensure that the most deprived groups will have access to funded facilities and services and will prevent 'creaming' or the admission of only the 'more desirable clients' which can be a feature of some programmes. The conditions include inter alia - Clear focus on target group; Mandatory access for the target group; Proof of the operation of strategies to attract the target group into the facility/program; Integration with existing or proposed initiatives in the area. Access for the target groups will be enforced where possible through the involvement of the Local Authorities and/or the VECs in the management structure. If this is not possible then it will be necessary for projects to provide a satisfactory access programme showing how the target group will be reached and quantifying the extent of access.

Main Results Achieved : A speech by Minister of State for Local Development and with special responsibility for the National Drugs Strategy, Mr. Eoin Ryan, T.D., at European Cities Against Drugs, Millennium Mayor's Conference, held in Cork, 28th April, 2000, overviewed achievement under the YPFSF. He stated 'Through the Young People's Facilities and Services fund, we are supporting the building or refurbishment of nearly 50 youth facilities, 20 sports clubs and nearly 20 community centres in disadvantaged areas. Almost 80 youth and outreach workers are being appointed to work with young people, offering them the type of developmental activities and educational programmes which were previously outside their reach, due to their family circumstances or their involvement with drugs or crime. The Fund is also supporting a wide variety of programmes, including early school leaving projects, family support programmes, art, drama and music, counselling and transport services'.

12.3 Evaluation of national strategies

The policy frameworks underlying actions in the drugs area i.e. the National Development Plan, National Anti-Poverty Strategy- NAPS and Programme for Prosperity and Fairness - PPF are underpinned by a culture of evaluation and accountability. Thus targets, review, evaluation, benchmarking, indicators and indexation are core concepts and increasingly specific resources are being set aside to develop the research capacity which can effectively deliver good quality monitoring and evaluation [see Social Inclusion Strategy, Annual Report of the Inter-Departmental Policy Committee 1999/2000]. Poverty and equality proofing are also to become an integral aspect of national and regional programme

development. Thus the more general social inclusion initiatives in the drugs area will be evaluated within this framework. The specific mechanisms in place to evaluate the LDTFs are outlined below.

Evaluation and the LDTF : The culture of evaluation ensures that evaluation is seen as an integral part of the planning exercises of the Local Drugs Task Forces. The Phase 2 updated plans [see above] were required to specify the proposed inputs and expected measurable outputs, outcomes and impacts in relation to each proposal and how it integrated into the overall drugs strategy. Thus, in addition to the evaluation of the overall process to measure its success or otherwise, evaluation of individual projects takes place with a view to mainstreaming those which are operating effectively [see above & DoF TSR (1999), Handbook, p45].

In the Handbook : Local Drugs Task Forces – A local response to the drug problem, published by the DoF TSR in 1999, the National Drug Strategy Team laid out the mechanisms they have developed to facilitate the evaluation process [see Box 12.3 below]. These guidelines state that the evaluation process must be objective and transparent and must be carried out by individuals with a recognised and proven track record, in accordance with agreed criteria.

Evaluation Criteria for Projects : Over 200 projects were approved for funding on foot of the initial Task Force plans. There was a wide variation in range, type and size of these projects. From a financial viewpoint, projects are divided into three types: those costing over Ir£50,000/Euro 63,487 per annum; those costing between Ir£10,000/Euro 12,700 and Ir£50,000/Euro 63,487m per annum; and those costing less than Ir£10,000 per annum. The majority of projects were set up with a view to being ongoing, but some were once-off.

Box 12.3 Mechanisms to Facilitate the Evaluation Process – LDTF

The following mechanism were put in place to facilitate the evaluation process :

- *a steering group (comprising of the National Drugs Strategy Team and the Task Forces) was set up to oversee and monitor the process*
- *a specially appointed Evaluation Co-ordinator devised terms of reference for the conduct of the evaluation, along with appropriate performance indicators and these were approved by the steering group and*
- *a panel of evaluators were formed. Task Forces were free to nominate persons or companies to this panel, provided they met the criteria outlined above. Task Forces could then make their selection of evaluators from the approved panel. In the event of there being excessive demand for the services of particular evaluators, the steering group determined their assignment.*

Acknowledging the wide variability of projects (including the fact that they address the drug problem under different themes, i.e. education/prevention, treatment, rehabilitation and community policing/estate management), it was

acknowledged that it would be difficult to devise an evaluation framework that would equally suit all projects. It was recommended thus to develop a process that could be applied in a flexible manner, depending on the type of project. It was envisioned that more rigorous evaluations would take place with the more expensive projects.

Guidelines as to how the evaluations were carried out, along with the ground rules, were considered to be necessary and these were developed by the steering group, in consultation with the Evaluation Co-ordinator, Local Drugs Task Forces and project promoters as the process developed.

As reported above, 140 Task Force projects were evaluated in April-June 2000 and 122 of these were mainstreamed. PR Consultancy coordinated a composite report on the evaluation. Arrangements are in train to evaluate a further 34 projects before end 2000.

Evaluation of YPFSSF – *An overall evaluation of the YPFSSF will be commissioned by the end of 2000. The evaluation will take into account good practise in relation to existing evaluation mechanisms e.g. mechanisms for the LDTF and the mainstream youth service projects.*

The culture of evaluation discussed above, is not as developed or formalised within drug treatment environments. Thus few evaluations of treatment programmes have been conducted to date. However, the National Advisory Committee on Drugs three year research programme includes a number of evaluation studies in the drugs area and Health Boards increasingly are adopting evidence based approaches in their work and developing research and evaluation capabilities.

The implementation of EDDRA in Ireland has helped promote a culture of evaluation in the treatment context. Actors in the drugs area are aware that inclusion of projects in the EDDRA database requires such projects to have built - in evaluation as an integral feature. In addition, EDDRA training was made available to all regional drug co-ordinators by the Drug Misuse Research Division in collaboration with the EMCDDA which covered inter alia, the planning and implementation of project evaluation. This training was evaluated highly by participants.

Conclusion – main changes and trends.

The main changes & likely directions in Irish drug policy, strategies, implementation and evaluation 1999 – October 2000 can be summarised as follows :

- a major review of National Drugs Strategy is underway*
- continued adoption of an integrated, inter-agency response to the drugs problem involving local communities*

- *adoption of the promotion of social inclusion as one of the priorities of the National Development Plan 2000-2006 and situation of drugs issue within this context*
- *greater devolution of power to regional structures, with which existing structures in the drugs area will co-operate*
- *roll-out of pilot extension of poverty proofing to local authorities*
- *Continued involvement of local communities in the development and implementation of drugs policy*
- *increasing role of voluntary and community sectors*
- *continued development of a culture of evaluation and increased resources of knowledge infrastructure to support same*
- *programme for Prosperity and Fairness identifies workplace initiatives dealing with drug misuse as an issue requiring attention*
- *cross border activity and co-operation in the drugs area likely to increase.*

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13. Cocaine and Base/Cocaine - Ireland : Paula Mayock

Introduction

In Ireland, the heroin epidemic of the 1980s, coupled with the public health crisis of HIV transmission through unsafe injecting practices, resulted in a concentration of attention on 'high risk' drug use categories, most notably heroin and other intravenous drug use. The major focus in the domains of drug policy, treatment and research centred on the 'threats' posed by enduring patterns of drug use, unsafe methods of drug administration and associated risk behaviours. Heroin, being a dominant drug of misuse among individuals receiving treatment, certainly, in the greater Dublin area (O'Brien, Moran, Kelleher and Cahill 2000), has attracted by far the greatest level of interest and attention. This situation is by no means unique to Ireland. As Egginton and Parker (2000), in a recent publication have remarked, "so distinctive is the impact of this drug that heroin has its own epidemiology"(p.7). In practice, prevalence studies and other empirical research focus on groups, such as opiate users or injectors, who are of concern at a particular time (Frischer and Taylor 1999). Put differently, attention to particular forms of drug use is very much a function of the drug political situation of any given jurisdiction (Cohen 1996).

Despite heroin's prominence, publicity and official concern, the past decade has witnessed increased recognition of the pervasiveness of drug use in society generally. Drug use, traditionally associated with social and economic disadvantage, is increasingly recognised as a widespread social phenomenon and is clearly no longer confined to marginalised communities. Population and school surveys point to a definite increase in the number of individuals reporting lifetime use of a range of illicit substances (Grube and Morgan 1986; Grube and Morgan 1990; Hibell et al. 1997; Brinkley et al. 1999). A recent population survey, examining the lifestyle, attitudes and nutritional status of people aged 18-55 years, revealed a lifetime prevalence rate of 17% for cannabis. Last year prevalence was estimated at 2% for amphetamines and ecstasy and 1% for tranquillisers and LSD (Friel et al. 1999). Although cannabis remains by far the most popular of the illicit drugs and the most likely to be used repeatedly across time, available data suggests that other drugs, including amphetamine, ecstasy and LSD are increasingly likely to be used, particularly among our adolescent population. It would appear that we are increasingly living amidst a drug conscious society.

In Ireland, relatively little attention has focused on the use of *individual* drugs. As a result, little is known about the extent and nature of specific forms of drug involvement. Attention to the use of individual drugs, apart from heroin, has concentrated almost exclusively on ecstasy. Bisset (1997), reviewing available data pertaining to the use of ecstasy in Ireland, concluded that the upward trend in ecstasy use by young people was likely to continue. Murphy, O'Mahony and

O'Shea (1998) compared Irish and European drug policies relating to the use of ecstasy. This research also included a small-scale qualitative study of ecstasy use by adults. More recently, a more detailed examination of patterns and levels of ecstasy use was undertaken in Northern Ireland (McElrath and McEvoy 2000). Other drug use, including amphetamine, LSD and cocaine have received little or no attention in an Irish context.

The purpose of the current paper is to examine cocaine use in Ireland. This research is timely in that it coincides with renewed attention, in a European context, to suggestions of a possible increase in the availability and use of cocaine. Increases in cocaine use across Europe have been visible since the late 1960s (Erickson et al. 1987). Studies have shown steady increases in various indicators of cocaine use in the UK during the past 10-15 years (Marsden et al. 1998). A recent British review of law enforcement figures, treatment statistics and other key prevalence indicators, reveals a steady and significant upsurge in cocaine use from 1991-98, suggesting that the UK may be witnessing the rapid spread of new cocaine use (Corkery 2000).

The primary aim here is to investigate levels and patterns of cocaine use in Ireland. The research was undertaken against a backdrop of anecdotal and impressionistic evidence suggesting that cocaine is very much 'around', more easily procured than previously and making a conspicuous breakthrough on the drug scene. Hence, the research sought to locate and analyse all available data identified as potentially useful in an assessment of the extent and nature of cocaine use.

The multiple existing data sources utilised in the research are described in detail below. However, as a starting point it is helpful to provide a brief description of the pharmacological properties of cocaine and of the principal routes of cocaine administration.

Pharmacological Dimensions of Cocaine and Modes of Use

Cocaine is a naturally occurring substance derived from the leaves of the coca plant, *Erythroxylon coca*, a shrub that grows in the Andean area of South America (Fischman and Foltin 1991). It is an odourless, white crystalline powder and is classified as a central nervous system stimulant. Cocaine was first extracted in 1855 and later became a popular stimulant and tonic. Up until 1904 Coca-Cola contained small quantities of cocaine (ISDD 1996).

The most common form of ingesting cocaine is 'snorting' - the sniffing of fine cocaine crystals via the nostrils. By snorting, cocaine is being conveyed into the bloodstream via the mucous membranes of the nose and throat in which it dissolves. Cocaine increases feelings of alertness and energy and produces intense euphoria. Negative effects include anxiety, levels of aggressiveness not appropriate to the actual situation, sleeplessness, sweating, impotence and

heavy feelings in the limbs. Very heavy users of cocaine may report strong feelings of paranoia.

The smokable form of cocaine is known as free-base, rock or crack cocaine, where the powder form is converted into cocaine base and smoked, usually through a pipe. This method of use produces a shorter but more intense high than snorting the drug (Corrigan 1997). The speed at which the crack cocaine produces effects is far more rapid than in powder form and this, coupled with the shorter duration of the euphoria, makes crack smoking a potentially highly addictive substance. However, neither tolerance nor heroin-like withdrawal symptoms occur with repeated use of cocaine (ISDD 1996). Users may develop a strong psychological dependence on the physical and mental well being afforded by the drug.

Finally, cocaine may be used intravenously, although this mode of ingestion is less common and is viewed as dangerous by most cocaine users (Cohen 1987). Intravenous injection results in an almost immediate high within 15 seconds of injecting (Pinger et al. 1995). Some drug users combine cocaine powder or crack with heroin to produce a drug cocktail known as "speedballs".

Prolonged heavy cocaine use is usually followed by a 'crash' if use is discontinued. This 'crash' is characterised by exhaustion, restless sleep patterns, insomnia and depression (Erickson et al. 1987). However, there is considerable disagreement over what constitutes 'addiction' or 'dependence' in the case of cocaine. Furthermore, there is little consensus on *who* is susceptible to or at greater 'risk' of cocaine dependence. Waldorf et al. (1991), in a study of 'heavy' cocaine users (users who the authors claim qualify as the most serious 1% of the cocaine using population), found that even among this group, a large number maintained a stable, although heavy pattern of use over several years without increasing their cocaine intake. They added that "it is exceptionally difficult to predict which users will maintain control and which will become compulsive" (p.102).

Other research has similarly concluded that many heavy cocaine users do not become dependent (Erickson et al. 1987; Cohen 1989; Chitwood and Morningstar 1985). Hammersley and Ditton (1994), in a study of Scottish cocaine users not known via their criminality or contact with drug services, concluded that "cocaine can lead to protracted bouts of heavy or excessive use, but many users can then stop or moderate use prior to encountering problems"(p.68).

The accumulated research evidence on cocaine use across several jurisdictions suggests that, among community samples of cocaine users (that is, users not in contact with drug treatment services), even heavy users will not necessarily develop symptoms normally associated with chronic drug dependence. Reinerman (1994), summarising three studies of cocaine users (Waldorf et al.

1977; Murphy et al. 1989; Waldorf et al. 1991), concluded that addiction is not an inevitable consequence of cocaine's pharmacological action on human physiology. Rather, both cocaine dependence and controlled use of the drug are contingent upon the social circumstance of the user and on the conditions under which cocaine is taken.

On the other hand, Parker and Bottomley's (1996) study of crack cocaine users, many of whom were known to drug services, revealed only a minority of controlled users. Among this group, there appeared to be a complex pattern of dependency on both cocaine and heroin, whereby users were "psychologically hooked into rock cocaine but physically dependent on heroin" (p36). Other research indicates significant differences between treatment and non-treatment cocaine users. Chitwood and Morningstar (1985) found that users in treatment were more likely than community samples to be heavy rather than light users of cocaine, and to be unemployed and lacking in support networks of close friends.

Research Methodology

There are three research components in this analysis of cocaine use in Ireland. The first examines existing, predominantly statistical, data sources in order to identify emerging patterns and trends in cocaine and base/crack cocaine use. Relevant data from several sources, all considered to be key indicators of drug misuse, are presented. The combined information from the data sources listed below, covering a range of population segments, are presented and analysed.

- Drug Seizures / Arrests
- Drug Treatment Figures
- Surveys : School-based and General Population
- Drug-related Deaths
- Hospital Morbidity
- Ethnographic / Qualitative Studies

Since no detailed empirical investigations of cocaine use have been undertaken to date in Ireland, two additional components were incorporated into the research in order to generate a more comprehensive picture of current patterns of use and to assess dominant perceptions of the scale of the 'problem'. The emphasis in the first was on accessing 'front line' indicators, that is, individuals working in the community and at street level who are well-positioned to detect current local developments. This is important since available figures may not accurately reflect current drug trends due to the time-lag between the collection and the processing and publication of relevant data.

Individual face-to-face and telephone interviews were conducted with a range of informants including drug service providers, An Garda Siochana - the police, youth workers, drug counsellors, general medical practitioners, hospital personnel, night-club owners and a number of key informants considered to have

experience of and insight into common and preferred drug-taking practices. The primary objective was to access the views, perspectives and concerns of individuals who have direct knowledge and/or experience of cocaine users and of the drug scene generally. In this context, there was a specific focus on uncovering information pertaining to the availability of cocaine, local drug markets, trafficking/dealing/ distribution patterns, health consequences and the negative repercussions of use. In addition, interviews with drug service staff addressed the issue of service provision, including the needs of cocaine users and implications for treatment intervention and other drug services.

Finally, in view of the widespread recognition of recreational or non-problematic forms of cocaine use in other jurisdictions (Erickson et al. 1987; Cohen 1989; Greene et al. 1995; Hammersley and Ditton, 1995), it was decided to undertake a small-scale qualitative study of adult cocaine users *not* in contact with drug treatment agencies. The primary aim of this exploratory research was to examine respondents' use of cocaine and other drugs. The research also sought to examine attitudes to cocaine and other drug use, to investigate perceptions of the risks associated with cocaine compared to other drugs and to examine dominant or preferred circumstances associated with the use of cocaine. The selection criteria and recruitment process are discussed in detail at a later stage in this paper.

It is apparent from the description above that multiple sources were utilised in order to build a fuller picture from partial data. The orientation of the research is therefore largely investigative, with each segment of data feeding into a "detective" approach (Douglas 1976). General principles of analytic induction were applied to the examination of pre-existing data and to data collected through face-to-face and telephone interviews. This approach involved establishing an initial description of the phenomenon and the continued refinement of that analysis in light of further evidence collected throughout the course of conducting fieldwork. The strength of this method is its ability to consider many alternatives and then progress dynamically as opposing or corroborating evidence appears (Adler 1990). Analytic induction was formulated by Znaniecki (1934) and later refined by Lindensmith (1947) as a procedure for verifying propositions on qualitative data in a study of opiate addiction. It was used by Becker (1963) in his classic study of marijuana users. This research orientation is particularly suited to gathering information in sensitive and 'hidden' areas of human behaviour (Stimson et al. 1999).

Research Findings

This paper is divided into three sections. The presentation of research findings draws first, on existing data sources and documents all available empirical research relevant to cocaine use in Ireland. The analysis then moves to present data generated from individual face-to-face and telephone interviews with drug services providers and other key informants. Finally, the findings of an exploratory study of social/recreational cocaine use among adults are presented.

Component 1 : Existing Data Sources and Other Relevant Empirical Research

In this section, the data pertaining to the use of cocaine (and other drugs) from several key data categories are presented. These include law enforcement and supply statistics, purity levels, drug treatment figures, general population surveys, school surveys, cocaine-related deaths, hospital morbidity and other relevant research findings arising from ethnographic and qualitative studies.

- *Law Enforcement and Supply Statistics*

Questions pertaining to the accuracy of police statistics are the source of considerable debate (Bottomley and Pease 1986; South 1995). One of the main difficulties with these figures is that they are not contextualised by reference, for example, to specific overt and covert operations or 'luck strikes'. Differences in drug seizures might also reflect variation in drug control strategies across time (Korf 1992). However, at a local level drug seizure figures provide a useful broad indicator or sensor of drugs supply and demand (Parker, Bury and Egginton 1998).

Available statistics pertaining to *seizure* and *offender* data is provided in the *Annual Reports of An Garda Siochana*. Table 13.1 presents the figures for seizures of cocaine made by Irish police and customs between 1990 and 1998. Seizure figures for heroin, cannabis, MDMA (ecstasy) and LSD are presented for comparative purposes.

Table 13.1 : Quantity of Cocaine and Other Drug Seizures , 1990-1998.

Year	Quantity Seized (Cocaine)	Quantity Seized (Heroin)	Quantity Seized (Cannabis Resin)	Quantity Seized (MDMA)	Quantity Seized (LSD)
1990	1.009 kg	.578 kg	114.76 kg	0	90 units
1991	.031 kg	.161 kg	1.10 kg	429t	3169 units
1992	9.850 kg	.794 kg	498.47 kg	271t+.225g	13431 units
1993	.348 kg	1.285 kg	4200.31 kg	744t	5522 units
1994	.046 kg	4.649 kg	1460.72 kg	28,671t	16,634 units
1995	21.800 kg	6.400 kg	15,529 kg	123,699t	819 units
1996	642.000 kg	10.800 kg	1,933 kg	19,244t	5,901 units
1997	11.020 kg	.821 kg	1247.88 kg	17,516t	1,851 units
1998	333.167 kg	.038 kg	2157.24 kg	604,827t	798 units

t= tabs; g = grams; kg = kilograms.

