European Monitoring Centre for Drugs and Drug Addiction

HRB Health Research Board

2012 NATIONAL REPORT (2011 Data) TO THE EMCDDA by the Reitox National Focal Point

IRELAND

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

REITOX

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Summary of each chapter

This report, written following European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) guidelines,[1] is divided into two parts. Part A is an overview of new developments and trends in the drugs area in Ireland for 2008 and, in some cases, for the first six months of 2009. These are covered under the following headings:

1. Drug policy: legislation, strategies and economic analysis
2. Drug use in the general population and specific targeted-groups
3. Prevention
4. Problem drug use
5. Drug-related treatment: treatment demand and treatment availability
6. Health correlates and consequences
7. Responses to health correlates and consequences
8. Social correlates and social reintegration
9. Drug-related crime, prevention of drug-related crime and prison
10. Drug Markets

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

11. Residential care for drug users in Europe
12. Drug policies of large European cities

Main points from Part A

1. Drug policy: legislation, strategies and economic analysis

Legislative provisions introduced during 2011 include the Criminal Justice (Community Service) Act 2011 which encourages the judiciary to consider imposing the alternative sentence of a community service order in certain circumstances in place of imprisonment. Provisions have also been introduced to give the Garda Síochána greater flexibility when detaining suspects for questioning in certain cases. The Garda Síochána have also been given powers to give directions to persons to desist from begging. The Spent Convictions Bill 2012 provides for the removal of records of previous criminal convictions in certain circumstances so that such convictions do not act as a barrier to the rehabilitation and employment prospects of previous offenders. However, the Irish Penal Reform Trust and the Irish Human Rights Commission have expressed reservations about a number of aspects of the proposed legislation, arguing that it does not go far enough.

The Law Reform Commission has highlighted in a consultation paper a number of serious deficiencies in the operation of the presumptive 10-year sentence as provided for in section 15A of the Criminal Justice Act 1999. This Act created a new offence of possessing controlled drugs having a value of £10,000 (€13,000) for certain drug offences. The Law Reform Commission has identified a number of unintended negative consequences of the legislation and has recommended that the provision be reviewed.

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

It is also reported that the government is currently considering whether to amend the law so as to make medicinal cannabis available in certain circumstances. In response to reports about the street sale of prescription drugs, the government is considering legislation to enhance garda powers to address the issue.
The government has deferred consideration of the report of the National Substance Misuse Strategy Steering Group, published in February 2012, and the associated action plan, until autumn 2012. A report on the implementation of the NDS in 2011 showed that progress was made in implementing 49 of the 63 actions, while 12 did not progress at all because of either insufficient resources or legislative and/or administrative delays. Two actions were dropped.

The government has initiated two reviews that will impact on the structure and functions of the country's 24 drugs task forces. It is anticipated that the recommendations from these reviews will lead to revamped national co-ordinating structures; revised funding arrangements, with statutory agencies playing a greater role; an enhanced role for local authorities; and a reduced number of drugs task forces, and consequent changes in their composition and roles. In response to the continuing economic downturn, a number of reviews of the nation's public expenditure system have also been undertaken. It is expected that these reviews will recommend a simpler, more streamlined regime of government funding of services, including drug-related services.

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

The results of three nationwide drug prevalence surveys are reported on:

- *The third all-Ireland general population drug prevalence survey, 2010/11*: Compared with the previous survey in 2006/7, the proportion of adults (aged 15–64 years) who reported using an illegal drug in their lifetime rose by just over 3%, and the proportion of young adults (aged 15–34 years) who reported using an illegal drug in their lifetime rose by just over 4%.
- *The fifth ESPAD survey of alcohol, tobacco and illicit drug use among 15–16-year-old students in Ireland, 2010/11*: In 15 years, between 1995 and 2011, lifetime use of alcohol has decreased by 10%, lifetime use of cigarettes by 31%, and lifetime use of any illicit drug by has fallen from 37% to 19%.
- *The fourth Health Behaviour in School-aged Children (HBSC) survey in Ireland, 2010*: Overall, there was a decrease in self-reported alcohol and cannabis use among school children in Ireland in 2010 when compared to 2006. This may represent a true decrease, possibly owing to children having less pocket money in recent years, or it may be the result of sampling variation, or a combination of both factors. While these decreases are welcome, the survey results show that at least one in ten 15-year-olds has been drunk by the age of 13, and more than half of Irish 15–17-year-olds have been drunk at some point in their lives.

A study of the prevalence of cigarette smoking and cannabis use in Irish teenagers, undertaken to quantify the strength and significance of the association of cigarette smoking and cannabis use and other high risk behaviours and to examine whether the above associations are independent of social networking, found that cigarette smoking is prevalent among Irish teenagers and is significantly associated with drug use and other risk-taking behaviours.

3. Prevention

A number of environmental measures, mainly contained in legislation, have been developed to restrict the sale, supply and use of alcohol and tobacco. These include age limits for purchasing alcohol and tobacco products, measures to curtail alcohol-related public nuisance, ban on smoking in public premises and restrictions on promoting and advertising tobacco products. Universal drug prevention in schools is under review with a commitment by Government to update the current life-skills approach to reflect changing attitudes and behaviour around recreational drug use

among teens. A substantive review of the literature has revealed that parental substance misuse is reportedly associated with poor outcomes for affected children. Youth cafés have become established sites of community-based intervention with young people in a number of geographical locations. Best-practice guidelines have been established and disseminated to improve the capacity of drug services working with members of the Traveller community. The Strengthening Families programme is being implemented in a number of locations and one evaluation has demonstrated improvements in all family and parenting outcomes measured and in most of the children's behaviour outcomes.

4. Problem drug use (PDU)

It is not possible to estimate the number of injecting drug users or PDUs, apart from opiate users, in Ireland as the National Drug Treatment Reporting System (NDTRS) does not use a 'unique identifier'. The government is due to publish a Health Information Bill at the end of 2012 that will provide for a unique identifier.

A qualitative study commissioned by the South Inner City Drugs Task Force explored aspects of problem drug use in south inner-city Dublin in 2010. NDTRS data were reported, showing that of the 420 adults who entered treatment in the south inner-city area in 2010, over two-fifths (62%) reported an opiate as their main problem drug, and 32% reported alcohol as their main problem drug. Only 4% were treated for cocaine as their main problem drug and 2% for cannabis. None were treated for benzodiazepine use as a main problem drug. Seventy per cent reported they had problems with one or two additional drugs, and 30% reported problems with three or more additional drugs. Forty-four per cent reported they had injected, and 47% reported they had first injected before the age of 19 years. Sixty-five per cent said they had shared injecting equipment.

5. Drug-related treatment: treatment demand and treatment availability

The Community Detoxification Protocols were piloted in Dublin's north inner city in 2008 and 2009, and in November 2011 a National Community Detoxification Pilot was launched. The protocols contain a structured, step-by-step detoxification process and clarify the roles of each stakeholder (service user, doctor, key worker) in the process. Following the completion of the Dublin-based pilot, the protocols were divided into two separate sets of guidelines – one for methadone detoxification and prescription and one for benzodiazepine detoxification and prescription – to reflect the different risks, processes and structural contexts associated with each substance.

Newly published data from the HSE show a reduction in the number of people waiting for methadone treatment in Ireland between March 2011 and the end of April 2012 – down from 230 to 137. An analysis of data from the ROSIE study indicates that having responsibility for children significantly improves the outcome of a client's treatment for heroin use. However, the use of alcohol and other opioids among this group may indicate that they have been substituting other substances for heroin.

A study examining the perceptions of clients of a methadone treatment clinic regarding their unmet needs, and the association between misuse of non-prescribed benzodiazepines and the extent of unmet needs, showed that a higher number of days of benzodiazepine misuse was significantly associated with a higher unmet needs rating. The authors recommend a more formal and active assessment of the needs of clients on methadone treatment and rapid access to evidence-based treatment for benzodiazepine misuse.

The number of cases entering drug treatment each year and reported to the NDTRS increased by 52% between 2005 and 2010. During this six-year period, opiates (mainly heroin) have been the most common problem drugs reported; the number of cases reporting cannabis as their main problem substance has increased significantly

over the period, while the number of cases reporting cocaine as their main problem substance has been decreasing since 2007. First reported in 2009, 'head shop' compounds reported as a main problem substance increased significantly in 2010, when they exceeded the numbers reporting amphetamines, ecstasy and volatile inhalants. The vast majority of cases treated between 2005 and 2010 reported problem use of more than one substance.

The profile of cases entering drug treatment remained stable between 2005 and 2010; in general, problem drug users were male and in their twenties. Half of the new cases entering treatment started drug use at or before the age of 15. The proportion of new cases aged less than 18 has increased since 2007, reaching 16% in 2010. Data show a decline in injecting and, among new injectors, an increasing interval between starting drug use and starting injecting. The data also show that employment rates among drug users declined significantly, from 22% in 2005 to 9% in 2010, most likely reflecting the current economic climate.

In response to the growing demand for treatment for problem use of substances other than heroin, combined with the high proportion of cases using multiple problem substances, many services are participating to an increasing extent in local inter-agency initiatives in order to provide a wide range of interventions and a continuum of care for clients, for example, through the development of case management and key working strategies.

6. Health correlates and consequences

Between 2001 and 2010 the overall number of new cases of HIV among injecting drug users declined. A relatively stable picture of HIV associated with IDUs is now emerging in Ireland: it is a more manageable chronic disease though, as evidenced by a recently completed longitudinal study of the natural history of injecting drug use in a community in Dublin, surviving injecting drug users are ageing and have other chronic diseases, posing new challenges for health services.

While hepatitis B notifications in Ireland in 2011 were 19% lower than in 2010, continuing the downward trend since 2008, there were 1,257 reported hepatitis C cases in 2011, compared to 1,236 in 2010, and where risk factor data were available, 82% of these hepatitis C cases were injecting drug users. A study of the relationship between methadone maintenance treatment and maternal characteristics, including blood-borne viral status, found that a higher proportion of methadone-exposed women were likely to test positive for hepatitis B, hepatitis C and HIV when compared to non-exposed women.

In 2010, there were 164 deaths owing to poisoning recorded in Ireland. This represents a substantial drop compared to 2009, when 216 such deaths were recorded. For the first time since 2005 there has been a decrease in the number of deaths owing to poisoning where heroin was implicated. Regardless of the overall decline in deaths owing to poisonings, opiates continue to be associated with most poisoning deaths recorded in the NDRDI, and indeed was higher than in previous years. The number of deaths where cocaine was implicated (either alone or with another drug or substance) declined again 2010. This reflects decreasing trends in relation to cocaine seen in other areas.

A total of 1,343 non-poisoning deaths were recorded among drug users in the period 2004–2009. The number of non-poisoning deaths increased over the reporting period, from 162 deaths in 2004 to 271 in 2009. Over half were due to medical causes and the remainder were due to trauma.

The first report of the national Suicide Support and Information System (SSIS) was published in July 2012 and presented the results of a pilot implementation of the system in County Cork between September 2008 and March 2011. The majority (71%)

of the 178 suicide cases died by hanging, 11% by drowning and 10% (19) by intentional drug overdose. Legal drugs used in the overdose cases included both prescribed (17%) and non-prescribed (83%) medication. Illegal drugs used included cocaine and heroin. Eighteen per cent of the total number of cases had taken medication and/or drugs in combination with other methods, such as hanging and drowning. In the year prior to death, 52% of the cases had abused alcohol and/or other drugs. Of these cases, 44% had abused alcohol only, 34% had abused both alcohol and other drugs and 16% had abused other drugs only. Two different clusters of suicides were identified in Cork, mainly involving men. A matched comparison between cluster and non-cluster suicide cases in terms of mental health and social risk factors was undertaken. All except three of the young males involved in the larger cluster had used multiple drugs (prescription and street drugs), often combined with alcohol, while this was less common among the non-cluster cases. Compared to the non-cluster cases, the suicide cluster cases were less likely to communicate their suicidal intentions and they were more likely to have lost a friend by suicide.

7. Responses to health correlates and consequences

The first report of the national Suicide Support and Information System (SSIS), including the results of a pilot implementation of the system between September 2008 and March 2011, is described. The objectives of the SSIS are to provide better support to bereaved family members; identify and better understand the causes of suicide; identify and improve the response to clusters of suicide and extended suicide; describe the incidence of and explore patterns of suicide in Ireland; and identify individuals who present for medical treatment owing to deliberate self-harm and who subsequently die by suicide.

Three studies of hepatitis C virus (HCV) treatment and management in Ireland are described.