Source : Annual Reports of An Garda Siochana, 1990-1998.

This table illustrates considerable variation in the quantity of cocaine seized by police and customs between 1991 and 1998. The record amount seized was

642kg in 1996. The figures for cocaine seizures are low however, compared to those for other drugs, including cannabis, heroin and ecstasy. Internationally, it is often estimated that approximately 10% of all drugs in circulation are intercepted (Boekhoutvan Solinge 1998).

Table 13.2 illustrates the number of cocaine offences where proceedings commenced between 1990-1998. The figures for heroin, cannabis and ecstasy are again included for comparative purposes.

Table 13.2 : Number of drug offences by type of drug, 1990-1998.

Year	Cocaine	Heroin	Cannabis Resin	MDMA
1990	11	71	1,413	--
1991	7	45	2,354	45
1992	11	91	2,643	31
1993	15	81	2,895	66
1994	15	230	2,848	261
1995	30	296	2,209	645
1996	42	432	1,441	340
1997	97	564	2,096	475
1998	88	789	1,749	439

Source: Annual Reports of An Garda Siochana, 1990-1998.

The number of individuals charged with or prosecuted on cocaine-related drug offences is small compared to heroin, cannabis and ecstasy. However, the figures generally do point to an increase in the number of offences where proceedings commenced between the year 1990 and 1998. Figures doubled between 1994 and 1995 and increased three-fold again, producing record figures for cocaine-related drug offences by 1997. 'Offender' data do, therefore, suggest that an increase of cocaine possession and supplying is occurring on the ground.

Drug product data is determined from analyses carried out by the Forensic Science Laboratory of the Department of Justice, Equality and Law Reform. These analyses are conducted on drugs seized by the Gardai. Information attained from this source indicates that the purity of cocaine has dropped over the past three years from 62% in 1996 to 38% in 1998. These figures however, may not accurately reflect the purity level of cocaine at street-level, as no empirical evidence on such a link is available.

- *Drug Treatment Figures*

Unlike heroin, no specific drug is used for the treatment of cocaine dependence and there are no prescription figures that can be used as a proxy measure of cocaine addiction. Hence, data pertaining to individuals receiving treatment for drug-related problems are an important indicator of the level and extent of cocaine use among this group.

The National Drug Treatment Reporting System, operated by the Drug Misuse Research Division of the Health Research Board (HRB), reports data on treatment provided by statutory and voluntary agencies countrywide. It is the primary national source of epidemiological information about drug misuse, providing annual figures on the uptake of services as well as socio-demographic data on clients receiving treatment. The regularity of data collection makes it possible to identify changing patterns and trends in the use of particular drugs across time. Between 1990 and 1994, data was collected in the Greater Dublin area only, but was extended to cover the whole country in 1995 (O'Brien and Moran 1997). One of the main advantages of more recent available figures pertaining to individual receiving treatment is that they are regionally sensitive. It should be remembered however, that the figures relate to those problem drug users who present to services, and not to all those who have a drug problem, or indeed all those who use drugs.

Health Research Board figures consistently indicate that opiates are the primary drugs of misuse. Four out of five individuals presenting for treatment in Dublin during the period 1990-1996 reported opiates as their main drug of misuse (O'Brien and Moran 1997). In 1998, 55.7% of first treatment contacts reported heroin as their main drug of misuse (O'Brien et al. 2000).

In this section the number of clients reporting cocaine as a drug of misuse within treatment services will be examined. It should be pointed out however, that because the development of drug services in Ireland has been orientated toward problem opiate use, cocaine users may not be attracted to these settings. Table 13.3 illustrates the number of individuals presenting with cocaine as a primary and secondary drug of misuse during the period 1995-1998⁷.

Table 13.3: Number of Individuals Presenting with Cocaine as Primary and Secondary Drug of Misuse, 1995-1998.

	<u>Cocaine as Main Drug</u>		<u>Cocaine as Secondary Drug</u>	
	All Contacts	First Contacts	All Contacts	First Contacts
1995	24	10	67	21
1996	25	17	121	50
1997	42	22	195	48
1998	88	32	291	60

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

⁷ Thanks to Mary O'Brien of the Drug Misuse Research Division who provided these figures.

Here we find a clear and consistent increase in the number of all and first contact clients presenting with cocaine as a drug of misuse during the period 1995-1998. This increase is most dramatic among individuals reporting cocaine as a *secondary drug of misuse*. The figure for all persons who made contact with drug treatment services reporting cocaine as a secondary drug of use shows an increase of over 400% during the period 1995-1998. Individuals presenting with cocaine-related problems were more likely to be male than female. Of the 42 who reported cocaine as a primary drug of misuse in 1997, 37 were male and 5 female. The gender breakdown for 1998 is somewhat similar, with 73 males and 13 females reporting cocaine as a main drug. For the year 1998, 72.5% of clients presenting with cocaine as either a primary or secondary drug of misuse were male (O'Brien et al. 2000).

It is important to consider the figures for cocaine misuse in the context of the overall drug treatment figures. Taking the 1998 figures as an example, out of a total of 1,625 first contacts nationally, the majority (904 individuals, or 55.7% of the total client group) reported heroin as their primary drug of misuse. This figure was followed by 24.8% reporting cannabis, 7.4% ecstasy, 2.5% methadone, 2.3% amphetamine and 2% reporting cocaine as their main drug of misuse (O'Brien et al., 2000). Hence, individuals reporting cocaine-related drug problems constitute a relatively small proportion of the total number presenting for the first time with drug-related difficulties.

Looking then at the regional breakdown of reported cocaine-related problems among all contacts within each of the Health Board Regions during 1997 and 1998, we find that individuals reporting cocaine as either a primary or secondary drug of misuse are concentrated within particular Health Board Regions.

Table 13.4: Residents of Health Board Areas Presenting with Cocaine as Primary and Secondary Drug of Misuse within each Health Board Region, 1997 and 1998. Numbers and Valid Percentages.

	All Contacts, 1997 Number (%)		All Contacts, 1998 Number (%)	
	Cocaine as Primary Drug	Cocaine as Secondary Drug	Cocaine as Primary Drug	Cocaine as Secondary Drug
EHB	30 (.7%)	173 (4.2%)	58 (1.1%)	263 (5.2%)
SHB	3 (1.2%)	7 (2.7%)	12 (4%)	7 (2.3%)
NWHB	----	----	----	1 (2.1%)
MHB	----	----	----	1 (1%)
WHB	----	1 (7.1%)	----	1 (7.1%)
MWHB	4 (4.0%)	2 (2.0%)	3 (3.1%)	2 (2.1%)
NEHB	2 (2.2%)	4 (4.3%)	2 (1.6%)	1 (0.8%)
SEHB	3 (1.9%)	5 (3.2%)	9 (4.5%)	5 (2.5%)

Source : O'Brien et al., (2000).

The highest number of contacts stating cocaine as a drug of misuse were resident in the Eastern Health Board region. This is hardly surprising given that the majority of treated contacts countrywide occur within this same region. The Southern Health Board and South Eastern Health Board areas had the next highest proportion of treated cocaine contacts in 1997 and 1998.

It is clear from the available figures that greater number of individuals than previously are presenting with cocaine-related difficulties. However, cocaine is clearly more likely to be a secondary than a primary drug of misuse. Individuals are less likely to present with cocaine-related difficulties, compared to other drug problems, most notably those related to the use of heroin, benzodiazepines, cannabis and ecstasy.

- *General Population, College and School-going Populations*

In Ireland, there is an absence of data, collected at regular intervals, on drug use among the general population and concerning specific groups, including young adults and adolescents. Furthermore, because differing methodologies are utilised in available surveys, it is difficult to compare drug prevalence rates accurately across time. This section will report on all available data pertaining to cocaine use in adolescent, college-going and general populations.

Survey research in Ireland has concentrated primarily on studies of secondary school students. Grube and Morgan's (1986) study of drug use by 13-16 year olds in twenty-four randomly selected schools in the greater Dublin area found a lifetime prevalence rate of 1.5% for cocaine, with 0.7% having used the drug during the month prior to completing the questionnaire. This figure is low compared to 13.2% who had ever used cannabis and 12.9% who reported the use of glue/solvents at some stage in their lifetime. Grube and Morgan's (1990) follow-up study revealed an increase of 0.2% in the numbers reporting past month use of cocaine. A more recent survey of rates and patterns of substance use among Dublin post-primary pupils did not report on the use of cocaine (Brinkley et al. 1999).

The most recently published national study of drug use by adolescents, carried out in 1995 as part of the European Schools Project on Alcohol and Drugs (ESPAD), found that 2% of students aged 16 years reported lifetime experience of cocaine (Hibell et al. 1997).

As with other drugs, including cannabis, ecstasy and amphetamine, regional surveys suggest somewhat lower cocaine prevalence rates than those reported in Dublin samples. A survey of post-primary school students in the Mid-Western Health Board Region found that 1.3% reported lifetime use of cocaine and 0.4% were current users of the drug (Gleeson et al. 1998). Jackson's (1997) survey of drug use in Cork and Kerry revealed a lifetime prevalence rate of 1% for cocaine. A much smaller proportion (0.1%) reported current use of the drug.

The figures above concur with findings related to school-going populations in the UK (Barnard et al., 1996; Balding, 1998) and suggest that cocaine use is relatively rare among adolescents, certainly compared to other drug use. Available figures indicate only a slight increase in the number of Irish adolescents reporting lifetime experience and use of cocaine during the past two decades.

Rather less is known about drug use among college students. A recent survey of drug exposure and alcohol consumption among 366 health service attendees at a Dublin University, revealed cocaine lifetime prevalence rates of 7.1% for males and 4.9% for females. This compared to a lifetime prevalence rate of 50% for cannabis, 16.5% for ecstasy and 10.5% for LSD (Denehan, forthcoming).

Few national surveys of drug use prevalence have been undertaken in Ireland. In 1998, a survey jointly carried out by the Health Promotion Unit of the Department of Health and Children and the Centre for Health Promotion Studies, NUI Galway, examined the lifestyle, attitudes and nutritional status of people in Ireland. Cocaine use during the twelve months prior to the completion of the questionnaire was reported by 1% of respondents (Friel et al. 1999). This is consistent with findings in the UK, where cocaine use remains at low levels of around 1% or less of adult populations (Baker and Marsden 1994).

In summary, although surveys suggest that drug use is increasingly a feature of youth culture (Hibell et al. 1997; Brinkley et al. 1999), cocaine use remains rare among school-going adolescents and has shown little sign of an increase during the past two decades. Lifetime prevalence among the general population is currently running at approximately 1%.

- *Morbidity and Mortality*

Both morbidity and mortality statistics are of limited value in the estimation of drug use and drug problems in general (Garretsen and Toet, 1992). However, available data relating to morbidity and mortality are presented as an indicator of the extent to which cocaine is implicated in death or illness.

Mortality statistics are based on death certificates which usually contain information on socio-demographic variables and on the cause(s) of death. Throughout the 1990s there has been a marked increase in the number of drug-related deaths throughout Europe. This upward trend appears to be more pronounced in Ireland than in other European countries (EMCDDA 1999) but is substantially due to improved data collection procedures, (in particular since 1988, with the introduction of Form 104). The numbers of deaths where drugs were implicated, during the period 1990-1998, are presented on Table 13.5 and suggest along with anecdotal evidence an increase in drug-related deaths during the 1990s.

Table 13.5: Numbers of Drug-related Deaths in Ireland, 1990-1998.

	All Ages	Age 15-49 years.
1990	7	7
1991	8	7
1992	14	14
1993	18	16
1994	19	19
1995	43	39
1996	53	50
1997	55	52
1998	99	90

Source: Central Statistics Office.

A recent analysis of drug-related deaths investigated by the *Dublin City and County Coroners* in 1998 and 1999 (Byrne 2000) reveals that cocaine was *implicated* in six out of a total of 86 drug-related deaths in 1998 and six cases out of 77 in 1999. Only in one of the 1998 cases, however, was death attributed directly to cocaine overdose. Five of the six cases had two or more drugs implicated in addition to cocaine. Heroin was implicated in all six of the cocaine-related deaths in 1999 and the quantity of heroin revealed in toxicology tests was higher than that for cocaine (Byrne 2000).

Hospital psychiatric data are available from the *National Psychiatric In-patient Reporting System (NPIRS)* which collects data on admissions and discharges from public and private psychiatric hospitals and units countrywide. It provides information on gender, age, marital status, socio-economic status, legal status, diagnosis and length of stay (O'Brien and Moran 1997). The figures for admissions to psychiatric hospitals with a diagnosis of cocaine use (ICD-10/F14) during the period 1994-1998 are presented on Table13.6⁸.

Table 13.6: Psychiatric Hospital Admissions with Diagnosis of Cocaine Use (ICD 10/F14), 1994-1998.

1994	18
1995	7
1996	8
1997	5
1998	9

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

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

^{8 8} Thanks to Mental Health Division of the Health Research Board for providing these figures.

Information from private hospitals is not included in this data base. One difficulty with these data is that each discharge record represents one episode of care. As a result, double-counting may occur where patients have been admitted to hospital on more than one occasion with the same or different diagnoses. It is important to note, therefore, that these records provide a better indicator of hospital activity than of the incidence of disease. Data relating to principal and secondary diagnoses of cocaine-related discharges is provided on Table 13.7 below.

Table 13.7: HIPE Figures for Hospital Discharges with Principal and Secondary Cocaine-Related Diagnoses, 1994-1998.

	1994	1995	1996	1997	1998
Cocaine Dependence (ICD 304.2)	2	9	11	11	13
Non-Dependent Drug Abuse (Cocaine) (ICD 305.6)	5	20	9	11	19
Accidental Poisoning (Cocaine) (E855.2)	0	5	4	10	4

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

The figures recorded for the diagnosis of cocaine dependence (ICD 304.2) have remained relatively stable during the period 1995-1998. Those for non-dependent drug abuse (cocaine), on the other hand, have tended to rise slightly in recent years, all be it from a low base.

Accepting that mortality and morbidity data are not reliable tools for estimating drug use or drug problems, they can, in association with other data sources, help to improve the interpretation of available information. Cocaine is implicated in relatively few deaths, certainly when compared to heroin. Admissions to psychiatric hospitals with a diagnosis of cocaine use indicate no clear upward trend since 1994.

- *Qualitative and Ethnographic Research*

The advantage of qualitative research in the drugs field is that it provides detailed knowledge about types and levels of drug involvement as well as important details pertaining to the lifestyles, attitudes and motives of drug users. However, only a small number of such studies have been conducted in an Irish context. Mayock (1999, 2000) investigated drug use and non-use among a sample of 57 young people, aged between 15 and 19 years, including abstainers, drugtakers and problem drugtakers, in an inner-city Dublin community. In this study, very few of the young people described as *drugtakers* (i.e. drug users who did not consider their drug use to be problematic) reported the use of cocaine at any time

and of those who did, it was generally a one-time experience. Cocaine use was far more prevalent among *problem drugtakers* (i.e. young people who considered their drug use to be problematic). All of the young people in this 'problem drugtaker' category (n=18) reported heroin as their primary drug of misuse. The vast majority (87.5%) also reported lifetime use of cocaine and nearly 20% reported cocaine use during the week prior to interview. In general, cocaine use occurred subsequent to heroin initiation and was frequently used in conjunction with heroin and other drugs (mainly benzodiazepines). Most reported the intravenous use of heroin and cocaine, a drug cocktail known as 'speedballs'. The reports below provide some insight into the nature of this group's cocaine involvement.

[When did you start using cocaine?]

Am, there was a big drought on and everyone was just, there was no heroin, so everyone was taking coke. I was taking tablets like for me sickness, I was going round stupefied on tablets, d'ya know what I mean, and then the coke just ... everyone just got strung out on coke.

Female, 18.1 years.

[Did you use coke when you were on gear?]

Yeah, used to mix it. Used to wash up the coke into the drugs, like cook the gear into the works, bung the two of them into me together. Then I would be gettin' a buzz like off the coke and then when I'm coming down off the coke the gear would bring me down nice.

Male, 19.1 years.

McElrath and McEvoy's (2000) qualitative study of ecstasy users in Northern Ireland found that 43% of respondents had tried cocaine powder. The mean age of the sample (n=106) was 25 years (range 17 to 45 years). However, only one respondent had snorted cocaine once a month during the previous six months. Cocaine use appeared to be more sporadic by this group. This finding suggests therefore, that cocaine is one of numerous drugs tried or used by young recreational polydrug users.

- *Conclusion*

The question of how many people are using illicit drugs is notoriously difficult to answer. The dearth of regular prevalence studies at both national and local levels, utilising uniform or comparable methodologies, compounds this problem. However, the difficulties associated with establishing accurate and reliable drug use prevalence figures is not just about the absence or paucity of relevant survey data. The illegality of drug use ensures that the activity is undertaken inconspicuously and that many drug users remain hidden. The best way, in the present situation, to assess the extent of particular forms of drug use is to utilise all available data from a wide range of sources.

Accepting that available sources such as survey and other empirical data can produce, at best, imperfect approximations, there are a number of conclusions that can be drawn from the data presented above. Extensive use of the drug, is not apparent among the general trend of increased drug experimentation, cocaine is far less likely to be used than cannabis, ecstasy, LSD and amphetamine, certainly among school-going teenagers. Among adult population samples, use appears to be restricted to a minority. The difficulty with these findings however, is that they fail to uncover substantial knowledge about individuals who *do* use cocaine.

At the other end of the drugs spectrum are individuals who develop drug problems. Unlike the two previously mentioned populations, many are known to drugs services. While heroin remains the primary drug of misuse among problem drug users who present to services, available figures suggest that cocaine is more likely than previously to be cited as a secondary drug of misuse. Irish drug treatment data indicate that cocaine is rarely clients' primary problem. Yet, there is evidence to suggest that the drug repertoires of long-term 'problem' drug users have extended to include a larger and more diverse range of substances including, among others, benzodiazepines and cocaine (Rooney et al. 1999). However, while cocaine is clearly available and increasingly likely to be used, it is clearly less endemic, compared to heroin, benzodiazapines, cannabis and ecstasy.

Component 2 : Views of Service providers and key informants

As stated earlier, this component of the research was concerned with accessing current perceptions of the extent and nature of the cocaine 'problem', from the perspectives of individuals working, or in regular contact, with drug users. The value of this data relates to its potential to report on current and 'new' developments on the ground. Tables 13.8 and 13.9 provide a breakdown of the number and range of individuals interviewed face-to-face and by telephone.

Table 13.8: Face-to-face Interviews

Individual Interviews	Number of Interviews
Drug Service Staff	5
Youth Worker	1
Youth Work Co-Ordinator	1
Key Informant	2
Police	1
Night-Club Owner	1
Hospital Personnel	1
Drug Counsellor	2
General Practitioners (G.P.)	1
Total	15

Table 13.9: Telephone Interviews

Telephone Interviews	Number of Interviews
Student Welfare Service	2
Youth Worker	2
Project Worker (Young People)	2
Drug Service Staff	2
Liaison Midwife	1
G.P.	3
Police	1
Hospital Personnel	1
Prison Staff	1
Total	15

It is evident from the range of individuals contacted that efforts were made to incorporate a cross-section of respondents, in terms of the nature of their experience of drug users and the drug scene. Table 13.10 summarises the issues addressed in the case of each 'subgroup' of interviewee. Separate interview schedules were designed for the respective 'subgroups' of study respondents where appropriate.

Table 13.10: Issues Addressed During Face-to-Face and Telephone Interviews

INTERVIEWEES	ISSUES ADDRESSED
Drug Service Staff (6)	Numbers presenting with cocaine-related difficulties (stable, increase, decrease) / evidence of crack cocaine? / cocaine as a primary drug of misuse / the treatment needs of cocaine users / implications for treatment and service provision.
Key Informants* (2)	<i>Who</i> is using cocaine (age group/background/SES)? Availability, cost and purity? Is cocaine more accessible than previously? In what kinds of settings is use taking place? Patterns of use (regular/recreational/occasional etc.)?
Police (1)	Drug seizures and arrests : have the figures for cocaine changed dramatically in recent years / any indicators of increased availability of cocaine on the streets? / if so, how have the Gardai responded to this 'new' development?
Youth Workers (within 'high risk' areas)	Is there evidence of increased use of cocaine among adolescents / any evidence to suggest that cocaine is easier to access and / or more affordable than previously? What are the dominant perceptions of the 'risks' associated with cocaine use? Are youth workers adequately equipped to respond to current drug use trends?
Night-Club Owners	Which drugs are most visible/available on the club/dance scene? Any evidence of cocaine use? If so, when did this come to your attention? Is cocaine more easily available then previously? Cost and accessibility?
General Practitioners	Numbers presenting with cocaine-related difficulties (stable, increase, decrease) / evidence of crack cocaine / cocaine as a primary drug of misuse / the treatment needs of cocaine users / implications for treatment and service provision.
Hospital Personnel	Any evidence of cocaine emerging as a drug of choice? Accident and emergency admissions? Paediatrics?