1. Having studied HCV treatment outcomes and barriers to HCV referral in a centre with a HIV/HCV co-infection clinic, researchers concluded that the availability of free treatment and the presence of a multidisciplinary team were two factors improving attendance and compliance. They further stated that dedicated co-infection clinics lower the threshold for treatment and improve management of liver disease in co-infected patients.
2. A cross-sectional retrospective review of all referrals made to an urban tertiary-care liver centre for HCV management found that an 'exceptionally high rate of dropout exists' among those attending services to monitor and manage HCV in injecting drug users, particularly in the early stages of service delivery. Innovative approaches to help optimise HCV management in this population have been developed, including texting reminders and using a change model to improve engagement and compliance with behaviour and treatment.
3. A study to measure knowledge of and attitudes towards HCV, and to identify the sources of knowledge, among 560 nurses working in general practice, public health and addiction, indicated that nurses working in public health services and general practice require formal training in HCV care and management, while nurses in the addiction services need to update their knowledge in certain areas.

The health of women, who had been prescribed methadone for the treatment of opiate dependence, and their infants born in the Coombe Women and Infants University Hospital (CWIUH) in Dublin, were the subject of two studies. The first study concluded that the services of a drug liaison midwife (DLM) were required to encourage pregnant women with opiate dependence to attend drug and maternity services regularly, and to liaise between professionals in both services. The second study found that the outcomes for mothers prescribed methadone and their new infants were not as good as those for other mothers and infants attending the maternity service.

8. Social correlates and social reintegration

Early school-leaving and homelessness among drug users reporting for treatment shows little change over the period 2005–2010, which suggests that measures to tackle these problems are not having the desired effect. Drug use among socially excluded groups continues to be a problem; research among the Traveller community, the homeless population and sex workers highlights the continuing problems that drug use brings to these already marginalised and troubled groups. In-depth interviews with 30 self-reported drug-using members of the Traveller community revealed that smoking heroin was their main problem drug; this group included 18 Traveller women, which represents the first documented report in Ireland of heroin use among female Travellers.

One in five of a cohort of 769 people using homeless services reported using heroin and one in three of the cohort reported using two drugs simultaneously. Over half of the cohort reported at least one diagnosed mental health condition and at least one diagnosed physical health condition and half were in receipt of disability benefit. In a separate study with 60 homeless women, just over a third of 60 homeless women reported using heroin often combined with crack cocaine, cocaine and benzodiazepines. Among these 60 women, multiple correlates of homelessness were reported with childhood poverty, childhood trauma and family breakdown and addiction being instrumental in their entry into homelessness and on their many unsuccessful attempts to exit homelessness. Interviews with 15 children aged 16-19 who reported episodes of homelessness revealed they were using alcohol and drugs and engaging in petty criminal acts while exposed to street culture.

In a study with 35 sex workers, all reported a history of injecting drugs with over half recent episodes of injecting heroin. The health status of the interviewees was poor, with 26 reporting to be HCV positive and seven reporting to be HIV positive.

The provision of sustainable accommodation for people affected by drug use remains sporadic; however, the application of the Housing First approach is currently being piloted among a small group of homeless people with entrenched addiction problems. Interviews with 20 people in recovery from addiction demonstrate that adult education contributes to recovery capital on social, cultural, physical and human dimensions. Finally, the proportion of all drug treatment cases in employment declined from 22% in 2005 to 9% in 2010, a decline most likely associated with the current economic situation in Ireland.

9. Drug-related crime, prevention of drug-related crime and prison

Criminal proceedings for the possession of drugs for personal use decreased in 2009 for the first time since 2004. Possession offences accounted for 69.1 % of total drug offences in 2010. Proceedings for drug supply increased slightly in 2010. Of particular significance has been the large increase in the offence of cultivating/manufacturing controlled drugs. In 2010 the number of prosecutions for such offences almost doubled on the previous year. In 2010 the number of prosecutions for driving under the influence of drugs decreased significantly.

A report was published by the Strategic Response Group, a partnership approach to address public substance misuse and perceived anti-social behaviour in Dublin city centre. The report identifies a number of measures necessary to address this complex issue. A position paper by the Irish Penal Reform Trust highlighted the causative connection between social exclusion, deprivation and crime. Following a review of the Dial-to-Stop Drug Dealing and Intimidation Campaign, it has been decided to put in place a more cost-efficient approach to promoting the campaign from 2012 onwards. A commission on anti-social behaviour, established by the former Lord Mayor of Dublin, issued its final report in June 2012. The report and recommendations of the commission were presented across a range of themes, including early intervention and prevention, education, discrimination and prejudice, management of offenders and alternatives to prison, alcohol and other drugs, city centre issues and urban design. In

late July 2011, the Courts Service and the Health Service Executive agreed to extend the catchment area of the Drug Treatment Court. A series of reports by the Jesuit Centre for Faith and Justice and the Inspector of Prisons have highlighted concerns about drug use and overcrowding in Irish prisons.

The Irish Prison Service' Three-Year Strategic Plan 2012–2015 commits the prisons to ensuring an increase in the number of prisoners receiving prison based treatment and programmes designed to aid rehabilitation and reintegration. The introduction of drug-free units in all closed prisons and the provision of equivalence healthcare to all prisoners in custody are also objectives of the plan.

10. Drug markets

A report by the North Dublin Inner City Local Drugs Task Force has highlighted the issue of polydrug use as a major issue of concern in the city. The total number of drug seizures increased from 6,362 seizures in 2005 to a peak of 10,444 seizures in 2007. Between 2007 and 2010, the number has almost halved, to 5,477. This decrease can be explained primarily by the significant decrease in cannabis-type substances seized. The decrease in cannabis seizures may also be partly explained by a change in the nature of cannabis use, with people moving from resin to more potent forms of cannabis. There has been a significant decline in seizures of cocaine and heroin since 2007. Ecstasy-type substances also decreased significantly between 2007 and 2010. However, in 2011, seizures of ecstasy-type substances increased by more than 900% over the previous year. The street sale of prescription drugs has also been highlighted in a number of recent reports.

Main points from Part B

11. Residential treatment for drug users in Europe

Residential treatment services for drug users have been provided in Ireland since the 1960s, partly by the public sector and partly by the voluntary and community sectors. In the 1980s and 1990s other drug treatment modalities came to the fore. However, in the last decade the need for a range of responses and alternative drug-free approaches has seen residential treatment services come to the fore again, especially within the context of the 4-tier treatment model and integrated care packages, which have been adopted as official policy since 2009.