* Key informants are individuals who have experience of and contact with the drug scene and are considered to have knowledge and insights that may contribute significantly to the data collected from other sources.

Face-to-face interviews were tape-recorded and partial transcripts of this material prepared. Detailed notes were taken both during and after telephone interviews. The major issues and themes arising from these data are documented in this section. The presentation of findings will concentrate on the key questions outlined on Table 13.8 and on other issues raised by informants in the context of the interviews. For the purpose of clarity and structure, the findings are

presented under three broad headings : cocaine availability, the extent and nature of cocaine use and implications for drug treatment and service provision.

- *Cocaine Availability*

Cocaine was believed, by the majority of respondents, to be more easily available than previously. Broadly speaking, the evidence revealed a definite consensus on increased accessibility and use of cocaine. A spokesperson from the Garda National Drug Unit described the current situation vis-à-vis cocaine in the following terms.

We are quite aware that cocaine is being used and offered for sale, particularly in certain areas. If we look at the statistics in relation to cocaine for say 1998, that shows quite an amount of cocaine being seized. We have 333 Kilos and 167 grams. This is a huge amount. Now some of that of course, came from major seizures. But, coke *has* become more popular. I would have no hesitation saying yes, it is more prevalent.

(Garda)

Several respondents involved in the delivery of drug treatment indicated that they had become aware of an increase in the supply of cocaine within the areas where they work, particularly during the past year.

You hear about it more and it's almost becoming a substitute drug for heroin. With the availability of methadone now people's need for heroin isn't so great.

(Drug Counsellor)

Similarly, many professionals working with young people in communities where drug use is concentrated stated that they were conscious of a discernible shift towards increased cocaine availability.

There is a strong sense that it's out there alright. I've no concrete evidence from the group we work with but a very strong sense that it's out there and available.

(Youth Work Co-Ordinator)

My impression is that during the past year or year and a half there has been a lot of selling going on and a good bit of use. Yeah, it's definitely amongst problem drug users and I think that you'd probably find a good number of urines testing positive for cocaine.

(Youth Worker)

Other respondents drew attention to a decrease in the street price of cocaine and felt that this served as a further indicator of the changed nature of availability and use of the drug.

It would seem now at the moment that a half a gram can be as low as £25. A number of years ago it was £300 a gram. Now it is down to between £60 and £80 a gram. One thing that is noticeable is that the price varies depending on where you buy.

(Drugs Worker)

Worthy of note also is that a number of individuals involved in the provision of methadone treatment reported a conspicuous upsurge in the proportion of urine samples revealing quantities of cocaine during the latter months of 1999 and the early months of 2000. Although this trend appears to have since abated, doubt was expressed, in some cases, about the validity of the assumption that a decrease in the percentage of urines revealing cocaine can be reliably viewed as an indicator of a downward trend in cocaine use among clients receiving treatment.

The prevalence rate (of cocaine in urines) would appear to be running at around 3% of the known drug users, the ones in treatment. Again, I think that's probably coloured by the fact that cocaine is short-lived in the system. Drug users can very easily get around the system and continue to use cocaine. If say, somebody is clear of every other drug and they're on weekly take-outs it's not a big deal for them to make sure that they don't use two days before they come in to pick up their methadone. So how much of an indicator it is I don't know. There certainly was a peak in the three months of December, January and February but that seems to have gone down again. Now whether it is that it's been challenged and drug users are altering their behaviour or whether they've just managed to work the system, I don't know.

(Drugs Worker)

It is important to state that the perceived increase in cocaine availability and use was associated with particular geographical locations in the Dublin area, which will remain unidentified in this paper. However, the most likely to be mentioned were two specific areas associated with concentrations of known drug users. This pattern was identified by a range of respondents including drug service providers, general practitioners and the police.

From the point of view of gaining insight into individuals in the community who do not identify themselves as drug users, a number of key informants with knowledge of and contact with the 'dance' scene were interviewed. These respondents indicated that cocaine was currently more visible on the club/dance/drug scene than previously. It was also felt that this trend was accompanied by increased acceptance of cocaine as a drug of choice.

I'm not into cocaine myself and I don't really hang out with people who are, ya know, but I know of people who are. I know it's become a usual thing for lots of people. It's just a natural normal thing that they do. There's definitely some people who get more into it and prefer to do coke and there's also that thing where it's seen as a slightly, you know, more prestigious. Coke has always been seen as a middle class drug; for people who have money essentially. You can link it directly in this country to the economic situation. People have more money, they're more affluent and cocaine is a more affluent drug.

(Key Informant # 1)

The majority of respondents stated that there was little evidence to suggest that crack cocaine was available or was making a breakthrough on the drug scene.

However, an interview with an ex-cocaine dealer and former crack cocaine addict suggested some use of 'home-made' crack cocaine. This respondent described himself as 'in recovery' at the time of interview, having previously had a chronic cocaine and heroin problem. He stated that he was involved in the distribution of cocaine, both within and outside of the Dublin area, for several years.

I went as far as South Dublin and out of Dublin to deal. I would travel, yeah. And people would travel from everywhere ta me or else, if they couldn't make it I'd make me way out ta them. Inner-city, apartments as well, ya know, well-ta-do people ... everywhere ... this would be sellin' cocaine. On most occasions I would have ta wash it up for them, turn it into crack for them like. Very few would actually just, very few people I actually dealt with were buying it ta snort, they were buying crack.

[But people say that there's no crack around?]

I hear this, and I've said it to xxx (friend), and it actually makes me blood boil 'cos there's a big problem out there like and it's like, look at heroin in the 80s. It was actually around before then but no, it's nothing, it's only a handful of people, that's what they said. And look at it now! And there's as much coke out there now as heroin. It's so easy to get, ya know. (Key Informant # 2)

Overall, the data points to increased awareness of the presence of cocaine, its availability on the street and of its potential to become a drug of choice for both recreational and problematic drug users.

- *The Nature and Extent of Cocaine Use*

The identification of drug use patterns at local level is difficult to quantify and requires specialist research (Parker et al. 1998). Hence, the aim here is not to advance evidence on the extent of cocaine use generally or among particular sub-groups of the population. Rather, the emphasis is on providing a description of what is perceived to be occurring on the ground, based on the reports of individuals who have regular contact with drug users.

One of the most noticeable features of informants' reports was that despite the belief that cocaine is easier to procure than previously, many felt that they had no concrete evidence of cocaine's emergence as a major issue, certainly compared to heroin and other drugs. In particular, participants felt unable to estimate the extent of cocaine use in the communities where they worked. There appeared to be a number of important factors associated with this absence of clear evidence or knowledge of cocaine's 'position' as a drug of use. First, respondents felt that cocaine use was extremely hidden and consequently, unlikely to come to their attention. Secondly, according to a large number of interviewees, cocaine users are unlikely to perceive their drug use as problematic and consequently, unlikely to seek treatment or advice of any kind in relation to their cocaine use.

I'm not sure that this area is awash with cocaine but what I would have a sense of is that the ones who are using cocaine are not in touch with services because

they don't really see themselves as having a problem.

(Drugs Worker)

You see, young people wouldn't seek treatment around that. Young people do come forward for treatment but it's mostly for heroin. They wouldn't see their use of cocaine as something they can get help for, or that they need help for.

(Youth Worker)

The picture that I'm getting is that the young people who start using coke don't see themselves as having a drug problem because they're not on heroin. So, heroin is still the biggie in people's perceptions and by taking coke you're avoiding having a drug problem.

(Drug Counsellor)

A number of professionals working in the delivery of drug treatment at community-level did however, report direct experience and evidence of cocaine use and considered this development to be recent. All stated that users were far more likely to be smoking or injecting cocaine than using the drug intranasally.

Although most of the people who access this service have an opiate problem, I have had contact with cocaine users. One person I'm thinking of now started using on holidays overseas and later developed a dependency.

(Drug Counsellor)

I think it (cocaine) is a serious problem, it's been a serious problem for quite a while. There's a lot of it going around in the flats. And we have an ongoing struggle with people on treatment who might be doing fairly okay as regards the heroin but dabbling or more than dabbling with cocaine.

(Drug Service Co-Ordinator)

Two respondents made specific reference to cocaine use among women. This is particularly noteworthy in view of findings documented in a recent study of drug using women working in prostitution in Dublin city (O'Neill and O'Connor 1999). Of the 77 women interviewed, forty reported past month use of cocaine. Following heroin and benzodiazepines, cocaine emerged as the next likely drug to be used.

Most of the clients who report cocaine use to me are women. And all of them say that it's very difficult to get off the drug, more difficult than heroin. These women would also be working on the street and there seems to be a link between the two.

(Drug Counsellor)

However, for respondents involved in the delivery of drug treatment, the dominant focus is on heroin users. There was general agreement however, that cocaine was far more likely than previously to be a secondary drug of misuse. Many respondents made reference to the practice of 'speedballing', one entailing the simultaneous intravenous use of cocaine and heroin. This practice was described by one of the study's key informants (a former heroin addict) in the following terms:

What I did then was I made speedballs. Ya know what a speedball is? Ya put your heroin on the spoon and cook it up, have your coke in the works, ya suck it up. The effects ya get from that! You're straight up in the air, like you head feels like it's goin' to go 'bump'. It's a great feelin'! And then ya sorta come down then nice and easy. It's the sorta feelin' (pause), it's unbelievable. It'd frighten ya at first 'cos ya think you'll die but this feelin' ya get from it it's, ya know, it takes all the pain away and all this shit, that's what it's there for at the end of the day.

(Key Informant # 2)

Several respondents acknowledged that 'speedballing' was a common practice and a number drew attention to the health implications of injecting risk behaviour.

What we would find here is that most people are speedballing, they're using a combination of heroin and cocaine together. So, in terms of harm reduction and looking at issues around health, the same difficulties will arise if people are using needles and injecting cocaine. (Drugs Worker)

Furthermore, respondents consistently drew attention to dominant risk perceptions and felt that cocaine was unlikely to be perceived by drug users to carry the serious health risks associated with heroin use. There is an implicit danger here, if as perceived, cocaine is increasingly finding acceptance and is more commonly in use.

I think the preference here (service) among drug users has been for the type of effects that heroin gives. Cocaine would not be seen by most of them as abuse. It would be seen as recreational. They don't see it as such a problem.

(Drugs Worker)

Heroin, as I said before, has that dirty, filthy, low-life thing and all of that, eventhough it hits all walks of life. Cocaine is looked at, 'ah, it's alright, it's only a line a coke'.

(Key Informant)

I think that the dominant perception is that cocaine is primarily a recreational drug, just as hash is understood as a recreational drug. The effects aren't as dramatic or rapid. And this is a problem too because I would certainly meet people who have serious problems with cocaine.

(Drug Counsellor)

It is important to point out that not all of the respondents reported concern about cocaine use among their client group. This is important since it suggests that different settings and services are more likely than others to attract cocaine users. A number of respondents stated clearly that opiates and benzodiazepines remained their overwhelming concern.

We have heroin problems and all sorts of other problems, tablets and all that. But from my point of view, and this is just an overview, we don't get cocaine coming up as a major issue. And it seems to me that there's a couple of angles on that, if we generally accept that heroin is the drug of choice. People will dabble with cocaine, but that's it they'll dabble but they'll revert to heroin. So, cocaine might be cheap on the streets, they might go for that for a while, it may

become problematic with them but they quickly get out of it and back almost to the safety of heroin, the known substance, the known area like.
(Drugs Worker)

Finally, while concern was expressed, by the majority of respondents, about an apparent increase in the availability and use of cocaine, the problem was not considered, as yet, to have reached epidemic proportions or to merit being viewed as 'out of control'. One informant, who previously worked with cocaine and crack cocaine users in London, drew a clear line of distinction between the situation in Dublin and that which prevailed in London a number of years ago, particularly in terms of service needs and responses.

A serious crack problem developed and all of a sudden agencies were inundated with these people and nobody could relate to them. And we had to do a lot of training to adjust to dealing with these people because it was totally different. The way you'd approach a heroin user, you wouldn't approach a crack user like that. But we're not getting that here.

(Drugs Worker)

To summarise, cocaine use was judged to be far more widespread than previously. However, respondents found it difficult to estimate the scale or extent of use among their client groups, or in the community at large. While the majority felt that the cocaine 'problem' was not comparable to that relating to heroin, they identified cocaine use as an issue requiring attention also.

- *Implications for Drug Treatment and Drug Service Provision*

The question of whether the needs of cocaine users can be adequately met within the context of existing treatment interventions was addressed with interviewees engaged in the provision of services to drug users. Considerable variation emerged on what was viewed as an appropriate way to address the issue of cocaine use within the context of existing services. While some respondents felt that specific tailor-made interventions were required to deal with the needs of cocaine users, others believed that current services needed to develop the knowledge and expertise required to deliver appropriate intervention and counselling. Some respondents stated that their agencies had already begun to address the issue informally.

I would say that there is a need for separate interventions. It's a separate drug, a separate addiction, one which can't be treated like heroin. If the two drugs are lumped in together, then it follows that they're going to be used together. If cocaine users are in a methadone clinic they're bound to pick up the habits that are all around them.
(Drugs Worker)

I do think it's a different kind of problem and one of the reasons it's different is that there doesn't seem to be the same physical withdrawal difficulties but there is an enormous psychological withdrawal and psychological cravings. So what we've done here is supported the person as best we could, get them into

counselling and we would also have treated them with acupuncture.
(Project Worker)

I think that as an agency we've already started to change our approach, even in thinking what services can offer somebody who might have a dependency on cocaine. There's no medical treatment so we have been looking at some level, looking at ways that we can provide appropriately as a service.
(Drug Counsellor)

More critical perhaps than the lack of agreement on appropriate interventions was the fact that several interviewees who are involved in drug treatment delivery felt ill-informed and ill-equipped to deal with the presenting behaviours and problems of cocaine users. In addition, a number of respondents drew attention to an absence of information on cocaine use and related risk behaviours at community level.

They've (drug users) had more information, more education on heroin so maybe the haven't had enough information about cocaine. Initially, they don't have a fear of cocaine because they would believe that it isn't addictive.
(Drug Service Co-Ordinator)

Prevailing perceptions of the risks associated with cocaine use were considered to be a compounding factor here. One informant drew attention to the importance of contextualising current perceptions of drug-related risk when attempting to alter behaviour and beliefs about cocaine.

It's largely a methadone culture and that's the context I'm speaking in. And methadone is perceived as the solution to the problem. And for people who are seriously dependent on cocaine and want help, the belief is that methadone is the solution for them as well and therefore, they want methadone treatment. That's the perception in the community. So we would have had to be quite strong in helping people to understand that it's a totally different drug and that there's absolutely no point putting the person on methadone, that you're actually introducing them to opiates. But this is all understandable in the context of a strong heroin and methadone culture.
(Drugs Worker)

Most respondents agreed that there was a need for more information and training on the effects of cocaine, the presenting behaviours of cocaine users and appropriate treatment and intervention options.

- **Conclusion**

Using existing data systems, including available data on drug users, the previous section of this paper found that opiates remain the primary drugs of misuse among drug users who access treatment. Despite this, there are subtle indicators of a possible shift in the drugs landscape, with increased likelihood of cocaine use among individuals whose main drug of misuse is heroin.

The reports of drugs workers confirm this trend. A large number of drugs workers stated that clients are now more likely to present with cocaine-related problems and the majority felt strongly that cocaine was more readily available and accessible than previously. The risk of 'microdiffusion', that is the dispersal of drugs knowledge, practices and techniques, through established user networks (Parker et al. 1998), may be substantial if, as indicated, cocaine is making a breakthrough on the drug scene. Further research is required to qualify and quantify a possible spread of cocaine use among problem drug users. In particular, the nature of the relationship between heroin and cocaine use, requires investigation. Preferred routes of cocaine administration and related risk behaviours need particular attention in this context. Grund et al.'s (1991) investigation of cocaine use in a sample of heroin addicts in Rotterdam found that the mode of ingestion paralleled that of heroin: injecting drug users injected cocaine-hydrochloride and heroin smokers smoked cocaine base. The authors documented the distribution of 'gekookte coke', otherwise known as 'cooked', 'base' or 'rock' cocaine, by a particular sub-population of drug users. The preparatory process is identical to that described by one of the current study's key informants, a former user and supplier of 'homemade' crack cocaine.

Well, basically all ya do is (pause) ya can add ammonia. That's a lazy way ta do it. I call it the lazy man's way a doin' it. Ya put your coke on the spoon, your gram a coke or whatever ya have on the spoon, ya pour a dribble of ammonia over it, light a flame underneath it. It's like cookin' heroin. It bubbles like fuck and it goes into sort of an oil and ya leave it cool or else ya can drain it off. Ya rinse it with cold water then, ya don't heat it up again, ya just rinse it with water 'cos if ya do that it'll just dissolve into ... And then ya take it off. And ya know a hash pipe? Like a seven-up bottle or something. Instead of using tobacco ya use the ash off the cigarette. It has ta be fresh ash. So like you'd have one ashtray for cigarettes, for puttin' out your cigarette. You'd have cigarettes burning everywhere but ya wouldn't put the cork out on it 'cos ya want the ash. Ya just break bits a lump off it and whatever and (inhales) ya smoke it and ya get your couple a seconds hit.

(Key Informant # 2)

At present, there is no way of establishing how widespread the practice of 'cooking' cocaine may be, or of the prevalence of this technique among drug users. However, problem opiate users are far more likely to be using injecting or smoking techniques than to be snorting cocaine (Grund et al. 1991). Research is required to explore dominant and preferred patterns of cocaine use among both treatment and community samples of heroin users.

Finally, the treatment needs of individuals engaged in the co-abuse of opiates and other substances requires attention. Rooney et al. (1999), comparing Irish drug users who are dependent on opiates and benzodiazepines with drug users who are not dependent on benzodiazepines, found that the former group tended to take more drugs in general. Thirty five percent [35.3%] of those dependent on opiates and benzodiazepines used cocaine compared to 13.8% of the opiate users not dependent on benzodiazepines.

While drugs workers and service providers in the current study expressed concern about increased availability and use of cocaine among their client groups, it also seems clear that some services are more likely than others to be currently treating clients who report the use of cocaine. Consequently, the lack of consensus on appropriate treatment and intervention responses to cocaine use is not altogether surprising. More critical perhaps, is the fact that drugs workers felt that they lacked adequate knowledge and understanding of cocaine use among their client groups, including information on dominant user practices and the effects, risks and health consequences associated with the co-abuse of heroin and cocaine.

Component 3 : Exploratory Study of Social/Recreational Cocaine Use

Population surveys in Ireland identify few cocaine users. However, anecdotal evidence suggests that cocaine is easily available and its use more widespread than previously. In this exploratory study of social/recreational cocaine use, the research challenge was to locate and gain the co-operation of a small number of adult cocaine users in the community, who are not currently attending, and who have at no stage contacted, a drug treatment centre. In other words, the emphasis was on accessing individuals who do not identify themselves as having a drug problem. The principal aim was to 'capture' users not normally accessible through treatment or other institutional settings and to examine patterns of use and attitudes to cocaine.

- *Study Parameters, Research Instruments and the Recruitment Process*

The study's selection criteria, in terms of past and current cocaine use, was deliberately broad. No strict or binding guidelines pertaining to precise levels of drug intake were applied at the outset of the selection procedure due to the absence of prior empirical research on cocaine use in an Irish context. However, to qualify for participation in the study, respondents must have used cocaine at least five times during their lifetime, preferably, at least once during the past year. Other criteria for entry to the study, in addition to some experience with cocaine, were that participants must be 21 years or over and must have been employed for at least six of the twelve months prior to interview.

The purpose of the research was not to ascertain how many people use cocaine, but rather to gain some insight into reported patterns of cocaine use among a small group of social users. Hence, the central concern was not one of generalisability but one of access. In this context, the guiding principle, in the words of McCracken (1988), was "less is more" (p. 17). McCracken (1988), who describes the key characteristics of the *long interview*, recommends working longer and with greater care with a small number of people, and suggests that eight respondents is sufficient for many research projects.

The research aimed to generate knowledge and insight into cocaine use by adults, a phenomenon not previously researched in an Irish context. Ten adult cocaine users were interviewed individually. The issues addressed in the context of individual interviews included past and current cocaine use, other drug use, typical cocaine-using contexts, availability, cost and quality of cocaine, the benefits of cocaine use, perceptions of risks associated with use and the appeal of cocaine. Study respondents were accessed initially via the researcher's personal contacts with potential participants. This gradually facilitated access to other individuals through 'snowballing', whereby, additional respondents were recruited through the recommendations of individuals previously interviewed. This technique is well-known in the drugs research field and is particularly suited to investigations of illicit and hidden activities (Biernacki and Waldorf 1981; Power 1989).

Attempts were made to access a variety of user networks. The recruitment task proved more difficult than originally anticipated, particularly during the early stages of establishing contact with cocaine users. Prospective participants were sceptical about the intentions of the research and understandably reluctant to divulge details about their drug use. They invariably asked questions about the purpose of the study and about the publication of study findings. The challenges to recruitment were overcome by gradually extending access routes and by providing assurances of anonymity and confidentiality. The recommendations of key informants – individuals who had contact with cocaine users - greatly facilitated this process. The time invested in the selection of participants resulted in six user networks across the sample. All interviews were tape recorded. Choice as to the time and place of the interview rested with the participant. Interviews took place in a variety of settings including the researcher's office (n=1) or home (n=1), a public venue (n=3) or at the home of the respondent (n=5).

Biographical details and drug history were recorded for each respondent using a pre-coded structured questionnaire. This included details of each respondent's age, gender, education, employment, household situation and current income. Lifetime drug use, past month, past week drug use, as well as future drug intentions were recorded for each individual participant.

All respondents were resident in Dublin city. The study does not claim to be representative of social/recreational cocaine users generally. Rather, it is illustrative of a 'mode' of cocaine involvement among adults who do not consider their drug use to be problematic. The primary objective of the investigation was to gain insight into patterns of cocaine use among groups not associated with problematic drug consumption. The question of how users first came into contact with cocaine, how their use progressed from the time of initial use, what they perceived as the positive and negative effects of the drug, and how they regulated their intake of the drug were key issues addressed during in-depth interviews. Importantly, the research examined respondents' use of a range of

mood-altering substances, so that cocaine was not examined in isolation of other drug use.

The protection of informants' identities was a priority throughout the research. No names, addresses or contact numbers were recorded on pre-coded questionnaires. In addition, all identifiers (place names, birth place, current area of residence etc.) were removed from transcript material and fictitious names substituted in all cases for the purpose of reporting the study findings.

- *Data Analysis*

Full transcripts of nine of the ten individual in-depth interviews were prepared. A partial transcript was prepared for one interview due to poor conditions at the interview site, resulting in a high level of background noise. This partial transcript was reinforced by notetaking both during and after the interview. The findings presented here are based on a thematic analysis of all transcript material. Boyatzis (1998) describes thematic analysis as a "process for encoding qualitative information"(p.4) and clarifies the meaning and use of themes for analytic purposes.

A theme is a pattern found in the information that at a minimum describes and organises the possible observations and at a maximum interprets aspects of the phenomenon. (Boyatzis 1998, p.4).

In other words, a theme is not merely a 'fact' or set of facts extracted from the data but a pattern that presents itself throughout a data set. Themes provide a useful interpretative structure for understanding the phenomenon of interest. The data was coded manually in accordance with the research aims. Ancillary codes were added as the fieldwork process advanced. In this way, the analysis incorporated both predefined categories and those that emerged directly from respondents' accounts of their cocaine use.

Interpretation of the results has to be qualified by a number of study limitations. First, the research is based solely on self-reports of frequency and quantity of drug consumption of a small number of informants, all of whom were resident in Dublin city at the time of interview. Second, the sample was opportunistic or one of convenience. Accordingly, it would be inappropriate to generalise the findings to cocaine-using adults generally.

A number of techniques were employed throughout the data collection and analysis phases of the research to ensure valid and reliable findings. The safeguards concerning confidentiality and anonymity help to validate the responses. Moreover, the questioning and data collection techniques employed meant that the consistency of cocaine and other drug use reported by participants could be checked. All respondents were asked about their drug use (lifetime use, past year and past month use) on two separate occasions during

the interview. This data was also recorded on a questionnaire. One hundred percent consistency was found in respondents' reports in practically all cases.

The presentation of research findings focuses first, on the socio-demographic characteristics of study respondents. Baseline data on cocaine and other drug use is then presented. The analysis moves then to present a more detailed description of respondents' use of cocaine, including the circumstances and locations associated with use, the appeal of cocaine, negative effects and the perceived benefits of cocaine use and risk perceptions. The issues of availability, price and purity are also examined.

- *Socio-Demographic Characteristics*

Eight males and two females were interviewed. The average age of the research participants was 27.3 years (range 25-29 years). Nine of the ten interviewees were born in Ireland. One was born in the UK but has been residing in Ireland for several years.

The educational attainment for the sample was high. All had completed their Leaving Certificate or equivalent and all attended a third level educational institution. Eight of the ten participants graduated with a third-level Degree or Diploma. Eight were employed full-time and two part-time at the time of interview. All had experienced periods of unemployment ranging from 2 months to 6 years. It is significant however, that in most cases, stated periods of unemployment coincided with time spent travelling abroad and extended for only one to two years. Two participants declined to state their current gross annual income. Of the eight who did, annual incomes ranged from £10,000 to £30,000. Seven of the ten respondents were earning in excess of £20,000 per annum and five had a gross annual income of between £25,000 and £30,000.

Finally, all respondents resided in Dublin city. All were single and over half (n=6) lived with a partner. Three participants lived with friends and one with their child. All participants resided in a rented private sector house or apartment.

- *Cocaine Use*

This section provides baseline data on the participants' reported cocaine use. The average age of cocaine initiation use was 21.2 years. Half (n=5) reported first use of cocaine between the age of 20 and 23 years. On average, respondents had a cocaine 'career' of 6.5 years since initiation. Eight of the ten respondents had used cocaine at least once during the month preceding the interview. The most popular mode of cocaine ingestion was 'snorting', or intranasal use of the drug. Two respondents reported having ingested the drug orally on a number of occasions and a third stated that he had smoked cocaine in a 'joint'. Apart from this, none of the participants reported smoking cocaine at

any stage. In fact, they were unfamiliar with this practice and did not regard this mode of administration as a future drug option.

Cocaine typologies have been devised by several researchers, based on participants' reported frequency and intensity of use (Hammersley and Ditton 1994; Waldorf et al. 1991; Ditton et al. 1996). Typologies will not be presented here due to the small sample size. However, it is helpful to summarise general patterns of cocaine use for the sample. The majority did not engage in subsequent use of cocaine for some time (sometimes 2-3 years) following first use of the drug. Overall patterns of cocaine use varied considerably across the sample. Although a number (n=4) reported bingeing on cocaine, the duration of such 'bouts' of use were short. The majority (n=6) had not used cocaine for more than two concurrent days. Monthly use was the most frequently reported current pattern of use and daily cocaine use of the drug was not the norm for this group of users. Nine of the ten respondents intended to use cocaine in the future. The remaining participant stated that she may well use cocaine at some time but had no definite plans to do so in the immediate future.

- *Other Drug Use*

Practically all participants were experienced users of a range of illegal drugs. Table 13.11 presents the figures for lifetime, past month, and past week use of cocaine and other drugs. Drug intentions are also included on this table. Alcohol and tobacco, being licit drugs, are referred to independently. Six of the ten participants were current smokers and all consumed alcohol on a regular (2-3 times weekly) basis.

Table 13.11 : Lifetime, Recent and Future Use of Cocaine and Other Drugs (n=10)

Drug	Lifetime Use	Past Month Use	Past Week Use	Future Drug Use*
Cannabis	10	10	8	10
Ecstasy	10	7	4	7
LSD	10	1	1	2
Amphetamine	10	0	0	1
Cocaine	10	8	4	9
Heroin	3	0	0	0
Methadone	2	0	0	0
Psilocybin	9	0	0	3
Glue/Solvents	2	0	0	0
Tranquillisers	3	0	0	0
Other	6	0	0	0

* Respondents were asked to state which drugs they intended to use in the future.

The average age of drug initiation for the sample was 15.8 years (range 13-19 years). Five respondents were 17 years or over at the time of first drug use. The table above indicates that respondents had tried or used a range of substances.

All reported lifetime use of cannabis, ecstasy, LSD and amphetamine. Nine had used psilocybin (magic mushrooms). Three respondents reported lifetime use of heroin, two had used methadone, two tranquillisers and two solvents or inhalants. Lifetime use of other substances not listed included opium (n=2) , mescaline (n=2) and crystal meths (n=2).

Cannabis was by far the most commonly stated first drug used. LSD and psilocybin (magic mushrooms) were frequently stated as second drugs used (n=7). Seven of the eight respondents were regular cannabis users (weekly or fortnightly users) and a significant number (n=6) reported past month use of ecstasy. A large number reported concurrent drug use, that is the use of two or more substances within a couple of hours of each other. The most popular drug cocktails were alcohol and cocaine; alcohol and cannabis; ecstasy and cannabis; cocaine, ecstasy and cannabis and ecstasy and cocaine. Cannabis was considered to be compatible with most drugs and was frequently smoked subsequent to the ingestion of another substances. Nearly half of the respondents (n=4) reported daily or near-daily use of cannabis.

Nine respondents intended to use cannabis and cocaine at some stage in the future and a large number expected to use ecstasy (n=7). Considerably fewer intended to use LSD (n=2), psilocybin (n=2) or amphetamine (n=1).

- *First Use of Cocaine*

Respondents were asked to describe the circumstances surrounding their initial use of cocaine. Use was invariably initiated in the company of friends in a social setting where alcohol and/or other drugs were being consumed. The majority stated that they had contemplated cocaine use in advance of first experimentation. However, while most stated that they intended to try cocaine at some stage, first use usually occurred incidentally. For this reason, first cocaine experiences were often free.

With friends at a party under the influence of another drug which was Ecstasy. I hadn't planned it as such but I had expressed an interest in taking it before that night anyway. I was up and ready for it but I hadn't planned it.
I was with some other musicians and they had it. It's a social drug and they were sharing it. At that time I was only starting to dabble with that kind of stuff. Someone asked me did I want some so I tried it.

For a smaller number of participants (n=3), first cocaine use was involved some advance planning.

I got it through friends. I asked to get it. I got it for a party. And I was in my early 20s at the time, about twenty-two.

At the time of initiation, most shared approximately one gram of cocaine with two or three friends, the typical intake being "two or three lines" or "a few lines".

Informants usually reported drinking alcohol and/or using one other drug - either cannabis or ecstasy - at the time of initial cocaine use. The majority reported first cocaine experiences in positive terms.

It was amazing. Down there (abroad) anytime I got it, it was absolutely amazing. I could really see the attraction in it ... it was weird being so high but so clear. I suppose it was a very confident buzz I got out of it.

I thoroughly enjoyed it, yes it was good. It has similarities to other stimulants as such but I would certainly differentiate between that and ecstasy or speed.

Only one respondent stated that he was not impressed with the drug at the time of first use and asserted that he "didn't really see what the attraction was". Most agreed that subsequent cocaine experiences were superior to first or early use episodes. A process of learning to recognise and appreciate cocaine effects clearly accompanied the initial stages of use.

I remember being able to deal with it and just kind of recognise the buzz and again it was probably just a learning thing going on.

There is not a huge kick off it (cocaine) which is why I think you don't know what to expect at first and maybe after the second time you probably you can tell people 'that was crap' and they say 'well, did you not feel this' ... and then you say, 'well maybe I did'. And then the next time you have probably talked yourself into the buzz, what you are supposed to feel.

At the time of first use, practically all respondents had previously experimented with and used a range of stimulant and hallucinogenic drugs. In fact, cocaine was commonly listed as a fifth or sixth drug ever used by the majority of respondents. On average, there was a five and a half year time lapse between first drug use and first cocaine use. Hence, the majority were 'experienced' drug-takers at the time they first tried cocaine. None expressed any doubt, scepticism or anxiety about the prospect of using cocaine when describing the circumstances surrounding first use of the drug. Hence, although cocaine initiation occurred later in respondents' drug 'careers', it was not an unexpected or unanticipated event.

- *Using Cocaine*

All respondents were asked explicit questions about the frequency and quantity of cocaine use generally, and in particular, during two specific periods: use during the 2-3 year period subsequent to initial use and cocaine consumption during the two years preceding the interview. Hence, early and current use of the drug were examined in detail in order to construct a picture of typical patterns of cocaine use across time, amongst this group. Given the substantial drug history of respondents prior to first cocaine use, coupled with frequent reports of the using cocaine in association with alcohol and other substances, cocaine use is examined here with reference to respondents' use of other substances. This

section will describe participants' cocaine use, in terms of the frequency, intensity, intake and duration of use. The circumstances surrounding use is an important component of this analysis.

As stated earlier, there was a considerable time-lapse between first and more regular use of cocaine. Hence, while cocaine initiation took place, on average, at the age of twenty-one years, more consistent use of the drug did not emerge for quite some time. Use of the drug was sporadic initially, and appeared to be dictated largely by economic factors: cocaine was expensive and most respondents had not yet secured their first job. Availability was an additional factor that appeared to deter regular use at this stage.

In those days I was a student and I had fuck all money anyway, you know. And a lot of the time when you're in that scenario, you probably get in with somebody and get to know somebody who has a contact somewhere else. Or, they might be dealing themselves or be able to get it irregularly or cheaply. And coke wasn't on of those kinds of drugs that you could get easily. And when you got it, it was never cheap.

When I was 21, £80 or £70 for a wrap of coke plus your drinking, plus getting into a club .. I just couldn't do it. £150 out of your pocket for a night, I just couldn't do it ... and I wouldn't have had it myself because I wouldn't really have known the people that you would get it from, so it would have been a real hit and miss thing which will change as you go along because you will find out people who sell it.

Consequently, early use of cocaine was intermittent and viewed largely as a 'treat', or an extravagant drug for special occasions. At this stage, other drugs were more likely than cocaine to be in use largely because they were more economical and easier to procure.

I'd say it was more sporadic (for several years after first use), you know. If it was available and if I had the money in my pocket I'd get it. But if there was other stuff available I wouldn't bother. I'd go the cheap route because number one it's (other drugs) cheaper and number two, it'll go further.

There were huge gaps between when I would take it, so it would be months between taking it. It could be two or three months before a similar party or circumstance would come up. But it was always party generated, you know, because of the nature of it.

It is significant that among this group of informants in their mid- to late-twenties, most only started to use cocaine more regularly during the past three years or less. Current frequency of use varied across the group. The largest number (n=7) reported monthly use of cocaine. One stated that he had used cocaine approximately eight times during the past year. For two others, use was less regular and less deliberate: some respondents did not secure a regular personal supply of the drug and described their current use as occasional.

It is very rarely an arranged thing. It would be a case of somebody saying 'I have two grams of coke, does anyone want to go in on it?'. That is probably the extent of my cocaine use at the moment. I wouldn't be a huge fan, I don't really see the value in it, shall we say.

A final participant reported having reduced her cocaine intake from former more regular and intense consumption levels, including two 'bouts' of use when she used cocaine several times weekly.

Given that regular cocaine use was quite a recent development for the majority of participants, it is important to examine how interviewees described this drug transition. As stated previously, all respondents reported a sizeable repertoire of drugs prior to cocaine initiation. Practically all had gone through a short phase of LSD use and a sustained phase of ecstasy use, ranging from several months to two years. While ecstasy was described in positive terms, the majority drew attention to the negative effects of regular, heavy use and indicated a definite shift from this particular phase of drug use. Most stated that while they currently used ecstasy on occasions, they had quit regular weekend use of the drug.

I have really gone off ecstasy just with mood swings during the week from it and there was a time when I would probably have said I preferred ecstasy. At the moment if I was to go out I would probably say no to an E and seek coke as a lot lighter. I don't feel as bad the next day so I would probably do a bit of coke.

I haven't done any (E) for a long time. It is so physically draining for me to take, you know, you take an E and for a couple of days you are just not really as sharp as you normally should be. You are not really on the ball. It takes an awful lot out of you. I haven't taken acid in a couple of years either and that's the same, it knocks you for six.

Many perceived cocaine to be a lighter and more manageable drug. First, cocaine did not induce powerful physical effects during times of use, certainly compared to ecstasy. Second, it did not produce profound negative side-effects during the days following use. Both factors emerged as primary motives for a reduction of ecstasy (and LSD) intake on one hand, and increased cocaine use, on the other.

I know if it is a line or two of coke I still find I can go about my daily routine. If it take ecstasy I know I won't feel the best the next day but Es are a funny thing. Sometimes you take one and you find that you can be in a pub atmosphere, enjoy a pint or two and its not too heavy. And then sometimes you take another and whatever is in it, you're just gone.

In comparison to ecstasy, physically with ecstasy it is hard to get up the next day and get through it, you know, you have black rings under your eyes. Usually on ecstasy you're higher than you are on cocaine, even if it is really good cocaine. And then mentally with ecstasy, you know sometimes you have to have a couple of days to recover from the night out as such. Coke does not have that effect, not on me anyway. It is far easier to just go out and have a good time with some

coke and get up the next day and either go to work or just get through the day and not be in a hassle.

Respondents' preferred circumstances of cocaine use varied but most favoured a relaxed setting in the company of friends. Respondents regularly drew attention to the circumstances of use and considered the setting to be a strong determinant of positive drug experiences.

Sometimes the buzz with coke is a bit better than others because of purity I suppose. But it is 90% circumstances. I am not saying that circumstances completely override the quality of coke at the end of the day, you know, if you are a relatively seasoned user. But at the end of the day when I look back at nights when I have taken coke or taken some other drug it is usually the circumstances and the company that I keep and whether I am enjoying myself, and my current state of mind. They are usually the predominant factors in how good the night was, you know.

A majority preferred to use cocaine in private social, rather than public, settings. Situations in which people wished to communicate and enjoy the company of friends were most frequently mentioned as those where cocaine use occurred. Less frequent, but visible also, were situations in which people wanted to dance.

I prefer to use coke in a house. Yes, with a few friends in the house. I have used it in clubs before but you wouldn't be using there often because you can't use it openly, you know.

It would be mostly at home or in the pub you might slip into the jacks and have a quickie in the coke sense. But generally it would be in a house situation. It is not really conducive to doing in a public place in that there is a little bit of preparation and that involved. You have to get it out into a line and it is not the ready-made package that our friend ecstasy is.

I'd be inclined to use cocaine in quieter more laid back circumstances ... say there was a weekend of music somewhere, a festival or something like that. I'd make up my mind, like I'd go for coke or for a few tablets as well, you know.

Taken on its own (cocaine) you are elated and you are aware of yourself but you are aware of yourself as being full of confidence and you feel really sexy and especially say, if you are dancing or you are in a club.

Most participants reported using cocaine in a social setting at night-time (either at home or out). However, a small number had also used cocaine during the day on occasions, although this was by no means a preferred or usual practice.

The last time I took coke was two weeks ago. It was in the middle of the day and I was sitting in. I was away for a week and I was sitting in the house drinking cups of coffee and smoking joints. And we decided it was time to hit the town so it was about mid-afternoon, something like that. And I had a line, went out, spend the whole day buzzing around and would have had maybe two or three more lines that night.

From the reports of participants it could be inferred that cocaine use is strongly related to lifestyles where going out, social gatherings and socialising are dominant. For the most part, cocaine use was confined to weekends and holiday times, when there was sufficient time to 'recover' and fewer potential negative repercussions from use or over-indulgence. Cocaine use was strongly linked with alcohol consumption. A number of respondents commented on the compatibility of alcohol and cocaine. In fact, cocaine was rarely, if ever, consumed alone. Although descriptions of use varied, cocaine using scenarios invariably involved the use of other mood altering substances including cannabis, alcohol and less frequently, ecstasy.