There is very limited information on the types and characteristics of residential drug treatment services in Ireland. In 2007 it was estimated that there were 634.5 beds for residential treatment (both drugs and alcohol) and a need for a further 252.2 beds. Subsequent national drug treatment data indicate an increase in the number of cases entering residential treatment but whether this reflects a true increase, or is due to some other intervening variable, is not clear. Detoxification and rehabilitation are intrinsically linked in Ireland as many centres require a person to be drug-free before entry, so it is difficult to distinguish residential detoxification from residential treatment.

The economic climate is adversely affecting the provision of all drug treatment services, including residential services; for example, the only residential mother and baby service in the state may have to close owing to lack of funding. New initiatives such as community detoxification have proved a successful alternative for those who require detoxification but for whom a stay in an inpatient facility is not the best option however there will always be a need for an alternative which includes residential treatment.

12. Drug Policies of large European cities

In this selected issue we have sought to address the specific questions raised by the EMCDDA. Dublin, Ireland's capital city, does not have its own specific drug policy. Drug policy in the city is considered within the context of the NDS. Much of the

information and data gathered by agencies such as the Health Research Board (HRB) or the National Advisory Committee on Drugs (NACD) that is regularly reported by the National Focal Point is not specific to Dublin. However, where possible, we have highlighted recent studies that focus on drug-related problems in the city. Along with these research studies and reports, other sources used include government websites, policy documents and parliamentary debates. We have also consulted with the Drug Policy Unit in the Department of Health.

Part A: New Developments and Trends

1. Drug policy: legislation, strategies and economic analysis

1.1 Introduction

The classification of drugs and precursors in Ireland is made in accordance with the three United Nations conventions of 1961, 1971 and 1988. Irish legislation defines as criminal offences the importation, manufacture, trade in and possession, other than by prescription, of most psychoactive substances. The **principal criminal legislative framework** is laid out in the Misuse of Drugs Acts (MDA) 1977 and 1984, and the Misuse of Drugs Regulations 1988. The offences of drug possession (s.3 MDA) and possession for the purpose of supply (s.15 MDA) are the principal forms of criminal charge used in the prosecution of drug offences in Ireland. The Misuse of Drugs Regulations 1988 list under five schedules the various substances to which the laws apply.

The **National Drugs Strategy (interim) 2009–2016** provides the implementation framework for illicit drugs policy in Ireland (Department of Community Rural and Gaeltacht Affairs 2009). The Strategy has an overall strategic objective, 'To continue to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research'. Implementation is based on a 'partnership' approach, whereby over 20 statutory agencies, multiple service providers and community and voluntary groups work together in a nationwide network of regional and local drugs task forces (DTFs) to deliver the Strategy, with the statutory agencies critical in terms of core service provision. The Minister for Health has overall responsibility for the National Drugs Strategy, and an Oversight Forum on Drugs (OFD), chaired by the Minister of State for Primary Care within the Department of Health, and comprising senior representatives of the various statutory agencies involved in delivering on the Strategy, and representatives from the community and voluntary sectors, meets every quarter to monitor progress and address any operational issues.

Priorities for **public expenditure on the drugs issue** are set out in the National Drugs Strategy. Public funds are allocated by way of the annual parliamentary Estimates process, which allocates funds to departmental Votes. Funding for regional or local initiatives may be either directly from government agencies and funds such as the Young People's Facilities and Services Fund (YPFSF), administered by the Department of Children and Youth Affairs (DCYA), or via the regional and local DTFs. Funding by DTFs proceeds from 'initial' to 'mainstreamed' funding as follows:

- *Initial funding:* DTF projects are initially set up as pilot projects with funding provided through the Drugs Initiative, administered by the Department of Health. The government department or agency most closely associated with the nature of the project acts as the channel of funding to the project during this pilot phase.
- *Mainstreamed funding:* after the pilot phase, each project is evaluated and a decision taken with regard to mainstreaming it in the appropriate government department or agency. Once a project is mainstreamed, the responsibility for the funding of the project transfers to that department or agency and the Department of Health is no longer involved. DTFs continue to have a monitoring role in relation to mainstreamed projects.

The governance framework and funding mechanisms are currently being reviewed and are expected to be redeveloped in the coming year (see Sections 1.3 and 1.4 for detail).

1.2 Legal framework

This update covers drug-related acts and bills of the Oireachtas introduced or progressed during the reporting year. It also identifies new substances brought under control within the terms of the Misuse of Drugs legislation. Subject to the obligations of European Union membership as provided in the Constitution of Ireland, the sole and exclusive power of making laws for the State is vested in the Oireachtas. The Oireachtas consists of the President and two Houses, Dáil Éireann (House of Representatives) and Seanad Éireann (Senate). Bills are proposals for new laws. They are usually approved by a Minister or another member of the government. Occasionally, a private member's bill is proposed by a member of the opposition. Such bills, because they have not originated in government, are less likely than government-sponsored bills to become law. To become law, a bill must first be approved by both the Dáil and the Seanad, although the Dáil can override a Seanad refusal to pass a bill. Joint committees are groups of members of Parliament, including both government members and members of the opposition, which discuss proposed legislation and make recommendations for amendments to the Minister. Bills can be introduced in either the Dáil or Seanad and there are five stages in considering a bill. The second and third stages are considered the most important as they offer the fullest opportunities to Members to discuss and amend the contents of the bill. Once the bill has been passed by the Oireachtas, the Taoiseach (Prime Minister) presents it to the President to sign into law, and then it becomes an Act.

Acts do not come into operation until a commencement order is issued in the form of a statutory instrument. There are five main types of statutory instrument: orders, regulations, rules, bye-laws and schemes. Statutory instruments have a wide variety of functions. They are not enacted by the Oireachtas but allow persons or bodies to whom legislative power has been delegated by statute to legislate in relation to detailed day-to-day matters arising from the operation of the relevant primary legislation. Statutory instruments are used, for example, to implement European Council Directives and delegate the powers of ministers. Specified government ministers and other agencies and bodies are authorised to make statutory instruments and several hundred instruments are made annually. Notice of the making of the commencement order is published in the Oireachtas newsletter *Iris Oifigiúil*.

Also considered below are relevant debates in the Oireachtas in relation to the impact of drug-related legislation, court decisions where the judiciary have provided specific interpretations of legislation, and academic and/or research findings in relation to drug-related legislation.

1.2.1 Laws, regulations, directives or guidelines in the field of drug issues (demand & supply)

This update covers drug-related acts and bills of the Oireachtas introduced or progressed between January 2011 and July 2012. It also identifies any new substances brought under control within the terms of the MDA legislation.