It is a drug you tend to mix as well, primarily with alcohol now, the two, for whatever reason seem to combine. Now medically they could be the worst thing for you, I don't know, but from a results or effects point of view they mix well and you tend to drink more and you tend to sit around and you would be in considerably better form, not really sure why, considerably better form.

Coke and alcohol are a very crucial mix for a night. If you are doing coke you have to have some booze so I would say that that goes hand in hand with the amount of booze you are going to go through.

Hash may or may not come into it as well. If we're out drinking and are back in someone's house we might have a smoke or not. I actually like mixing ecstasy with a bit of coke too, you know it's good fun. You get a good energy and physical (pause), an energetic rush from the ecstasy both mentally and physically and taking it with a bit of coke also maintains the same kind of rush that you would have got from ecstasy. So it is almost prolonging the effect that you get from ecstasy. They are both stimulants so they are both doing the same kind of thing but ecstasy makes you more amorous and friendly to others and you would be less likely to talk about yourself.

Current frequency of use was strongly linked with economic factors. Individuals with more disposable income were far more likely to use monthly or weekly. One respondent stated that cocaine was simply not economical and that he could not afford to buy the drug regularly. Compared to other drugs, cocaine's short-lived effects relative to its high cost rendered other drug choices more cost-effective.

For the same money, if you want to compare them as regards what the user gets out of it, you get a much better night or a much better hit of six Es which is the equivalent (cost wise) as a gram of coke. It think it (cocaine) is very expensive and prohibitively expensive which is probably a good thing because if it got any cheaper, it would become a lot more popular very quickly because I have noticed an increase in its popularity in the last year, year and a half.

On a scale of drugs that I'd take, it would probably be the least common drug that I'd use. Um, because for value for money, it's the worst. Because you could actually buy a gram and consume the whole gram in one night. So that eighty

quid, gone, whack. Whereas you could get a good quality ecstasy tablet for a tenner that would last you the whole night. So, it's down the list for me anyway.

Other respondents, by contrast, stated that their current income permitted more regular use of cocaine than in the past.

Well, at first it was never really something that I went out of my way to go off and take and then when I had a bit more disposable income and I was growing tired of other drugs that I had taken, ecstasy really, then I started doing it a bit more.

As a young adult I couldn't really afford it whereas now I can afford it so there is that sort of thing.

One respondent attributed his increased cocaine consumption during the past year to a heavy workload, resulting in more stress and fatigue.

It (cocaine intake) has probably increased a little this year. I don't know why really? Probably work because I am working a hell of a lot more and so, I would have two nights off. And I kind of go for it big, kind of a more intense night out. And that is probably one of the reasons for it. Plus, in the last few months... it gives you that sort of a pick up. Because at the moment I have changed job so I am working more hours and am more tired.

The study's regular users of cocaine generally restricted use to weekends, when their intake of the drug ranged between one and two grams per session. Most reported periods of abstinence ranging from one month to several months. While a number of informants stated that there were times when they had exceeded their usual intake, bingeing on cocaine was not a common practice. Cocaine was rarely used on more than two consecutive days.

I suppose in the past I may have taken a load of coke and not slept, had a meal or something like that and then started a session again if there was a particular reason to be on a party buzz. And then I may have done it two nights in a row, sometimes I suppose three but I have never gone on a complete weekender without any sleep.

I've never actually taken coke for more than like two days or something like that. I've never gone on a binge of coke.

One respondent did report two separate phases of intense and regular cocaine use. On both occasions, the individual had easy access to the drug and did not have to pay a high price for a 'good' supply.

I have gone on coke sprees. I remember one in particular and it was really, really good. About three years ago it was with my boyfriend's friend. He had loads of it and it was pure and when I think about that, it is interesting because now that I remember it, it was great because there wasn't any comedown. I think I have particularly bad comedowns because of what it is mixed with. But he was giving us the good stuff.

To summarise, while frequency of cocaine use varied across the ten persons interviewed, it was possible to identify a number of distinct patterns of use. The largest group of cocaine users (n=5) had previously used a range of other stimulants (ecstasy and amphetamine) and hallucinogenic drugs and had significantly curbed their intake of these substances. While all reported that they enjoyed past drug experiences, the cumulative negative effects of ecstasy use, in particular, were considered to be too costly. In this context, cocaine had increasingly emerged as a drug of choice. This shift also appeared to coincide with significant lifestyle changes. In particular, respondents reported increased career commitments. Importantly, this group of mid-to relatively high-earners had more disposable income than previously. Cocaine was considered to be a 'cleaner' drug and use did not impinge on routine responsibilities which centred largely on work. Most engaged in weekend cocaine use, with use frequency varying between one and four times monthly.

Four additional participants described a pattern of less regular cocaine use. This groups' drug preferences did not focus as strongly on cocaine and they reported more regular use of other drugs. While cocaine-using occasions were sometimes planned, most occurred by chance. For this group, cocaine was not a primary drug of use and was more likely to be incorporated into a polydrug repertoire and used intermittently. Finally, one participant, a former regular cocaine user, had not used cocaine for several months.

In general terms, the broad picture emerging for the study participants is one of illicit polydrug use. It would appear that cocaine has become a more regular and valued feature of this groups' polydrug 'careers'. While regularity of cocaine use varied across the sample, use frequency appeared to be determined by a number of interacting factors including past drug experiences, current income and user drug preferences.

- *Availability, Purity and Price*

Respondents were asked to comment on current availability and ease of cocaine accessibility. Across the sample, there was general consensus that cocaine is more easily available and more commonly used than previously.

It is far more freely available now, you would see more and more types of people doing it and there are bars and clubs in town where a lot of people would use it ... it would have had that tag of being a more exclusive drug years ago because it wasn't freely available and used more for an occasion. But now a lot more people I know do it every weekend.

It's a lot easier to get it now really, but that's probably down to my own circle of acquaintances as well. Yeah, if I want it I can get it.

Coupled with increased availability, there was a strong belief in cocaine's *acceptance* as a drug of choice.

There is a large acceptance, people that I know and people's parents do it the odd time, do a line, and it is fine by them.

There is a big difference now, sure even if you look at toilets in a club, it is nothing to see two males go in and out of a cubicle together and the likelihood is that they are both going in to do a line but nobody bats and eyelid. I think years ago whereby we were told how bad drugs were, people would readily stand up and go 'listen'. That is not on nowadays. There just doesn't seem to be that anymore. Nobody is going to turn around and be disgusted that you are doing something like that.

Strong differences emerged however, in the perceived reliability of personal access routes to cocaine, particularly in relation to expectations regarding the quality and purity of available supplies. Regular cocaine users had sought out and located one or more reliable supplier of the drug and felt self-assured about the quality of cocaine they purchased.

I find availability okay. I wouldn't buy it off somebody I didn't know, and you are still taking a bit of a gamble with somebody you know with what you are getting, you are still not getting extremely good quality but I would have no problems, if I got muck in cocaine, giving it back to the person (supplier) as well. I wouldn't pay that amount for something that's not acceptable at all.

Others, who did not have a regular dealer, relied on friends to secure a supply of cocaine. It appeared that those who socialised in user circuits were able to access cocaine easily.

If I wanted it (cocaine) I would have to talk to a particular friend ... and he would talk to the guy who deals it for him. I don't have a dealer so if I heard there was something going on at the weekend and people getting stuff I could ring up and just say put me down for a wrap or whatever.

Less committed and regular users of the drug, on the other hand, had to go to greater lengths to procure "good" cocaine and a number did not have a reliable dealer.

I have a regular supplier for years and I wouldn't be a heavy coke user. So anytime I go to get coke, it's more of a hassle for me to go and get it because I have to go out of my way to get it because he doesn't supply it.

The quality varies from very poor to very good. Again, there is no trend to that either, it's totally pot luck. I am sure there are people, and again this is my experience because I don't know many people or one person, to be honest, who sells the stuff. If you knew more people that sold it, the chances are you would probably be able to get it more regularly and get good stuff.

Respondents' reports indicate that the current street price of cocaine varies between £50 and £80 per gram. The majority stated that the quality and purity of supplies vary enormously depending on the source and availability of the drug.

Most respondents had used cocaine out of Ireland at some stage and frequently mentioned the inferior quality of cocaine here, certainly compared to that which they had sampled abroad.

The way you kind of socially create sources for obtaining coke, well after a while you do notice that one person gives you coke and it may not be as good as the next person. And sometimes after a few years or after a while of taking it you can actually take some lines of coke and you can actually see what it is cut with, you can taste it or you can see it. It is just something that you develop over the course of time and the purity in Dublin anyway is not always the best.

It is pricey, but as well as that you see it is hard to tell because in Ireland it is hard to get good cocaine. You can get it but it is few and far between, it is a bit of a gamble when you go to buy because you don't know if its going to be good. But if you have a regular source and you know what is good then you are fine. And you will find that there are times when you will get really good stuff all the time and then other times you are getting crap, you know.

In general, the evidence suggests that cocaine is readily accessible to individuals who are motivated to use the drug and have established contact with a reliable supplier. Less frequent users, while having easy access to cannabis and ecstasy via their regular dealers, had inferior access routes to illicit cocaine supply systems. They were not motivated to seek out a more reliable cocaine supply route and allowed situational factors to determine the quality of the cocaine they consumed. At the buyer level then, it would appear that cocaine, albeit of variable quality, is relatively easily available to individuals who opt to use the drug.

- *Perceived Attractive and Unattractive Aspects of Cocaine*

All psychoactive substances have appealing and unattractive attributes and cocaine is no exception in this regard. All of the respondents were well-versed on the drug-induced outcomes of a variety of substances, they distinguished clearly between the effects of individual drugs and had preferences for specific drugs or drug combinations, depending on the circumstances or settings associated with use. In this section, the perceived appealing and negative aspects of cocaine will be examined. Reference is made to the perceived advantages of other drugs in instances where this has a bearing on respondents' attitude to cocaine.

The data revealed three major cocaine attractions. They are not discussed here in hierarchical order, as it was difficult to determine individual advantages which prevailed over others in terms of their significance. Rather, all three merged as components of a psychoactive 'hit' which was perceived to be gratifying, beneficial and enjoyable. Cocaine's appeal focused on three central themes - pleasure, control and lifestyle.

Cocaine simply made partying better, according to the majority of respondents. The psychoactive 'hit' produced feelings of exhilaration, confidence and psychological pleasure, thus enhancing social occasions in which the drug was in use.

Taken on its own you are elated and you are really aware of everything and you are aware of yourself but you are aware of yourself as being full of confidence.

It boosts the night by about five fold. If you are out and you are having a great laugh it seems to add that little bit extra to the night. The banter is a bit quicker as it goes on ... It is just like a mood enhancer.

With coke you can have a little stash of it and you can stay up all night. It is just that it breaks down all those barriers and you are just babbling away having a good time, socialising with people.

Closely linked to the social and psychological pleasures described by respondents was that cocaine provided an immediate injection of energy and enthusiasm and made the night last longer.

If I was taking uppers - speed, cocaine, something like that - it would be to promote my energy levels for the evening or elongate it so you can go with the craic for longer.

Two respondents drew attention to the enhancement of sexual experiences following cocaine use.

Coke is more of an indoor drug and if you are with someone that you are quite into a relationship with it is good as well. You can lock yourself in and have a gramme of coke and have a really good night sexually as well as mentally.

As with other drugs, the pleasure factor was high on respondents' list of priorities when rating cocaine as a drug experience. The physical and psychological pleasures cited by participants in the current study are very similar to those documented by Ditton et al. (1996) in their sample of cocaine users in Scotland.

A second key advantage of cocaine over other drugs, according to many informants, was that unlike other drugs, cocaine permitted the user to retain a high level of 'control' during times of use. Discretion was closely associated with control : cocaine did not demand much preparation and users felt able to conceal the fact that they had taken the drug. In addition, cocaine consumption facilitated and enhanced communication with others, rather than hampering it. At the same time, the rapid onset of cocaine-induced effects following consumption, coupled the short duration of these effects allowed the user to maintain charge over his/her disposition and behaviour.

Its immediately effective and it's convenient to carry around and its convenient to take, relatively. Like, there's no work, you don't have to prepare anything, you know. And you get an immediate kick out of it.

You can control it insofar as it only lasts ten minutes and then you can take some more of it if you want it. Whereas ecstasy, you take it and you are out of it for at least two hours.

It is the most social because you can sit there and you can converse with everyone and you don't look like you are out of it. It's a good drug like that.

It doesn't stop me thinking and I don't do anything stupid, you know what I mean. You can get into a taxi and talk to the taxi man and you know what you're doing.

Critically, cocaine use, according to several respondents, did not result in the negative after-effects associated with ecstasy and other drug use. Half of the respondents (n=5) reported several undesirable side-effects following a sustained period of regular ecstasy use. Cocaine, on the other hand, did not give rise to feelings of physical or psychological exhaustion, or feelings of being 'wrecked', during the days following use. It would appear that many of the respondents felt more 'control' over their physical condition following cocaine use than they experienced with other drugs.

If you do acid or ecstasy the next day you are feeling a bit rough physically, a couple of days later you may be feeling a bit depressed or even the day after doing it you are lacking in energy and lacking in lustre in general. The advantages of cocaine for the user would be that in comparison to other drugs, the next day you are grand. Well, you might have a bit of a head on you but nothing that a shower and a fry wouldn't pretty much cure.

I have really gone off ecstasy just with mood swings during the week from it. And there was a time, I think, when I probably would have preferred ecstasy but at the moment if I was to go out I would probably say no to ecstasy and see coke as a lot lighter. I don't feel as bad the next day so I would probably do a bit of coke. Maybe I'm getting old! I'm not really able for it anymore and the high just isn't worth it, the low now outweighs the high.

Respondents' need to function clearly, in the context of holding down a job which they valued, was closely linked with cocaine's appeal and the perceived absence of serious and costly after-effects. Cocaine use did not encroach on the user's ability to carry out work-related responsibilities efficiently. Hence, it allowed the user to maintain a lifestyle where work played a central role.

I like the fact that you can go out and have a really good night, have a blast and then the next day you can carry on and you can function properly and go to work and do your job. You don't want to just go in and be useless for the day because one day lost is bad really.

Despite cocaine's notoriety as the 'champagne of drugs', few respondents overtly referred to cocaine's traditional association with the rich and famous. However, subtle references were made to cocaine's glamorous image and its acceptability within particular social circles.

I think in terms of image it is definitely viewed as, it is almost always viewed as glamorous. Of all of them (other drugs) it is probably associated with rock and film stars. So, I think it has a very glamorous image.

Initially, especially, it was that kind of feeling, maybe a little bit of superiority in a sense because you had it (cocaine) and it can become part of your evening. And yet other people aren't doing it and it kind of sets you on a different level to some people and that is some of the attraction of it.

Relatively few negative aspects of cocaine use were mentioned by respondents, certainly compared to its positive attributes. Cost emerged as the dominant disadvantage of cocaine use. For a considerable number, this was a key factor deterring regular use. In addition to cost, cocaine's unpredictability, in terms of the quality and purity of supplies, meant there was a significant risk of getting a 'bad deal'. Other drugs were more reliable and considered to be better value in terms of the nature and duration of the resulting psychoactive 'hit'.

My experience of cocaine is that it's very much potluck and that could mean £60 or £70 down the tubes ... it's too expensive, it really is like.

In terms of how cocaine rates here, I wouldn't rate it that highly at all because I'd have, I know I can get much better quality stuff that would give me a similar buzz, or better, for cheaper.

Four of the ten respondents described cocaine as a "greedy drug". When asked to elaborate on this statement, some drew attention to the user's desire to recreate the original 'high'. Others described scenarios where they had noticed people (friends and acquaintances) behaving in a self-indulgent way during sessions of use.

It is physical and it is mental. What happens when you are taking it is, with the first few lines that is when you feel you are most high. And then usually after that you are trying to recreate that high and what happens is that the process is (pause) ... anyway you want to recreate that buzz that you originally got and that may take a bit more than you originally took, if you follow me. And therein lies one aspect of the greed.

It is strange to see people with it (cocaine), it is a very greedy drug. I have never found it that way and maybe because I see everyone else being so greedy I tend not to be. And they slip off (for an extra line). I hate to be like that. I suppose I have been disappointed in a few people, in their behaviour on it.

I have been at parties where, let's say, two or three or four people bought a gram of coke each. It is down on the mirror and it is there and you all set out having a nice line. And the next minute everyone is watching everyone else in case they nip in and get a line ahead of them. So it can speed things up ... because you don't want to miss a line.

When respondents were asked if they had experienced negative side-effects following cocaine use, a number (n=3) stated that they had, at times, experienced irritability and agitation.

On one or two occasions there when I did too much of it I was lying there with my heart pounding and then I must say it was a bit scary.

I think that the more you take of coke, the more irritable you become. In a physical sense, like you'll actually get quite nervous as you go. So, there are some side effect with the use of the drug that would say, prey on your nervous system. I don't know? I've found that, you know. If I took four lines in one night, I'd probably start feeling very kind of, what's the word I'm looking for? Not nervous. Edgy, yeah. For me anyway, if I took more than four lines of coke in a night I'd be feeling fairly edgy.

One respondent stated that while on a positive note, cocaine induces strong feelings of self-confidence, this can, at times, prompt an aggressive attitude on the part of the user.

It gives you that kind of feeling that you have a stronger presence and you hold better eye contact. You are very direct about what you are saying but at the same time that can roll on to being quite aggressive. And I have had nights out where I have had arguments about the most ridiculous things but I was right! And then you go home and think, 'Jesus Christ, what was I talking about?'.

However, negative effects, including irritability and arrogance or aggression were attributed largely to having exceeded normal cocaine intake levels on particular occasions and only qualified as minor and uncommon irritations.

A small number of less regular users claimed that they had observed negative behaviour in others who used the drug regularly. These respondents considered cocaine to be an individualistic and egotistical drug that all too often, encouraged self-indulgent and assuming behaviour. Others referred to mood swings and depression among regular users.

I am talking about people I know and people who would use it as their drug of choice and not just on weekends, but on a regular basis. And it has changed them hugely. Like, you know, mood swings, vicious mood swings, and basically just depressed when they are not high on coke. And it makes for a sad life.

To summarise, cocaine was regarded as superior to other drugs for a variety of reasons. Users' subjective experiences suggests that cocaine was viewed positively by the majority. From the vantage point of the user, attractive features of cocaine included its energising effects, the ability to maintain control while intoxicated and the sociability of the drug. Cocaine was perceived to be a 'clean' drug, one which did not carry the negative image or undesirable after-effects of other stimulant drugs. Perhaps surprisingly, in view of cocaine's apparent allure, only two respondents described cocaine as their 'favourite' drug. Cannabis was

by far the most popular drug across the sample (n=6). Two respondents stated that their preferred drug was ecstasy, in tablet or powder form.

- *Risk Perceptions and Self-Regulation of Cocaine Intake*

Respondents were asked to express their views on the risks associated with cocaine and other drug use. In general, respondents had no reservations about using cocaine, provided they felt relatively self-assured about the source of the drug. Most stated that they would avoid buying cocaine from a stranger in social settings such as nightclubs. However, concerns about getting bad value for money tended to be higher on respondents' risk agenda, than anxieties about the presence of contaminants. Hence, one of the biggest 'risks' with cocaine was the gamble of getting a 'bad deal'. Other drugs were considered to be far more reliable in this respect.

Cocaine isn't dodgy. You would probably be more likely to get a bad E that makes you ill for whatever reason. You will get bad coke but it is poor quality as opposed to anything else. When it's cut sometimes you can taste the glucose. E is probably more dangerous in that sense.

One interviewee compared cocaine to legal substances when expressing his view on the risk of getting substandard cocaine.

I don't wonder what's in a cocktail at a bar because it's so readily available and acceptable. With cocaine it doesn't come into my head either to be honest.

The overwhelming view was that cocaine was a 'safe' drug.

I think it's probably one of the safest drugs. You can't, of all the drugs that you can take, if you take acid there is a small chance that you will have a bad trip. But I think that cocaine is the safest drug. The effects are short-lived. There will only be ill-effects if you are doing it all the time but that won't happen easily because of the price of it.

When asked about the addictive potential of cocaine and other drugs, several respondents placed a great deal of emphasis on the individual's relationship with any given substances (including alcohol). The general belief was that the pharmacological properties of the substance played a secondary role in the development of drug-related problems, certainly compared to other factors. This group of cocaine users did not believe that their own behaviour around drugs was comparable to the behaviour, personal or social conditions they associated with individuals who experience drug problems.

I'd say it depends on your personality or your state of mind. But I could easily imagine if you're in a scenario whereby you have an altered state of being, by being on a drug and your life is a piece of shit, well, you'll obviously going to get back to where you were last night as soon as possible. Now that depends on probably, your state of mind, your education, your ignorance of drugs. All of that,

all those levels - your social circumstances, the amount of friends you have around you. If you feel lonely and you feel down, you know, you just more than likely want to get off your head. I could easily see somebody getting addicted to any drug. But specifically to cocaine? I don't know? I think if it was me I'd want to be seriously fucked in the head to get addicted to cocaine.

I can see why people can get addicted and having said that I could never see myself becoming an addict to coke. About a year and a half ago I kicked cigarettes and I think that is about as addictive as anything you can get.

Many pointed out that their use of cocaine and other drugs took place in social settings where friendship and other social relationships were more important than the use, *per se*, of any drug. Respondents distinguished clearly between *drug use* and *drug abuse* and did not equate their own cocaine use with dangerous or addictive patterns of drug consumption. Again, 'control' emerged as an organising construct in the discourse and respondents' invariably pointed out that they, and not the drug, maintained 'charge' in most situations where drugs were in use.

I enjoy the fact that I have a fairly stable and happy atmosphere in my head and I am confident that I can do it (cocaine). And if I ever felt that being threatened then there'd be no argument there. If it retarded my sense of drive or whatever, that'd be it.

I like to have control and I know how much I can handle. Yeah, I've overdone it at times but at the end of the day, drugs aren't important enough to me to let things get out of hand.

Several respondents recognised situations and emotional states that were not apt for cocaine use. For example, most respondents restricted use to the company of friends and a number stated that they did not use the drug when socialising with their parents and/or other family members. While most admitted that there were times when they went 'overboard', cocaine use was generally confined to times when it was least likely to impact on work and other responsibilities. Respondents' also made reference to the importance of the individual's emotional or psychological state at the time of use.

If I had to work the following day I wouldn't take it. If I was hungry I wouldn't want to suppress my appetite for a while because I would want to have a meal. I would say that if I had a lot on my mind, if I was stressed or if there was an awful lot going on at work and in my life in general and I didn't want to deal with a hangover because at the end of the day if I go off and do some coke I am going to have a pretty bad alcohol hangover too because I tend to do the two together. And you think you're superman regarding alcohol intake so if my head doesn't feel right at the time then I wouldn't be taking it. Usually for me, if I had a lot going on in general I would avoid it for that reason. And then you are either in the mood or you're not, it's like anything, you know.

The quotes above illustrate the range of informal social controls that are practised when people consume drugs. Other respondents drew attention to how they regulate their intake of cocaine during the course of a night out.

I would take cocaine more during the early part of an evening and then just let it peter out. What I don't like is coming in at three o' clock in the morning and sitting there wide awake and not being able to sleep. So, for myself I would have the bulk at the beginning of the early part of the evening and then later in the evening have one or two lines just for a perk. And then when I get home, I am home to actually sleep.

While the level of 'control' exercised by respondents varied across the sample, all mentioned conditions which were more or less apt for cocaine use. Overall, it would appear that respondents' perceived the risks associated with cocaine use to be minimal, in terms of the drug's potential to cause physical and/or psychological harm. Interestingly, two respondents expressed concern about the legal risks associated with the possession and use of controlled substances.

The illegality of it is a huge worry because other than the fact that I use drugs for recreation, I am a 100% law abiding citizen. I pay my taxes etc. So, it is very hard to keep reminding yourself that you are actually a criminal. But you do, you actually have to remind yourself on occasion. Even though you are a really nice bloke, you are actually a criminal and if you get caught you could well end up inside ... and the repercussions could be huge from a legal, family, work point of view. Huge repercussions.

The majority, however, felt that it was relatively easy to conceal their use of cocaine and that the chances of getting 'caught' were small or negligible.

I would never worry about being stopped because I can't really see what provocation there would be for the police to stop me.

I know it's a class A drug but I usually wouldn't worry. I wouldn't want to get caught but I usually wouldn't worry much so long as I am not carrying too much.

To summarise, cocaine was viewed as a relatively innocuous substance and users did not consider that it had any dramatic ill-effects on their health or well-being. Many felt that cocaine was 'safer' than other drugs. None expressed concern about any short- or long-term health implications associated with their personal use of the drug.

- *Summary and Conclusion*

Respondents in the current study described themselves as social/recreational drug users. Across the ten people interviewed, use was relatively modest and none could be considered to be current heavy users of cocaine. Cocaine was clearly integrated into social events; it was shared in social settings, sometimes in small intimate groups and other times in larger gatherings. Cocaine was

thought to facilitate communication and to induce feelings of self-confidence. The stimulating properties of the drug were mentioned frequently in conjunction with a 'controlled' high. This dynamic was important, particularly to more regular users, who did not wish cocaine to interfere with their normal activities or with their physical and psychological well-being.

Almost all respondents reported the concurrent use of alcohol and other drugs during cocaine-using events. In fact, the vast majority had extensive drug repertoires and cocaine was just one of several drugs they had used over a time-span of approximately five years since first cocaine use. Most respondents had gone through a phase of regular weekend ecstasy use. While the pleasure factor associated with ecstasy was rated highly, all had reduced their intake of the drug during the past 2-3 years, due to the significant negative repercussions experienced as a consequence of sustained use of the drug. For this group, cocaine was perceived to be 'lighter' and 'cleaner' and did not interfere with the user's desired level of functioning and well-being.

Relatively few disadvantages of cocaine were mentioned by respondents. However, most drew attention to the high cost of cocaine and to the poor quality of available supplies. Others commented on their observations of friends and acquaintances during sessions of cocaine use and felt that cocaine consumption sometimes produced undesirable self-indulgent behaviour, including arrogance and greed. Few respondents reported significant negative physical or psychological side-effects following cocaine use.

The majority of respondents expected to find themselves in social settings where cocaine was available and practically all intended to use cocaine at some time in the future. The street price of cocaine varied between £50 and £80 per gram, according to respondents. Noticeable differences emerged in the quality and reliability of respondents' contact and association with local cocaine distribution networks. Respondents who socialised regularly in users circuits were more likely to have reliable access routes to cocaine.

Respondents reported using informal control mechanisms similar to those documented by Decorte's (1999) in a sample of cocaine and crack cocaine users in Belgium. In the current study, respondents prioritised work, friendships and their partners, and did not wish to jeopardise these relationships. Specifically, they did not allow cocaine (or other drug) use to impinge on their performance at work. Reference was made to a range of circumstances under which the drug was not used, including during work, in the company of parents and other family members. Respondents also considered their own emotional and physical well-being prior to using cocaine. Cohen (1989) similarly reports a range of control techniques and behaviours utilised by 'non-deviant' cocaine users.

None of the study's respondents reported 'problems' as a result of their cocaine use and none considered their current intake to be worrying or damaging, certainly in the short-term. The majority considered the addictive potential of cocaine to be low, certainly from a personal viewpoint. Indeed, it is claimed that in many circumstances, cocaine is enticing rather than addictive (Hammersley and Ditton 1994). Drug dependence is, of course, strongly mediated by the circumstances, disposition and views of the user (Zinberg 1984). The cocaine users here did not fear addiction. Neither did they believe that they were susceptible to developing a dependent relationship with cocaine, due largely to a belief in their ability to 'control' their intake of the drug.

Cocaine Use in Ireland : Discussion and Conclusion

The drug scene in Ireland has undergone dramatic change during the past decade and has become increasingly diverse by age, drugs of choice, availability and price. National and local surveys of youthful populations indicate a clear upward trend in the range of drugs used, suggesting that recreational drug use has become a more obvious feature of adolescent lifestyles. At the other end of the drugs spectrum, long-term opiate users, many of whom are known to drug services, appear to have extended their repertoire from heroin and methadone to polydrug patterns. Benzodiazepines have been identified as a primary supplement to opiate users drug intake (Rooney et al. 1999). The propensity of cocaine, particularly in its injectable and smokable form, to appeal to this endemic group of heavy users is an issue of critical concern.

This research has attempted to build up a picture of cocaine use nationally using available indicators of drug use/misuse and the perceptions of key informants and drugs workers. The research did not set out to estimate the prevalence of cocaine use. Rather it aimed to provide information on the nature and possible extent of cocaine use, with specific reference to particular sub-groups, namely recreational drug users and problem drug users who seek treatment. A multi-method approach, using several indicators, was judged to be the most effective means of analysing the current cocaine situation.

The findings suggest increased availability of cocaine. Law enforcement statistics point to an upward trend in the availability of cocaine. In addition, the study has repeatedly noted the ease with which users can obtain cocaine. Population and school surveys suggest that cocaine is used by small numbers experimentally or intermittently. However, the exploratory study of 10 cocaine users provides evidence of individuals who use cocaine regularly for recreational purposes. Reference was made by most study respondents to the visibility of cocaine on the club/dance scene, a development which was regarded as recent. While there is no systematic evidence of widespread cocaine use, the broad picture uncovered is one of increased likelihood of cocaine use among certain groups of recreational drug users. The extent, nature and frequency of cocaine use among such groups, however, remains unclear.

Coupled with a possible expansion of cocaine use within the recreational drug scene, are signs of increased cocaine use among opiate users who come from the more deprived urban areas, particularly within Dublin City. While cocaine has clearly been 'around' for some time, supply and availability appear to be stronger than previously. The reports of a diverse range of study participants confirms that this development is recent, certainly, no more than three years old. Available reports and impressions strongly suggest that cocaine use has become a more conspicuous and accepted drug option.

It is important to state that the nature of cocaine use is likely to be diverse and that role and function of cocaine within the drug repertoires of social/recreational cocaine users is likely to differ substantially from that of 'seasoned', heavy and problematic opiate drug users. Whereas members of the former group interviewed do not perceive their drug use to be problematic, treatment data indicate that the latter group tend to report cocaine as a secondary, rather than a primary drug of misuse. In addition, routes of administration are likely to vary between the two groups. Social users interviewed for the purpose of this research ingested cocaine intranasally or orally. None had been exposed to crack cocaine and did not consider using cocaine in this form.

Available statistical indicators, coupled with the reports of drugs workers, suggest that cocaine use is currently becoming more apparent than previously among clients in treatment for heroin misuse. However, as stated earlier, there is currently little knowledge or understanding of preferred patterns of cocaine use, or of dominant routes of cocaine administration among problem drug users. This information is essential if cocaine's role in the drug repertoires of opiate users is to be fully understood. Furthermore, an understanding of smoking versus injecting cocaine rituals would greatly enhance knowledge and awareness of the possible range of health risks associated with cocaine use.

It would be premature to conclude, on the basis of the current study, that cocaine is a major 'drug issue', or that there is a high risk of a spread to neighbourhoods which already host a disproportionate number of heroin users. Further research and monitoring of drug trends at local level is required to confirm or alternatively, discount the proposition that cocaine is an expanding 'problem'. Despite this, the heroin epidemic has taught us that particular communities are susceptible to drug outbreaks. If cocaine continues to be easily available and gains acceptance among drug users, it may have the potential to find its way into communities that traditionally attract drug problems. In this sense, the current research might be appropriately viewed as an 'early warning sign' (Parker et al. 1998) of cocaine's emergence, thus, signifying the opportunity to monitor the situation and 'get ahead'. In this context, a cautious response to possible signs of increased cocaine use is more appropriate than either outright rejection of the possibility, on the one hand, or hysteria and over-reaction, on the other.

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14. Infectious Diseases : Lucy Dillon

As in other European countries, the advent of HIV/AIDS and the connection made between its spread and injecting drug use, can be seen to have played a key role in influencing the development of drug related policy and services in Ireland (Butler 1991; O’Gorman 1998). Prior to the early 1990s, abstinence was seen as the most acceptable goal for Irish drug treatment programmes. However, the early 1990s saw a move toward more harm reduction strategies and the expansion of substitution and needle exchange programmes within Irish drug treatment services. A 1991 report produced by the Government Strategy to Prevent Drug Misuse confirmed both the shift in treatment philosophy from one based solely on abstinence to one that included a harm reduction strategy, and the central role the advent of HIV had played in this policy shift:

“Insofar as HIV infection is concerned, of the 1049 cases identified, 582 (or 57%) are drug misuse related.....It is clear from the foregoing that the prevention of transmission of HIV virus in this country must include strategies developed to deal with the drug misuse problem.These strategies must be community based, client orientated and, given the serious nature of the problem, of necessity, innovative. They must include emphasis on outreach programmes involving counselling, methadone maintenance and needle exchange. Advice on risk reduction services generally must form an essential part of any such strategies to minimise the spread of the disease, [HIV/AIDS].”
(Government Strategy to Prevent Drug Misuse 1991, p 7)

Furthermore, while the two reports (October 1996 & May 1997) produced by the Ministerial Task Force to Reduce the Demand for Drugs continued to reiterate the ultimate aim of all treatment programmes as abstinence, harm minimisation strategies specifically aimed at preventing the spread of HIV (i.e. substitution and needle exchange programmes) became a central feature of drug treatment services. The second report of the Task Force argued that it had developed “a strong philosophy of harm reduction and treatment of the consequences of drug abuse - stabilisation, methadone maintenance, detoxification, rehabilitation and re-integration” (Ministerial Task Force to Reduce the Demand for Drugs 1997,p7)

While HIV/AIDS may be seen as the drug related infectious disease that was at the centre of drug policy development in Ireland, other diseases, in particular hepatitis C, are attracting an increasing amount of attention from those working in the area. The following sections of the report will address three key issues on drug related infectious diseases in the Irish context. The topics covered will be:

- 14.1 Prevalence of HIV, HBV and HCV among drug users
- 14.2 Determinants and consequences
- 14.3 New developments and uptake of prevention, harm reduction and care
 - 14.1 Prevalence of HCV, HBV and HIV among drug users

Epidemiological analysis of drug related infectious diseases in Ireland is somewhat restricted by a lack of data. The gap in information is particularly acute

in relation to hepatitis B and C. The following sections will examine the data that are available in relation to each of the relevant drug related infectious diseases:

- HIV
- Hepatitis B
- Hepatitis C

14.1 HIV

The majority of data collected on drug related infectious diseases are related to HIV. There are two main sources of data that will be discussed below: first, the routine data on HIV positive tests that are reported by the Department of Health and Children; and second, the special studies which have been carried out which have estimated the prevalence of HIV among particular cohorts of drug users.

Routine data on HIV testing

In Ireland, the Department of Health and Children, in collaboration with the Virus Reference Laboratory, produces statistics on HIV positive tests which are published every six months. The figures relating to HIV tests are broken down according to risk category. There are a number of risk categories identified in relation to HIV infection including injecting drug use, homosexual sex and haemophiliac contact. Therefore, it is possible to get a breakdown of the number of positive HIV cases attributable to injecting drug use in a given year. However, there are a number of limitations to this data source that should be noted:

- It is limited to the *tested* population. Nothing can be inferred for those drug users who have *not* been tested.
- It is not possible to identify non-injecting drug users within the data set.
- No socio-demographic data is collected on those who are tested.
- There is only a limited geographical breakdown available.
- A gender breakdown has only been made available since 1997.
- Both risk behaviours (e.g. injecting drug use) and test locations (e.g. prison) are used as categories. This makes the data somewhat unclear. For example, it is not known through what risk activity those tested in the prison setting became infected with HIV.

Despite these limitations, this data source provides the best information with which to examine the epidemiological profile of HIV in Ireland over the past decade and a half.

The cumulative figures for the positive cases of HIV from the start of data collection in 1982 up until 1985, show that just over 60% (n=221) of all positive cases (N=363) were attributed to injecting drug use (see table 14.1). Since 1985, injecting drug use has continued to be one of the main risk categories, accounting for 41.6% of the cumulative number of positive cases up until December 31st 1999 (see table 14.1). Since data has been collected, injecting drug use has continued to be one of the main risk categories for infection. Two

possible explanations have been given by O’Gorman (1999) for the high proportion of intravenous drug users in the known HIV positive population. She argues that the culture of injecting drug use that existed among drug users in Ireland during the 1980s, at a time when both information on safe injecting practices and access to clean injecting equipment were limited⁹, resulted in the rapid transmission of HIV among the injecting population. Secondly, she argues, the injecting drug using population may be more likely to have been tested for HIV through their contact with drug treatment services than those individuals who may be at risk of infection through other routes e.g. heterosexual sex (O’Gorman 1999, p. 6).

Table 14.1: Ireland 1985-1999. HIV positive cases by risk category. Numbers and percentages

Year	IVDUs n (%)	Homosexual Sex n (%)	Heterosexual Sex/ Risk unspecified n (%)	Other n (%)	Total n (%)
1985*	221 (60.9)	39 (10.7)	0	103 (28.4)	363 (100.0)
1986	112 (66.3)	11 (6.5)	21 (12.5)	25 (14.8)	169 (100.0)
1987	72 (49.7)	21 (14.5)	26 (17.9)	26 (17.9)	145 (100.0)
1988	58 (50.4)	17 (14.8)	20 (17.4)	20 (17.4)	115 (100.0)
1989	57 (49.1)	33 (28.5)	0	26 (22.4)	116 (100.0)
1990	50 (45.1)	25 (22.5)	24 (21.6)	12 (10.8)	111 (100.0)
1991	34 (36.9)	27 (29.4)	25 (27.2)	6 (6.5)	92 (100.0)
1992	82 (40.8)	58 (28.9)	50 (24.9)	11 (5.5)	201 (100.1)
1993	52 (38.0)	48 (35.0)	21 (15.3)	16 (11.7)	137 (100.0)
1994	20 (23.5)	31 (36.5)	22 (25.9)	12 (14.1)	85 (100.0)
1995	19 (20.9)	33 (36.3)	30 (33.0)	9 (9.9)	91 (100.1)
1996	20 (18.9)	41 (38.7)	27 (25.5)	18 (17.0)	106 (100.1)
1997	21 (17.7)	37 (31.1)	40 (33.6)	21 (17.7)	119 (100.1)
1998	26 (19.1)	37 (27.2)	47 (34.6)	26 (19.1)	136 (100.0)
1999	69 (33.0)	40 (19.1)	59 (28.2)	41 (19.6)	209 (99.9)
Total	913 (41.6)	498 (22.7)	412 (18.8)	372 (17.0)	2195 (100.1)

Source: Department of Health and Children

The proportion of positive cases attributed to the intravenous drug user category generally decreased from 1992 through to 1998. In 1994, for the first time, intravenous drug use accounted for less new positive cases than the ‘homosexual sex’ or ‘heterosexual sex/ risk unspecified’ categories (see table 14.1). In fact, the proportion of positive HIV tests attributed to intravenous drug use fell from 49.7% in 1989, to a low of 17.6% in 1997 (see table 14.1). It is suggested that the reduction both proportionately and in absolute numbers over this period may be attributed, at least in part, to the expansion of services aimed at reducing the spread of HIV among injecting drug users, i.e. substitution and needle exchange programmes. In an analysis of the trends up until 1998 the National AIDS Strategy Committee has commented that:

⁹ The first needle exchange programme in Dublin was established in 1989.

* Cumulative figures

“Epidemiological surveillance of HIV would indicate that in recent years the overall incidence of HIV among intravenous drug users is reducing. While we must be wary of drawing major conclusions from short term changes in infection patterns service providers are optimistic that this trend is as a result of the intervention through a combination of substitution therapy with methadone and needle exchange services.”

(National AIDS Strategy Committee 2000, p. 63)

Despite the apparent reduction in the proportion of positive cases attributed to injecting drug use and the actual number of positive tests, figures from 1999 show a substantial increase in the number of positive cases. Between 1998 and 1999 the total number of new cases of HIV increased from 136 to 209. Furthermore, the number of new positive cases attributed to injecting drug use increased from 26 of the total new cases (n=136) in 1998 to 69 of the new cases (n=209) in 1999. Therefore, proportionately, injecting drug use as a risk category increased from accounting for 19% of new HIV positive cases within this data source in 1998, to 33% in 1999. This is the highest annual proportion of new positive cases attributed to injecting drug use since 1993.