The **Criminal Justice (Community Service) Act 2011** requires a court, before which an offender stands convicted of an offence for which a sentence of up to 12 months imprisonment would be appropriate, to consider imposing the alternative sentence of a community service order.

The **Criminal Justice Act 2011** amends the criminal law and procedure relating to the investigation and prosecution of certain offences. It amends the Criminal Justice Act 1984 to provide for the suspension in certain circumstances of the detention of persons detained by the Garda Síochána under that Act. This can provide the Gardaí with further time to investigate complex cases without the detention period provided for under the Criminal Justice Act 1984 expiring. It also provides a power for judges of the District Court to order persons in certain circumstances to produce documents or provide information for the purposes of the investigation of offences.

The **Communications (Retention of Data) Act 2011** requires service providers, those engaged in the provision of a publicly available electronic communication service or a public communication network by means of fixed line or mobiles or the internet, to retain data relating to fixed and mobile telephony for one year, and data relating to internet access, internet email and internet telephony for two years, and provides for disclosure in relation to the investigation of specified offences, including Customs offences.

The **Criminal Justice (Public Order) Act 2011** prohibits harassment or intimidation of members of the public by persons who engage in begging and confers powers on members of the Garda Síochána to give directions to persons to desist from begging, in certain circumstances such as where they are begging near cash machines or in front of places of business. It also provides for a series of sanctions including fines and possible imprisonment for breaches of the law.

The **Road Traffic Act 2011** (in advance of provisions of Part 2 of the Road Traffic Act 2010, which will come into force in late 2011) amends existing legislation to provide for mandatory alcohol testing of drivers of mechanically propelled vehicles in certain circumstances, including involvement of road traffic collisions The Act also clarifies the position regarding mandatory preliminary breath testing.

Current status of relevant Bills before the Dáil is shown in Table 1.2.1.1

Table 1.2.1.1 Status of bills before the Dáil relevant to the drugs issue, June 2012

Title and exploratory memorandum	Status
The **Spent Convictions Bill 2012** provides that in the case of convicted persons whose sentence is below a specific threshold, they may, under certain circumstances, withhold details of the conviction, for example, when seeking employment. This is intended to apply where a prison sentence not exceeding 12 months or a fine or penalty have been imposed, and then only after a certain number of years have elapsed without a further conviction. The purpose of the bill is to help rehabilitate convicted persons through facilitating their reintegration into the workforce and allowing them to build new careers. As many problematic drug users whose offence is drug-related receive relatively short prison sentences, this legislation could have a positive impact in terms of facilitating rehabilitation interventions.	New Bill May 2012
The **Criminal Justice (Search Warrants) Bill 2012** amends, inter alia, the provisions in the Criminal Justice (Drug Trafficking) Act 1996 relating to the issue of search warrants under section 26 of the Misuse of Drugs Act 1977. The bill amends section 8 of the Criminal Justice (Drug Trafficking) Act 1996. Section 8(2) permits a superintendent (or above) to issue a warrant under section 26 of the Misuse of Drugs Act 1977 in circumstances of urgency requiring the immediate issue of a warrant and where it would be impracticable to apply to either a District Court judge or a peace commissioner. The amendments insert two additional safeguards. Subsection (1) of the bill inserts two new subsections after subsection (2) of section 8 of the 1996 act: ° New subsection (2A) provides that only a superintendent who is independent of the investigation concerned may issue a warrant under section 26. 'Independent of' is defined as not being in charge of, or involved in the investigation concerned. ° New subsection (2B) requires a superintendent who issues a warrant under section 26 to record the grounds on which he/she issued the warrant either at the time or as soon as reasonably practicable after issuing the warrant.	New Bill June 2012

1.2.2 Laws implementation

Spent Convictions Bill 2012

The Irish Penal Reform Trust (IPRT) welcomed the publication of the Criminal Justice (Spent Convictions) Bill 2012 as a positive step in supporting the rehabilitation of offenders. However, it argued that some issues remain which must be resolved in order to get the balance right between public safety and the reduction of barriers to reintegration for those who have moved on from offending behaviour.

Liam Herrick, executive director of the IPRT, said:

> IPRT very much welcomes the introduction of this Bill, which represents an improvement on previous proposals and brings Ireland into line with all other European countries which give less serious offenders a second chance. At the same time, we believe that the legislation could go further than is currently proposed in terms of raising the maximum sentence covered by the bill, in shortening the rehabilitative periods, and in reconsidering the blanket exclusions of certain categories of employment, such as all persons working with children. (Irish Penal Reform Trust 2012, 4 May)

The IPRT called for a number of aspects to be strengthened:

- 12-month limit: The threshold for prison sentences should be extended from 12 to at least 30 months.
- Rehabilitative periods: These could be shortened to two to four years (rather than three to seven). The length of the required period of rehabilitation should be proportionate to the seriousness of the offence committed, and yet not be so long as to be discouraging.
- Exclusions from the scheme: A blanket exclusion on wide areas of employment, such as for those working with children and vulnerable adults, is too broad. Instead, the relevance of the conviction to the position sought should be considered.
- Discrimination against those with criminal records: Discrimination on the basis of criminal convictions should be prohibited in relation to employment, education and in access to goods and services. Wider issues of data protection, the 'right to be forgotten', and the need for greater regulation of Garda vetting information should also be addressed.

The Irish Human Rights Commission (IHRC) also published its observations on the Spent Convictions Bill 2012 (Irish Human Rights Commission 2012). In its observations, the IHRC suggested that the proposed legislation is overly restrictive and will not assist in re-integrating people convicted of minor offences back into society and employment. The following key recommendations were outlined in the IHRC press release (Irish Human Rights Commission 2012, 11 June):

- assess benefits of Spent Convictions Bill in light of the impact of the Vetting Bill also currently before the Oireachtas, particularly in light of the scope of vetting being undertaken in Ireland;
- introduce prohibition on discrimination on grounds of criminal conviction into equality legislation;
- shorten rehabilitation periods in legislation to make it proportionate with offences;
- redefine 'vulnerable person' to comply with international human rights standards;
- make information on spent convictions subject to data protection provisions;
- remove requirement to declare spent convictions outside of Ireland;
- remove limitation on number of convictions per person to be considered spent;
- extend the sentencing threshold beyond 12 months to enable people convicted of a more serious offence to apply to a court to have their sentences considered spent.