Anecdotal evidence suggests a couple of explanations for the increase in the number of positive cases being attributed to injecting drug use during 1999. Firstly, leading on from the *Protocol for the Prescribing of Methadone* issued in 1993, guidelines were developed for GPs prescribing methadone within the general practice setting and for pharmacists in their dispensing of methadone. Following the completion and evaluation of a pilot programme, in January 1998 the Report of the Methadone Treatment Services Review Group made a number of recommendations on tightening control on both the prescribing and dispensing of methadone, in accordance with the 1993 protocol. Consequently, the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations, 1998. The regulations aim to create a more controlled environment for the prescribing and dispensing of methadone. Within this context, all those who were receiving methadone in Ireland were integrated into a structured programme. Furthermore, drug users were integrated into a structured programme setting where there is an active policy of carrying out virology in relation to HIV and hepatitis. It is suggested therefore, that this may have resulted in an increase in the number of injecting drug users being tested for HIV and, in turn, an increase in the number of positive cases being attributed to injecting drug use during 1999. Secondly, it has also been suggested anecdotally that perceptions may be beginning to change among the drug using population in relation to HIV. It is argued that the availability of new treatment (HAART) and the visibility of individuals in the community for whom treatment has been effective, has encouraged people to come forward for testing so that they can avail of treatment if necessary.

Prisoners: As mentioned above, within the Department of Health and Children's reporting system on HIV positive tests, those who are tested in prison are categorised according to the testing location, i.e. prison. While the proportion of

positive cases from the testing location category of prison which are attributable to injecting drug use is *not* known, anecdotal evidence suggests that most of those being tested have a history of injecting drug use. Since 1989, a total of 39 new positive cases have been attributed to 'prisoners', 13 of whom tested positive in 1999. The use of both risk categories and testing locations in the Department of Health and Children's reporting system does not allow for any conclusions to be drawn as to the significance of these figures in relation to the injecting drug using population. It is important that the risk category of these cases be clarified.

Gender: While there are no socio-demographic data collected on those who are tested for HIV from the Department of Health and Children's Data source, the gender of the individual being tested has been reported since 1997. An examination of the figures by gender suggests a possible change in the profile of those who are testing positive for HIV in Ireland (see table 14.2). In 1997, females only accounted for 3 of the 21 new positive cases attributed to injecting drug use. In 1998 this had increased to 10 of the 26 positive cases among injecting drug users, and in 1999 it had increased further to account for 34 of the 69 positive cases. Speaking in percentage terms, women have increased from representing 14.3% of the positive tests among injecting drug users in 1997, to 38.5% in 1998 and finally 49.3% in 1999. Due to the lack of information on gender prior to 1997, it is not possible to explore trends over a more extended period of time. Anecdotal evidence suggests that these figures may reflect a real increase in the number of women injecting drug users who are becoming infected with HIV. However, it is also suggested that these women may be becoming infected through their sexual behaviour rather than their injecting drug use. Once identified as an injecting drug user however, their infection will tend to be attributed to their injecting drug using behaviour. Anecdotal evidence also suggests that a growing number of women may be attending for testing in order to be able to minimise the risk of infection to their baby were they to become pregnant.

Table 14.2 Ireland 1997-1999. HIV seropositive intravenous drug users by gender. Numbers and percentages.

Year	Male n (%)	Female n (%)	Total n (%)
1997	18 (85.7)	3 (14.3)	21 (100)
1998	16 (61.5)	10 (38.5)	26 (100)
1999	35 (50.7)	34 (49.3)	69 (100)

Source: Department of Health and Children

Special Studies

A number of special studies have been carried out which have explored the prevalence of HIV among cohorts of drug users in a range of study locations. The studies include drug users located in: the community, drug treatment centres,

needle exchange programmes and prisons. A summary of the research findings on the prevalence of HIV infection among particular cohorts of drug users is presented in Table 14.3 below.

One of the first studies of drug use in Dublin began in 1985 when O'Kelly *et al.* (1996) identified a cohort of known intravenous drug users in an inner city area. The prevalence of HIV infection among this group was monitored over the next decade. In 1991, 57.3% of the total cohort (N=82) were known to be HIV positive, by 1994, 64.6% of the cohort had tested positive for HIV. In total, 18 of those who had tested positive by 1994 had died. O'Kelly *et al.* (1996) argue that the high prevalence rate of HIV among this cohort reflect the context in which their intravenous drug use developed. It was argued that "the uncontrolled use of injected drugs and the sharing of scarce equipment were commonplace at the time; the true impact of these practices is now clear in terms of the spread of HIV infection among the young people who lived there" (O'Kelly *et al.* 1996, p. 114). Another study carried out with a cohort who had begun injecting during the same period found similar rates of HIV prevalence. Williams *et al.* (1990) found that of a cohort of sixty-nine individuals on a methadone maintenance programme 70% were HIV positive.

These high prevalence rates of HIV were not found in studies subsequent to those of O'Kelly *et al.* (1996) and Williams *et al.* (1990). Johnson *et al.* (1994) found that in 1991, 14.8% of a sample recruited from a needle exchange programme were HIV positive. The Dorman *et al.* (1997) study, which was carried out in 1992 in the context of a World Health Organisation multi-national research initiative, found that 8.4% of a sample of 180 injecting drug users, recruited from both in and out of treatment, were HIV positive. In contrast, the Smyth *et al.* (1998) study of a drug treatment sample tested between 1992 and 1997 found a prevalence rate for HIV of only 1.2%. This is low in contrast to an estimated 8% prevalence rate (based on laboratory reports) among injectors attending Eastern Health Board methadone clinics in 1997 (Joe Barry, cited in Allwright *et al.* 1999, p. 2).

More recently, two studies have been carried out which report on HIV prevalence among the Irish prison population (Allwright *et al.* 1999; Long *et al.* 2000). Included in the data are the prevalence rates for those prisoners who have a history of injecting drug use. It was found that 5.8% of committal prisoners¹⁰ (Long *et al.* 2000) and 3.5% of general prisoners (Allwright *et al.* 1999) with a history of injecting drug use were HIV positive. Among those prisoners who reported no history of injecting drug use the infection rates were 0.5% among the committal population (Long *et al.* 2000) and 0.9% within the general prison population (Allwright *et al.* 1999). In an environment where injecting drug use is

¹⁰ Committal prisoners are prisoners who have been admitted to the prison within the preceding 48 hours, accused or guilty of a new crime, excluding those on temporary release or transferred from another prison. The committal population includes individuals entering on remand, following sentence, committed as a result of a bench warrant and non-nationals without valid documentation (Long *et al.* 2000: p.2).

on-going in the absence of any provision for clean injecting equipment, the risk for the spread of infection within this population is high.

Table 14.3 Ireland 1994-1999 : Summary of research findings on the prevalence of HIV infection among particular cohorts of drug users

Author	Study period	Sample Source	Self Report/ Test	Serum/ Saliva	Sample size tested	% infected of those tested
Long <i>et al</i> (2000)	1999	Committal prisoners N=593	Test	Saliva	IDUs ¹¹ (n=173)	IDUs 5.8%
Allwright <i>et al</i> (1999)	1998	Irish Prison Population N= 1178	Test	Saliva	IDUs (n=509)	IDUs 3.5%
Smyth <i>et al</i> (1998)	1992-1997	Drug treatment centre N=735	Test	Serum	IDUs (n=600)	IDUs 1.2%
Dorman <i>et al</i> (1997)	1992	Drug treatment centre & non-treatment IDUs N=185	Test	Serum and saliva	IDUs (n=180)	IDUs 8.4%
O'Kelly <i>et al</i> (1996)	1984-1995	IDUs in community N=82	Test	Serum	IDUs (n=66)	IDUs 65%
Johnson <i>et al</i> (1994)	1991	Needle exchange N=106	Test	Saliva	IDUs (n=81)	IDUs 14.8%

In summary, injecting drug use continues to be one of the main risk categories to which HIV positive cases are attributed each year. Despite the rates of new HIV positive cases attributed to injecting drug use plateauing in the early and mid 1990s, recent figures suggest that there is an upward trend in the number of new HIV positive cases among Irish drug users. The information available on those who are testing positive for HIV remains limited. Analysis of the figures highlights the need for more information, in particular of a socio-demographic and behavioural nature, to facilitate comprehensive epidemiological analysis of the trends.

14.2 Hepatitis B

There is very little information in Ireland on the prevalence and incidence of hepatitis B among both the general population and the injecting drug using population. While data are collected on the number of positive tests carried out for hepatitis B by the Virus Reference Laboratory, no behavioural data is collected and therefore those infected through drug use cannot be identified. Information on prevalence rates is therefore confined to a small number of special studies that have been carried out in the field.

¹¹ IDUs: Injecting drug users

The Smyth *et al.* (1998) study of drug users located within a treatment setting found that only 1% were infected with Hepatitis B. However, more recent research carried out in the prison setting found significantly higher prevalence rates among injecting drug users. Allwright *et al.* (1999) and Long *et al.* (2000) found 18.5% and 17.9% prevalence rates for hepatitis B, respectively. While these figures suggest that hepatitis B may be prevalent among the injecting drug user population, the lack of data prohibits any in-depth epidemiological analysis of the situation Ireland.

Table 14.4 Ireland 1998-2000 : Summary of research findings on the prevalence of Hepatitis B infection among particular cohorts of drug users

Author	Study period	Sample Source	Self Report/ Test	Serum/ Saliva	Sample size tested	% infected of those tested
Long <i>et al</i> (2000)	1999	Committal prisoners N=593	Test	Saliva	IDUs (n=173)	IDUs 17.9%
Allwright <i>et al</i> (1999)	1998	Irish Prison Population N= 1178	Test	Saliva	IDUs (n=509)	IDUs 18.5%
Smyth <i>et al</i> (1998)	1992-1997	Drug treatment centre N=735	Test	Serum	IDUs N=729	IDUs 1%

14.3 Hepatitis C

In Ireland, there is no routine data collection in the area of hepatitis C. However, there have been a number of special studies carried out among samples of drug users in a variety of study settings (see table 14.5).

The first study of hepatitis C infection among injecting drug users was carried out between August 1992 and August 1993 by Smyth *et al.* (1995). The study sample was identified through a treatment centre where all new attenders and re-attenders who presented during the study period and who reported a history of injecting drug use were encouraged to take part. In total, 272 injecting drug users took part and a prevalence rate of 84% for infection with hepatitis C was found. Among those injectors who had been injecting for between six months and two years inclusive the prevalence rate was 70%. Among those with a longer injecting history, i.e. an injecting history of longer than two years, the prevalence rate was 95%. Furthermore, there was a significant difference between genders in terms of infection. 156 of the 194 males (80%) tested positive, whereas 73 of the 78 females (94%) were positive.

Further studies were carried out by Smyth *et al.* (1998, 1999a), which examined the prevalence of hepatitis C among in-treatment populations. Consecutive new attenders at a treatment service who attended between July 1993 and December 1996 were approached to take part in the study. In all, a sample of 353 injecting

drug users who reported an injecting history of less than 25 months were recruited. Overall, a prevalence rate of 52.1% was recorded within this sample. In an extension of this study cohort, Smyth et al. (1998) later found that of 733 consecutive new attenders between September 1992 and September 1997 at the same treatment centre, 61.8% were hepatitis C positive.

In two prison studies, which have been discussed in previous sections, the prevalence of hepatitis C among prisoners was explored (Long et al. 2000; Allwright et al. 1999). The prevalence of hepatitis C was found to be high within this population. Allwright et al. (1999) found that among 509 prisoners with a history of injecting drug use, 81.3% tested positive for hepatitis C. In contrast, only 3.7% of those prisoners who did not report a history of injecting drug use had tested positive for hepatitis C. A follow-up study of the committal prisoner population (Long et al. 2000) found that of 173 prisoners with a history of injecting drug use, 71.7% were hepatitis C positive. Only 1.4% of those prisoners who reported that they had no history of injecting drug use tested positive for hepatitis C.

Table 14.5 Ireland 1995-2000 : Summary of research findings on the prevalence of Hepatitis C infection among particular cohorts of drug users

Author	Testing period	Sample Source	Self Report/ Test	Serum/ Saliva	Sample size tested	% infected of those tested
Long et al (2000)	1999	Committal prisoners N=593	Test	Serum	IDUs (n=173) Non IDUs (n=420)	IDUs 71.7% Non IDUs 1.4%
Allwright et al (1999)	1998	Irish Prison Population N= 1178	Test	Serum	IDUs (n=509) Non IDUs (n=669)	IDUs 81.3% Non IDUs 3.7%
Smyth et al (1999a)	1993-1996	Drug treatment centre N=353	Test	Serum	IDUs N=353	IDUs 52.1%
Smyth et al (1999b)	1997	Drug treatment centre N=84	Self-report	n/a	IDUs N=84	IDUs 89%
Smyth et al (1998)	1992-1997	Drug treatment centre N=735	Test	Serum	IDUs N=733	IDUs 61.8%
Smyth et al (1995)	1992-1993	Drug treatment centre N=272	Test	Serum	IDUs (n=272)	IDUs 84%

While it is not possible from the available data to analyse infection trends over time, it would appear from the studies available that hepatitis C infection has been prevalent among Irish injecting drug users over the past decade. Anecdotal evidence suggests that the relative ease with which hepatitis C can be spread through injecting drug use, and a lack of knowledge among users about hepatitis

C and the associated risks, have all contributed to its spread. In summary, the prevalence rate for hepatitis C has been found to be consistently high within the drug using population over the past decade.

Summary

In summary, the most comprehensive data available on drug related infectious diseases in Ireland are for HIV. While the number of new positive tested cases for HIV, which were attributable to injecting drug use, appeared to stabilise in the mid 1990s, figures for 1999 show an increase in the number of cases. For both hepatitis B and C, analysis is dependent solely on data from special studies. Despite the absence of comprehensive data it appears from the evidence available that hepatitis C continues to be highly prevalent among Irish injecting drug users. Overall, it would appear from the data that is available that drug related infectious diseases continue to be an issue of concern in relation to Irish injecting drug users. Furthermore, this highlights the need for more comprehensive data collection in the area of all drug related infectious diseases in order to monitor changes in the trends over time.

14.4 Determinants and consequences

This section will address some of the determinants and consequences of drug related infectious diseases in the Irish context. It will examine the research that has been carried out which looks at the risk behaviours engaged in by Irish drug users, both in relation to their injecting drug use and their sexual behaviour. Furthermore, it will explore the data available on both the health-related consequences and the wider social consequences of drug-related infectious diseases.

▪ Risk behaviours

Injecting risk behaviour

Once the link between the spread of HIV and injecting drug use was established in the mid 1980s, the risk behaviours engaged in by the injecting drug using population became a focus of research. In the Irish context, studies on the injecting risk behaviour of drug users have spanned the last decade. During this period the provision of harm reduction strategies has expanded from being available through a small number of programmes which were accessible to a small number of drug users, to more widespread availability to a significant number of programmes which cater for a significant number of drug users. This section will describe the findings of research related to the risk behaviours of the general injecting population and then those findings relating to three sub-groups of particular interest: young injectors, female injectors and injecting drug users in prison.

General injecting drug users: Research carried out by Johnson et al. (1994) in 1991 among a sample of attendees at a Dublin needle exchange, found that 52.6% of respondents reported that they had not shared equipment during the preceding 28 days, while over 34.2% had shared with two or more other people. A study carried out a year later, in 1992 (Dorman et al. 1997), among a sample (N=185) of injecting drug users both in and out of treatment, found that 55.7% of the sample had shared and 61.6% had lent injecting equipment in the previous six months.

Despite the expansion of harm reduction strategies since the two studies described above (Johnson et al. 1994; Dorman et al. 1997) were carried out, more recent research has found that Irish drug users continue to engage in risky injecting behaviour. In a study of those attending a needle exchange programme Cox et al. (2000) found that 59% of the sample who had a history of injecting drug use (N=1323), reported sharing injecting equipment at some stage in their injecting drug using career. Furthermore, 29% of these respondents reported sharing recently (i.e. in the previous four weeks). Among the 29% who reported sharing recently, 17% had lent their injecting equipment, 50% had borrowed it and 33% had done both. Data from the National Drug Treatment Reporting System operated by the Drug Misuse Research Division of the Health Research Board offers further evidence that Irish drug users continue to engage in injecting risk behaviours. In 1998, 575 of first treatment contacts (N=1625) reported that they had ever injected a drug, 45.6% of who reported that they had ever shared injecting equipment. Furthermore, 352 of this sample reported that they were *currently* injecting (i.e. within the last month), 32% (n=118) of who reported that they were *currently* sharing injecting equipment (i.e. within the last month).

Young injectors: In a study specifically aimed at exploring the risk behaviours engaged in by a sample of young injectors (n=485), i.e. those under the age of twenty-five, Cassin et al. (1998) found a significant proportion regularly engaged in injecting risk behaviours. Compared with a cohort of older injectors (n=285), i.e. those over the age of 25, who were attending the same service, younger clients were found to be significantly more likely to have reported both lending and borrowing used needles and syringes in the 4 weeks prior to first contact with the syringe exchange programme. Furthermore, 64.3% of the younger cohort reported that they had shared injecting paraphernalia (i.e. spoons and filters) in the four weeks prior to contacting the service, compared to only 43.8% of the older cohort.

Female injectors: Female drug users have also been looked at specifically in the literature in relation to their injecting risk behaviours. Cox et al. (2000) found that among a cohort of needle exchange clients, women (n=304) were significantly more likely than men (n=1000) to report sharing injecting equipment with their sexual partner and to share injecting paraphernalia with other injecting drug users. While 53% of men reported that they had shared injecting paraphernalia, 63% of females reported that they did so. The gender difference was more acute in relation to sharing injecting equipment with a sexual partner,

13% of men compared to 37% of women reported that they did so. However, this was directly related to the fact that 68% of women reported that they had a sexual partner who was an injecting drug user, compared to just 24% of men. Cox et al. (2000) argue that the greater personal involvement of women with other drug users has consequences in terms of health related problems and risk behaviour. The social opportunities created by living in close proximity with other injecting drug users creates an environment in which risk behaviour flourishes (Cox et al. 2000).

Injecting drug users in prison: To date, Irish prisoners do not have access to clean injecting equipment and only a very limited number have access to a methadone maintenance programme within the prison setting. This implies that where injecting drug use occurs in the prison, it may be particularly risky in relation to the spread of drug related infectious diseases. O'Mahony's (1997) study in a Dublin prison found that 42% (n=45) of a sample of 108 prisoners had used heroin while in prison serving their current sentence. Thirty-seven of these forty-five had engaged in intravenous use. One sixth of those reporting a history of drug use had tested positive for HIV, while a quarter had never been tested. In addition, half of these drug users said that they had tested positive for at least one form of hepatitis. O'Mahony described as 'alarming' (O'Mahony 1997, p. 107) the finding that of those who reported having tested positive for HIV, sixty percent had engaged in needle sharing since being notified of their positive status. An earlier study based on data gathered between 1987 and 1991, found that during this period, 168 known HIV positive prisoners had spent time in Mountjoy. A study of a sub-sample of these HIV positive individuals, selected on a random basis, found that ninety four percent had engaged in drug use within the prison, suggesting a potential spread of HIV to uninfected prisoners (Murphy et al. 1992). A more recent study of HIV and hepatitis B/C prevalence among prisoners found that users share injecting equipment within the prison setting (Allwright et al. 1999). As may be expected in an environment where there is no formal access to injecting equipment, it was found that injecting drug users were more likely to share injecting equipment while in prison than when they were in the community. Fifty-eight per cent of injecting drug users reported that they had shared all injecting equipment (i.e. needles, syringes, filters, spoons) while in prison, compared to 37% who reported sharing in the month prior to being incarcerated. Furthermore, of those injecting drug users who had shared injecting equipment inside the prison, 89.1% had tested positive for hepatitis C.

Sexual risk behaviour

In 1985 Irish family planning legislation was amended to allow for the sale of condoms to people over the age of eighteen without a prescription from a range of named outlets. The sale of condoms was not deregulated in Ireland until 1993, when the law was changed to make condoms available for sale through outlets other than pharmacies. This change in the law was principally in response to public health concerns in relation to HIV/AIDS, and the law referred to condoms as infection preventers rather than pregnancy preventers (Prendiville et al. 1993).

Condoms are now available for sale from a wide range of sources, including vending machines. Furthermore, condoms are distributed freely to groups considered to be at high risk of infection, including injecting drug users. Despite the wide availability of condoms, research carried out among drug users suggests that they continue to engage in sexual risk behaviours which may facilitate the spread of HIV and other infectious diseases.