Dr Maurice Manning, president of the IHRC, said:

> This legislation has relevance to a large number of people in Ireland who have come into contact with the law through the commission of minor offences or receiving fines and is a welcome initiative. While the aim of the Spent Convictions Bill is to remove barriers faced by people seeking employment who were convicted of minor offences, the IHRC considers that the legislation as it is currently drafted falls very short of achieving that goal. … For a person who is convicted of a minor offence or fined to have to reveal that conviction for three to seven years seems entirely disproportionate.

> While a conviction may be declared 'spent' for the purposes of the Spent Convictions Bill, information on the existence of the conviction will still be available to a wide range of potential education institutions and employers through the operation of the Vetting Bill. While the vetting process has an important role in protecting children and people in vulnerable situations, the broad scope of vetting in practice could further weaken the purpose of the Spent Convictions legislation, and result in barriers for people convicted of minor offences who are trying to re-enter society and employment, particularly those not seeking to work directly with children or people in vulnerable circumstances. The contradictions in these two pieces of legislation need to be clarified to ensure that the Spent Convictions legislation can achieve its aim. (Irish Human Rights Commission 2012, 11 June).

The IHRC considers that the Spent Convictions Bill is insufficient on its own to deal with discrimination that may arise on the basis of previous convictions. Dr Manning said:

> Discrimination on the basis of previous conviction is a real issue that has serious implications for former offenders. Once a criminal conviction is imposed it follows the individual for life and can inhibit their access to education or employment, their ability to obtain licences, insurance and housing and can place restrictions on their travel. The grounds of discrimination in the Employment Equality and Equal Status legislation should be extended to include discrimination on the basis of a criminal conviction. Without such a prohibition on discrimination the Spent Convictions Bill may be of little assistance in practice. Such an anti-discrimination provision would enable the future Human Rights and Equality Commission to consider cases of discrimination based on a person's criminal record. (Irish Human Rights Commission 2012, 11 June).

Criminal Justice (Psychoactive Substances) Act 2010

In response to a parliamentary question on the impact of the Criminal Justice (Psychoactive Substances) Act 2010 (Irish Focal Point (Reitox) 2011) (Section 1.2.2) on 'head shops', the Minister for Justice, Equality and Defence, Alan Shatter TD, stated:

> I am informed by the Garda authorities that since the Act came into effect a series of test-purchasing operations has been conducted at such premises by personnel from the Garda National Drug Unit, with approximately 70 inspections under the provisions of section 12 of the legislation having taken place nationwide. This has resulted in the seizure of a range of products, including cannabinoid products, cathinone substances and substances suspected to contain benzylpiperazine or its derivatives, the value of which are estimated to be worth less than €100,000. At this time, three of the remaining outlets which continue to operate are selling products intended for human consumption. During a test purchase operation at one of these premises a product subsequently found to contain 'Salvinorin A', a psychoactive substance which has now been placed under the control of the Misuse of Drugs legislation, was purchased. The proprietor of the premises was arrested and interviewed resulting in the submission of an investigation file to the Law Officers and further directions in this matter are awaited. Finally, I am advised that the Garda National Drug Unit is continually monitoring retail outlets involved in the sale of products traditionally sold by 'headshops' and, in partnership with its European counterparts, is constantly monitoring the topography of the headshop phenomenon in order to identify emerging trends and patterns in this area. (Shatter 2011, 15 November)

Mephedrone was placed under legislative control in Ireland in 2010 2010 (Irish Focal Point (Reitox) 2011) (Section 1.2.1). A research study investigated the impact of this

legislation on mephedrone use in Ireland (Van Hout and Bingham 2012b). The study focused on the 'lived experiences' of a sample of 22 recreational club drug users aged 18–35 (eight females and 14 males), with the majority semi-professional and employed, and the remainder in third-level education. The research found a reduction in mephedrone use among the sample, with less than half reporting continued use. The study also found that 'mephedrone appeared to become immersed in illicit street trade, with some user interest in online purchasing' (p. 161). Mephedrone pricing increased but remained cheaper than cocaine. However, users reported that the quality of cocaine and MDMA improved subsequent to the ban, while concerns about street contamination of mephedrone also discouraged its use and saw respondents revert back to cocaine and MDMA use. The authors speculated that 'the new and improved MDMA and cocaine emergent after the ban in Ireland was the product of clever blending with mephedrone in response to market forces, and thereby caused this localised market shift' (p. 161).

The authors concluded that there is a need for the 'continued monitoring on the impact of legislation on drug use patterns, processes and harms…in order to guide the development of proactive harm reduction interventions and policies' (p. 161).

Impact of organised crime legislation

In response to a parliamentary question about the impact of the Criminal Justice (Amendment) Act 2009 (Irish Focal Point (Reitox) 2010) (Section 1.2.1) introduced in response to organised criminal activity, Minister for Justice, Equality and Defence, Alan Shatter TD, stated:

> … my Department is currently undertaking a specific review of the provisions of the Criminal Justice (Amendment) Act 2009…to see if its provisions can be strengthened. Figures available with regard to the operation of the 2009 Act up to 31st January 2012 indicate that, although no convictions have been recorded, the legislation has been used on 160 occasions where arrests have been made relating to organised crime activity and eight individuals have been charged under the provisions. Two persons had been charged under Section 71A of the Criminal Justice Act 2006 as inserted by section 5 of the Criminal Justice (Amendment) Act 2009 (directing a criminal organisation) and six persons charged under Section 72 of the Criminal Justice Act 2006 as inserted by section 6 of the Criminal Justice (Amendment) Act 2009 (participating etc. in organised crime).' (Shatter 2012, 07 February).

Review of mandatory sentencing legislation

The Law Reform Commission (LRC) has highlighted in a consultation paper a number of serious deficiencies in the operation of the presumptive 10-year sentence for certain drug offences and has recommended that the provision be reviewed (Law Reform Commission 2012). Section 15A of the Criminal Justice Act 1999 created a new offence of possessing controlled drugs having a value of £10,000 (€13,000) or more for sale or supply, which attracted a presumptive sentence of 10 years' imprisonment, except where there were 'exceptional and specific circumstances' relating to the offence, or to the person convicted of the offence.

According to the LRC, the changes introduced in this legislation 'marked an important turning point in the Irish sentencing regime which had until 1999 – with the exception of the sentences for murder and capital murder – accorded primacy to judicial discretion in the determination of sentences' (p.102). This occurred 'against a backdrop of an escalating drug problem and a growing realisation that Ireland had become a portal not only to the Irish drugs market but also to the British and European drugs markets' (p.102).