A study of first attenders at the Eastern Regional Health Authority needle exchange programmes from 1990-1997 found that only 55% of first time attenders (N=5152) reported using a condom during sexual encounters in the previous year (Mullen 1998). A study of drug using women working in prostitution (N=77) (O'Neill et al. 1999), 83% of whom reported injecting drugs in the previous month, found that while 92% 'always' used condoms with *clients* for vaginal sex, only 15% 'always' used condoms with their *partners* for vaginal sex. Furthermore, while none reported 'never' using condoms with *clients* for vaginal sex, 52% reported that they 'never' used condoms with *partners* for vaginal sex. There were similar findings in research carried out with a cohort of clients attending a syringe exchange programme (N=1,309). It was found that 25% of those who reported having no regular sexual partner reported 'never' using condoms, whereas 41% of clients who reported having a regular sexual partner (N=865) reported 'never' using condoms. It has been argued that the reluctance to use condoms within long-term or steady sexual relationships can be particularly problematic, this has been argued both in the context of the drug using population (Cox et al. 2000) and the general population (Mahon et al. 1998).

Summary

In summary, this section highlights the extent to which Irish drug users continue to engage in behaviours conducive to the spread of drug related infectious diseases, both through their injecting drug use and their sexual activity. Despite the expansion of harm reduction strategies since the early 1990s, Irish drug users continue to engage in these risk behaviours. The findings of studies carried out in the early 1990s in relation to risk behaviours may be explained by a lack of appropriate service provision and a lack of knowledge among both service providers and users of the risks involved in sharing. However, the more recent study findings show that these patterns of risk behaviour continue to exist despite the presence of appropriate services. Section 14.3 will present the research findings which consider whether the introduction of harm reduction strategies have had an impact on injecting drug users' risk behaviours.

Consequences

The consequences of drug related infectious diseases have not received significant attention in the Irish literature. The following sections will discuss these

consequences in two parts, first the health related consequences and second, the wider social consequences.

Health related consequences: The most obvious consequences of HIV and hepatitis B and C are the impact these diseases have on the individual's health. There are no data available on the number of drug users who develop chronic hepatitis C or require care for hepatitis B infection. The only data collected on the health consequences of drug related infectious diseases are those on AIDS related cases and deaths. Since recording began in 1982 and up until December 31st 1999, there have been 691 AIDS cases reported in Ireland, and 349 AIDS related deaths (see Table 3.3, Appendix 3). In 1999 there were 41 new AIDS related cases recorded. Intravenous drug users continue to represent one of the main risk categories recorded in this data source. In 1999, intravenous drug users accounted for 39% of new AIDS cases, and 41% of the year's AIDS related deaths.

Another area of concern is the extent to which HIV/AIDS is passed on from mother to baby. From January 1986 to December 1999, a total of 172 HIV positive cases were attributed to the category 'children at risk', representing 7.84% of the total HIV positive cases reported over the period (Department of Health and Children). However, this category does not indicate the route of infection and it is therefore not known to what extent HIV among these children is attributable to maternal injecting drug use. However, the statistics collected on AIDS cases and deaths indicate where a child's infection is attributable to maternal drug use. In total, from 1982 to 1999 14 children born to drug users were recorded as AIDS cases, this represents 2% of the total 691 cases recorded up to December 31st 1999. Furthermore, there were 8 AIDS related deaths among children of injecting drug users recorded in the same time period, which accounts for 2.3% of the total 349 deaths recorded up to December 31st 1999.

Summary

In summary, little is known about the health related consequences of drug related infectious diseases in Ireland. While there have been improvements in treatment procedures, particularly in the area of HIV, coping with the impact of the high prevalence rates of hepatitis C infection will present a particular challenge to service providers.

Wider consequences: The close link between social deprivation and problematic drug use in Ireland, has meant that those who are affected by drug related infectious diseases are generally from areas characterised by high levels of social deprivation. Individuals who may be considered socially excluded may therefore suffer further exclusion as a result of being affected by a drug-related infectious disease. In this context, it is important that the wider social

consequences of drug-related infectious diseases be considered. However, little research has been carried out in this field, either on individuals infected, their families or the community at large. As part of a wider study on heroin use in Dublin's inner city, McCarthy et al. (1997) surveyed 26 opiate users and 18 families in which there was a drug using member. Among both groups drug-related infectious diseases were raised as an issue of concern. A number of respondents reported that they had to cope with either their own or a family member's infection and its effects. Particularly acute were the concerns expressed of individuals within families where another member was HIV positive. Twenty-eight of the respondents from the family cohort reported that they had a family member who was HIV positive or living with AIDS. One mother reported that four of her children had died from AIDS-related illness between 1989 and 1995 (McCarthy et al. 1997; p. 58). It was also found however, that none of the respondents who lived with a person who was infected with HIV had availed of any formal support services for themselves in relation to HIV/AIDS issues.

O'Gorman (1999) carried out a qualitative study of the experiences of both people directly infected by HIV and also those whose lives have been affected by HIV, i.e. the parents, partners, children and siblings of people who are HIV positive. In total, members of 19 families participated in the study, 26 adults and 7 children who had been diagnosed HIV positive, and a further 29 adults and 54 children who were affected by HIV/AIDS. This study highlights the complex nature of the problems faced by both those infected and those affected by HIV/AIDS. The problems identified included the trauma involved in being diagnosed, informing other family members (e.g. partners, children) who may be at risk of infection, caring for a child who is HIV positive when the parent is also HIV positive, complying with treatment regimes and coping with an AIDS-related death. O'Gorman (1999) argues that in the absence of adequate public information campaigns, HIV and AIDS continue to be widely viewed within Irish society with "prejudice, fear and ignorance" (O'Gorman 1999, p. 55). Consequently, those infected with the disease and their families have to live with the added strain of coping with the stigma and secrecy that surrounds HIV.

Summary

In summary, as in other European countries the consequences of drug related diseases in Ireland are multifaceted. While they encompass consequences on the health and general well-being of the infected individual, they also impact on the infected individual's family and wider community. The wider social consequences of drug related infectious diseases have been largely neglected in the Irish context and are in need of further attention.

14.5 New developments and uptake of prevention/harm reduction, care

As mentioned in previous sections, harm reduction strategies play a key role in the provision of services for drug users in Ireland. Both needle exchange programmes and those based on substitution treatment were expanded in an attempt to curb the spread of HIV among injecting drug users. More recently there has been an increased focus on the role these services play in preventing the spread of other drug-related infectious diseases, i.e. hepatitis B and C. This section of the report will give an overview of the harm reduction services available to Irish injecting drug users, which aim to prevent the spread of drug related infectious diseases among this population. Furthermore, it will give a brief overview of those services which provide care for those already infected. The following areas of service provision will be addressed:

- Harm reduction programmes
- Testing and treatment
- Hepatitis B vaccination

- **Harm Reduction Programmes**

A number of harm reduction strategies have been developed which specifically aim to prevent the spread of HIV and other drug-related infectious diseases among injecting drug users in Ireland. However, the impact of these programmes on infection rates among injecting drug users are unclear. Smyth et al. (1999a) attempted to explore the impact these programmes had on the spread of hepatitis C by carrying out tests for hepatitis C among a cohort of drug users. The cohort included those who had begun their injecting drug use both before and after the expansion of harm reduction programmes in Ireland. Smyth et al. (1999a) argue that the findings suggest that those injecting drug users who began their injecting drug use after the introduction of harm reduction strategies, demonstrated a reduced risk of HCV infection. However, Smyth et al. (1999a) emphasise that it was not possible to control for other factors that may explain the decline in the HCV infection rate, such as a possible reduction in overall injecting frequency among more recent injectors.

In this section three specific harm reduction services will be briefly overviewed, and any research findings in relation to the impact they may have had on the spread of drug related infectious diseases presented. The services that will be covered in this section are:

- Information and education programmes
- Needle exchange programmes
- Substitution programmes

Information and education programmes: Information on drug related infectious diseases is made available to drug users through a number of sources. Leaflets containing information on what these diseases are and how they are spread are available to drug users from a number of locations, including drug treatment

centres, health centres, drop in centres and voluntary organisations. An information booklet dealing specifically with hepatitis C has recently been produced which is directly aimed at informing drug users and their families about the disease (Keating 2000). Furthermore, there have been a limited number of education programmes aimed at informing drug users directly about drug-related infectious diseases and the associated risks. In 1996 the Health Promotion Unit of the Department of Health and Children produced guidelines for effective HIV/AIDS education (Department of Health 1996). An example of an education programme aimed directly at drug users was established by the Probation and Welfare Service in Mountjoy Prison Dublin. This Drug Awareness Programme is a four-week programme consisting of one session per week. The principal aim is to educate participants about their drug use and the associated risks. It is aimed at all prisoners with a history of drug use, including those who have ceased their drug use and those who are continuing to use within the prison setting. Included in this programme is a session on HIV and Hepatitis.

While education and dissemination of information about drug-related infectious diseases and the associated risks have been an important component in Ireland's prevention strategy, the effectiveness of information dissemination and the impact of such information on risk behaviour is unclear.

Prior to the development of the Probation and Welfare Service's Drug Awareness Programme an award winning booklet and video containing information for prisoners on HIV discrimination, infection and prevention were produced and were supposedly available to all prisoners. However, a study carried out based on focus group interviews with prisoners and former prisoners, found that HIV positive individuals in the focus groups had seen neither of these materials (O'Brien et al. 1997). Furthermore, as will be discussed in more detail below, Smyth et al. (1999b) found that even where injecting drug users may be attending a treatment service and have regular contact with health professionals, this does not necessarily result in the drug user developing a better understanding of hepatitis C and the related risk behaviours. Bourke (1998) also found that within a cohort (N=66) of young injecting heroin users (aged 15-22) attending services "whilst most understood the significance of sharing needles few were aware that sharing barrels, spoons and filters put them at risk" (Bourke 1998, p. 4).

It would appear from the evidence available that information is not always passed on to injecting drug users in an effective manner. Despite the existence of education and information materials as part of the prevention strategy in the area of drug-related infectious diseases, it would appear that there is a need for this information and education to be delivered in a more effective manner.

Needle exchange programmes: The first needle exchange programme in Ireland was established in 1989. Since then the service has been expanded to include approximately 12 sites. All of these sites are located in the Health Board

of the Eastern Regional Health Authority¹² [ERHA], which includes Dublin City and surrounding areas. Three types of programmes exist:

- The Merchant's Quay Project is a voluntary organisation which, among other services, provides a needle exchange programme.
- There is a mobile clinic which provides low threshold services to drug users including a needle exchange and a low dosage methadone programme. This clinic services four areas in Dublin city and the surrounding suburbs on a Monday to Friday basis.
- The remaining programmes are all in statutory services run by the ERHA. These are located in health centres and drug treatment centres around the city.

A one-for-one exchange of needles is aimed for by all needle exchange services. However, there is flexibility in order to ensure the service is client-friendly. The mean number of needles given out to injecting drug users at first attendance at ERHA exchange programmes is 4.0 (Mullen et al. 1998). Overall, the ERHA programmes estimate that approximately 60-70% of needles are returned to its exchange programmes. For 'first time' clients at the Merchant's Quay Project the number of syringes and needles given is normally two barrels and six needles (or six microfines) (Cox et al. 2000). In 1998, a total of 16,509 syringes were dispensed by the Merchant's Quay Project through its exchange programme (Cox et al. 2000).

While there has been an expansion in the number of needle exchange programmes available to Irish drug users, a need for further expansion has been identified. An external review of drug services in the Eastern Health Board has described needle exchange provision in Dublin as "patchy and not very comprehensive" (Farrell et al. 2000: 13). While it is recognised that community resistance may impact on the expansion of these services, it was argued that there needed to be a wider geographical distribution of these services. Pharmacies have been suggested as a *potential* source for clean injecting equipment for injecting drug users.

While there are no restrictions on pharmacies in relation to selling injecting equipment in Ireland, in practice anecdotal evidence suggests that this rarely happens. Currently there is no central policy or programme under which pharmacists provide needles to injecting drug users. The Pharmaceutical Society of Ireland has stated that they support "the principle of needle and syringe exchange. Its members are ready and willing to provide such a service as part of a comprehensive national needle and syringe exchange network" (McDermott 1999).

In an evaluation of the Merchant's Quay Project's syringe exchange programme, it was found that it had a positive impact on reducing the incidence of injecting risk behaviours among clients. Clients were questioned about their risk behaviour

¹² Formerly the Eastern Health Board [EHB]

when they first attended the service and then again after three months. Within this period it was found that there was a 76% reduction in the numbers reporting lending injecting equipment and a 71% reduction in the numbers reporting borrowing injecting equipment (Cox et al. 2000: 69).

Substitution programmes: As described in section 9.4.2 of this report, substitution programmes currently account for the majority of treatment programmes available to injecting drug users in Ireland. At the end of August 2000 there were 4,813 clients receiving substitution treatment in Ireland. The service is provided in a range of settings including addiction centres, satellite clinics and from general practitioners in their own surgery. It is assumed that by providing a substitute opiate (i.e. methadone) and monitoring illicit drug use through urinalysis, participation on a substitution programme will reduce the illicit opiate intake of a client and, in turn, their injecting drug use. However, a secondary function of substitution programmes in relation to preventing the spread of drug related infectious diseases is the dissemination of information to clients about HIV and hepatitis and associated risk behaviour.

Williams et al. (1990) carried out a study with 69 clients of a methadone maintenance treatment programme to investigate the extent of 'at-risk' behaviour for HIV transmission among those known to be sero-positive, and to measure the degree of positive change in their risk behaviour. It is important to note that this study was carried out in 1988, prior to the introduction of needle exchange programmes by the health board. Of those who were HIV positive (n=48), 63% admitted that they had continued to share injecting equipment since getting a positive test result. However, when comparing their reported pre-test activities the findings were deemed to be encouraging. Prior to being tested 98% reported that they had shared injecting equipment, compared to 63% after testing.

More recently, in 1997 Smyth et al. (1999b) carried out a study of knowledge regarding hepatitis C among a sample of injecting drug users (N=84) in a treatment setting in Dublin. Included in the sample were individuals who were on a methadone maintenance programme and those who were on a short-term detoxification programme. Their basic hypothesis was that those injecting drug users with increased contact with medical services would demonstrate better understanding of hepatitis C and associated risk behaviours, i.e. a 'dose-response' type effect. This hypothesis was not confirmed. Seventy-three of the sample recognised the four main infection routes, i.e. injecting drug use, sex, transfusion and vertical. However, only 44% recognised activities with no recognised risk, i.e. injecting without sharing, smoking heroin and kissing. Smyth et al. (1999b) expressed concern about the finding that substantial minorities believe that there is a risk of exposure even when not sharing injecting paraphernalia. They argued that perceived personal vulnerability to infections such as hepatitis C is likely to be a factor in leading individuals to avoid practising unsafe injecting behaviour. Where this vulnerability is diminished by false beliefs about already having been exposed to infection when actually engaging in 'safe' practices, then the preparedness to share injecting equipment may well increase.

Summary

In summary, while section 14.2 of this report showed that a significant proportion of Irish injecting drug users continue to engage in injecting risk behaviours, it would appear from this section that harm reduction strategies have had some positive impact on injecting drug users risk behaviours. While there is a need to improve on how some services are delivered, the findings would suggest that infection rates would be higher in the absence of the current harm reduction strategies.

• Testing and Treatment

Testing: Testing for hepatitis and HIV is offered to all those entering treatment and is encouraged by low threshold services such as needle exchange programmes. In these settings clients are given test results and may be offered referral to treatment where appropriate. The actual proportion of injecting drug users who have been tested for either hepatitis or HIV remains unknown. A study of HIV and hepatitis B/C prevalence among the prison population (Allwright et al. 1999) found that of 509 prisoners with a history of injecting drug use, 59.3% reported that they had been tested for hepatitis C, 49.6% for hepatitis B and 65% for HIV. In the Cox et al. (2000) study of needle exchange attenders, 49% reported that they had been tested for HIV. It has also been found that young injecting drug users (below the age of 25) are significantly less likely to have been tested for either HIV or hepatitis than the older cohort (Cassin 1998). While the specific nature of these study populations needs to be considered, these figures would suggest that a significant proportion of drug users have not been tested for the various drug-related infectious diseases.

Treatment: The provision of treatment for those infected with both HIV and hepatitis C is a key aspect of drug related infectious diseases. Treatment programmes for both HIV and hepatitis C are available free of charge in Ireland. While it is not essential for drug users to be referred by drug treatment clinics for HIV and hepatitis C treatment, this is the route generally followed.

Highly Active Anti-Retroviral Treatment (HAART) is available free of charge to drug users through referral to genito-urinary medicine (GUM) and infectious disease clinics in Ireland. There are four clinics that provide HAART, three of which are based in Dublin, the fourth in southern Ireland in Cork. The selection of patients for HAART is based on medical criteria as set out by international recommendations, and the motivation of the individual to undergo the treatment. A drug user generally has to be stable on a substitution programme before he/she will be accepted on to a HAART programme. This is due to problems of compliance with the treatment regime and concerns about the risks of prescribing HAART to those who are continuing to engage in illicit drug use.

Treatment for hepatitis C is also available to drug users where its provision is deemed appropriate. Guidelines have been developed for selecting suitable candidates for hepatitis C treatment. It is generally agreed among service providers that a potential client should be 'drug stable' (i.e. free from street opiates and injecting drug use) for a minimum of a year prior to starting treatment and that they should not be drinking alcohol (Keating 2000). As with HAART, it is argued that an individual needs to be drug stable in order to maximise the chances of compliance with the treatment regime involved for hepatitis C. Therefore, while a person with a history of injecting drug use may access treatment for hepatitis C, an active injecting drug user may not.

▪ **Hepatitis B vaccination**

Hepatitis B vaccination is available free of charge to all injecting drug users through the drug services and, where the individual is entitled to free medical care, through their general practitioner. However, anecdotal evidence suggests there is a lack of knowledge among drug users about hepatitis B in general, and the availability of a vaccination. Furthermore, anecdotal evidence suggests that not all service providers are offering drug users the hepatitis B vaccination. While the total proportion of injecting drug users who are vaccinated against hepatitis B is not known, special studies have found that a relatively low proportion report having received a vaccination. A study of those clients attending the Merchant's Quay Project found that only 19% of clients reported having been vaccinated for hepatitis B (Cox et al. 2000). Furthermore, a study of HIV and hepatitis B/C prevalence among committal prisoners (Long et al., 2000) found that of 175 prisoners with a history of injecting drug use, only 23% (n=41) reported that they had been *fully* vaccinated for hepatitis B. There is also a need to ensure that drug users who begin a course of the hepatitis B vaccination complete the three injections. In their study of HIV and hepatitis B/C prevalence among the prison population Allwright et al. (1999) found that while 300 respondents reported that they had been vaccinated against hepatitis B, only 184 had completed the three doses.

Conclusion

In conclusion, there appears to be on-going evidence that a significant proportion of Irish drug users may be infected with at least one drug related infectious disease. However, analysis of the situation remains restricted in the absence of comprehensive routine data collection in the field. It would also appear that while harm reduction programmes have played a role in containing the spread of drug related infectious diseases to some extent, a significant proportion of Irish injecting drug users are continuing to engage in risky behaviours. It would appear that there is a need for more comprehensive education and information dissemination strategies targeted at drug users, and in particular young injectors. Furthermore, there is a need for a more effective delivery of testing services and in particular hepatitis B vaccination to drug users.

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ANNEX

Drug Monitoring System and Sources of Information – New Developments

Information of this report was gathered with the co-operation of a wide range of Government Departments, agencies, community and voluntary sector informants etc. as acknowledged in the Forward to this report.

New developments in systems include

- National Drug Treatment Reporting System which is being extended currently to include GPs and will be extended in the near future to include the Prison Service.
- Drug co-ordinators in the Regional Health Boards plan to collect information on Demand Reduction activities in their areas.
- Electronic treatment data capture at source is planned in the ERHA with the development of the DIAS system. Other health boards are exploring the development of electronic systems for drug treatment services.

Following the report of the Interim Advisory Committee on Drugs, the Drug Misuse Research Division of the Health Research Board will develop a National Documentation Centre. Collaboration with the Virtual Library project of the EMCDDA is envisioned. The Document Centre will be a major information resource in the national and European contexts.