In the years immediately following these provisions, however, the courts appeared resistant to allowing their discretion to be eroded in this way. The LRC paper cited a Department of Justice report on judicial sentencing practices for drug offences under

section 15A of the MDA, which concluded that 'the courts showed a marked reluctance to impose the mandatory minimum sentence … for fear that it would result in a disproportionate sentence in individual cases' (p.105). That report had found that, out of 55 cases between November 1999 and May 2001, a sentence of 10 years or more had been imposed in only three cases.

The LRC also suggested that further legislation was introduced to address this 'apparent rift which had developed between legislative intent and judicial execution' (p.102). Introducing the Criminal Justice Bill 2004, the government announced that it would be making a series of legislative amendments in order to strengthen the presumptive sentencing provisions for drug offences. In its final form, the Criminal Justice Act 2006 created a new offence of importing drugs having a value of €13,000, which would attract a minimum sentence of 10 years. In addition, it introduced provisions to oblige the court to consider evidence of previous drug trafficking convictions. It also clarified that the *mens rea* regarding the value of the drugs was not an element of the offence; consequently, 'the prosecution needed only to establish that the accused knew that he or she was in possession of drugs with intent to supply and not that he or she knew the value of the drugs involved.' (p.105)

Following a lengthy consideration of the way in which the legislation has been applied in the courts, the LRC highlighted a number of criticisms of the presumptive sentencing regime. As a consequence of the constraints it places on the exercise of judicial discretion, the LRC suggested that the regime had created 'a discriminatory system of sentencing where all cases are treated alike regardless of differences in the individual circumstances of the offenders' (p.189). The LRC also referred to an assertion that the sentence is akin to a 'one-strike rule'. In this regard the LRC referred to the observation of one sentencing expert that 'by contrast to the "three strikes" laws enacted in some US states, [the Irish regime] does not require the accused to have a previous conviction for drug dealing or anything else before the presumptive minimum may apply' (p.131).

The LRC also stated, 'it has been observed that the majority of those being caught for offences under section 15A are drug couriers rather than drug "barons"' (p. 132). Those at the higher levels of the drugs trade had simply adapted to the sentencing regime by using expendable couriers or 'victims of circumstance', such as 'impoverished individuals from African countries or underprivileged Irish citizens', to hold and transport drugs, thus avoiding detection themselves. The regime had also, the LRC concluded, subverted the normal criminal process by leading accused people to plead guilty simply to avoid the sentence, rather than testing the prosecution case.

In recommending a review of the sentencing regime, the LRC stated that the legislation had merely led to a 'bulge in the prison system comprising low-level drugs offenders' (p. 189) serving lengthy prison sentences, and that it had not contributed to any reduction in levels of criminality.

Medicinal cannabis

In response to a parliamentary question in relation to the possibility of changing the law to allow cannabis-based medicinal products such as Sativex to be prescribed by a medical practitioner in Ireland, the Minister of State at the Department of Health with special responsibility for the National Drugs Strategy, Róisín Shortall TD, stated: 'My Department is currently examining how cannabis-based medicinal products, such as Sativex, may be legally prescribed by medical practitioners and used by patients for the treatment of Multiple Sclerosis in Ireland.' (Shortall, Róisín 2012, 23 May).

Street sale of prescription drugs

The street sale of prescription drugs such as benzodiazepines and zimmovane (Z-Hypnotics) has been a topical issue in Ireland in recent years. In June 2012 two reports called for legal changes to address this issue (Lord Mayor's Commission on Antisocial Behaviour 2012) (Strategic Response Group 2012). Responding to a parliamentary

question on the issue, Minister of State at the Department of Health with special responsibility for the National Drugs Strategy, Róisín Shortall TD, stated:

> Under the Medicinal Products (Prescription and Control of Supply) Regulations, it is prohibited for a person to supply a prescription medicine except in accordance with a prescription and the supply must be made from a registered pharmacy by or under the personal supervision of a registered pharmacist. A person who contravenes these Regulations is guilty of an offence. The Regulations also make it illegal for prescription medicines to be supplied by mail order. The definition of mail order includes reference to electronic custom solicitation and order for supply. This includes ordering prescription medicines through internet sites. Furthermore, a person who has in his possession a prescription medicine containing a substance controlled under the Misuse of Drugs legislation for the purpose of selling or otherwise supplying it, is guilty of an offence under that legislation. My Department is reviewing the Misuse of Drugs Regulations with a view to introducing additional controls on certain prescription drugs being traded illicitly, for example benzodiazepine medicines. These additional controls include introducing import and export controls as well as an offence of possession, thereby assisting the law enforcement roles of Customs and of the Garda Síochána. (Shortall, Róisín 2012, 6 June).

1.3 National action plan, strategy, evaluation and co-ordination

1.3.1 National action plan and/or strategy

On 7 February 2012 the report of the National Substance Misuse Strategy Steering Group was launched (Department of Health 2012a). In 2009, having decided to include alcohol in a national substance misuse strategy, the government established this steering group, chaired by the Department of Health, to advise on a new strategy. The steering group was drawn from relevant government departments and agencies, medical professional bodies, the community and voluntary sectors and the alcohol industry. Its terms of reference were to:

- set out an evidence-based framework identifying effective policies and actions to tackle the harm caused to individuals and society by alcohol use and misuse;
- decide on appropriate structures and frameworks for an effective and efficient implementation plan for the National Substance Misuse Strategy;
- align, as far as possible, the proposed policies and actions with the existing pillars of the National Drugs Strategy; and
- make proposals for an overall National Substance Misuse Strategy, incorporating the National Drugs Strategy 2009–2016.

The steering group adopted a population-based approach. Its report contains 45 recommendations under the supply, prevention, treatment and rehabilitation, and research pillars ((Mongan 2012c), (Mongan 2012a)).

In response to a Dáil question on 27 March 2012, Minister for Health James Reilly TD commented that the steering group's report was 'encouraging public debate' and that an action plan would be developed on foot of the report for consideration by the government later in the year. He also noted that a national substance misuse strategy as such, combining drugs and alcohol, would not be developed until after 2016; in the interim, the proposed action plan on alcohol will be taken in conjunction with the National Drugs Strategy 2009–2016 as the overall National Substance Misuse Strategy ((Reilly, James 2012, 27 March)). }). In July 2012 it was reported that the action plan had been completed but that the government had deferred consideration of it until the autumn ((Cullen 2012)).

Author of a comparative study of alcohol and drug policy in Ireland between the 1950s and the 1990s (Butler 2002), Shane Butler compared the report of the National Substance Misuse Strategy Steering Group with the UK government's alcohol strategy, published in March 2012 (Butler 2012). He looked at three aspects:

1 *Ideological content* – apart from some specific policy proposals common to both reports, Butler commented that 'the ideological assumptions underpinning the two reports could not be more different'. The UK report focuses on 'alcohol misuse', targeting 'binge drinking', while the Irish report 'is based on a more hard-line, public health approach which identifies alcohol *per se* as a problem drug … and takes a scattergun approach to all alcohol consumption across the total population.' (p. 1)
2 *Policy status* – according to Butler, the British report is a government strategy, which the UK government is committed to implementing, while the Irish document is 'just a report to government which has been published by the Department of Health, and it would be foolish to confuse committee recommendations with Government decisions.' (p. 2)
3 *The implementation question* – noting that for a long time national governments have failed to turn alcohol policy aspirations into effective actions, Butler does not see any evidence in the two newest publications 'that things are about to change radically'. With regard to the Irish report, his prediction is based not so much on the tenor of the recommendations as on a break-down of policy co-ordination mechanisms:

> When the decision in principle was taken, at the end of March 2009, to integrate alcohol into Ireland's National Drugs Strategy, the real promise of change lay in the fact that this strategy had for more than a decade been based upon a cross-cutting or 'joined-up government' model, consisting of cross-cutting structures which ensured a much higher degree of policy integration than is the norm in the traditional 'silo' style of governance. However, this cross-cutting model of management of illicit drug problems has been largely abandoned in the meantime and, as the lead department for alcohol policy, Ireland's Department of Health is back to fighting a rearguard action against other sectors of government which have different policy interests to protect. (p. 2)

Butler concluded that there is little reason to believe that in the current economic difficulties the government would implement measures damaging to the drinks industry.

1.3.2 Implementation and evaluation of national action plan and/or strategy

In line with Action 59 of the NDS, which calls for the development of 'an overall performance management framework for the NDS across all Departments and Agencies to assess and monitor progress', an update on implementing the 63 actions in the NDS is published annually. A summary of the 2011 report (Department of Health 2012b) is set out Table 1.3.2.1. It shows that progress was made in implementing 49 of the 63 actions, while 12 did not progress at all because of either insufficient resources or legislative and/or administrative delays. Two actions were dropped: in 2011, the Office of the Minister for Drugs, established on foot of Action 57 in the NDS, was subsumed in the Department of Health and its work split between a policy unit and a programmes unit, and following consideration, it was decided not to establish a dedicated treatment agency (Action 63).

While reporting on implementation of individual actions, the annual report does not report on progress in relation to the key performance indicators and objectives set under each pillar in the NDS, or on the achievement of the overall strategic aims and objective specified in the NDS. Moreover, while a review of the previous NDS, covering the period 2001–2008, was undertaken at the mid-way point (Department of Community Rural and Gaeltacht Affairs 2005), a similar mid-term review of the current NDS, covering the period 2009–2012, has not yet been announced.

Table 1.3.2.1 Progress reported in implementing actions in NDS, December 2011

Pillars	Reported status of actions	Further information in other Sections
Supply reduction	*Actions under way or completed*	
	◦ community and voluntary sector participation in various fora addressing local drug-related policing issues (Actions 2 & 4)	
	◦ drug-related intimidation – a framework for assisting those subject to drug-related intimidation has been developed by the Gardaí in conjunction with the FSN; and a pilot project is being conducted in the Dublin Metropolitan Region with regard to drug-related intimidation and the use of children in the drugs trade (Actions 3, 5 & 7)	
	◦ implementing measures to reduce the supply of drugs in prisons continues (Action 8)	9.7
	◦ drugs and driving, and how to tackle it, continue to be the subject of research, legislative development and training (Action 9)	1.2.1
	◦ the prohibition of the sale of alcohol to persons under 18 years of age is the focus of ongoing Garda law enforcement activities (Action 10)	
	◦ a presumptive testing process was introduced in February 2010 (Action 12)	
	◦ the Drug Treatment Court is currently under review, following a previous review completed in May 2010 (Action 13)	9.6.1
	◦ continuing international co-operation with the EU, the EMCDDA, the WCO, MAOC – Narcotics in relation to the emergence of new synthetic substances, drug precursors, drug trafficking, and collection of data regarding drug seizures (Actions 14–18)	10.2.2
	Actions on hold	
	◦ integrated system to track progress of offenders with drug-related offences through the criminal justice system owing to insufficient funding (Action 6)	
	◦ plans for a new Forensic Science Laboratory, owing to public expenditure restrictions (Action 11)	
Prevention	*Actions under way or completed*	
	◦ school-going population – ongoing prevention and education work, including research and development of education and prevention initiatives (e.g. SPHE), targeting early school leavers and keeping students in school (Actions 20, 21 & 31)	3.3.1
	◦ young people outside the school environment – ongoing prevention and education work, e.g. in Youthreach Centres of Education, VTOs, and community training facilities, through DCYA initiatives including the National Quality Standards Framework for Youth and a Children and Youth Strategy, which is currently under development, and through the provision of facilities for young people, e.g. late-night soccer leagues, youth cafés (Actions 23, 24 & 25)	3.3.3, 3.5.1
	◦ information and communications technologies continue to be developed via the internet, digital media and social media to provide news, information, help, and self-assessment tools (Action 27)	3.6
	◦ a sustained range of awareness campaigns including the 2010 national drug awareness campaign 'Legal or illegal highs – they are anything but safe'; production of two specific videos on problematic use of codeine and benzodiazepines; and a national awareness campaign planned for 2012 on issues relating to alcohol (Action 28)	3.6
	Actions on hold or delayed	
	◦ four actions that call for an integrated approach to developing drugs and alcohol prevention and education policies and targeted interventions are on hold, pending the completion of the National Substance Misuse Strategy (Actions 19, 22, 26 & 30)	
	◦ interventions to support families, parents and children – acknowledging initiatives taken at the regional and local levels, the authors of the report commit to a more co-ordinated approach at national level in the coming years, with the HSE and Department of Education adopting 'a planned and inclusive approach bearing in mind each organisation's core responsibilities' (Action 29)	
Treatment and rehabilitation	*Actions to enhance services under way or completed*	
	◦ evaluation framework for rehabilitation services being piloted (Action 32)	5.2.1
	◦ national directory of service providers at advanced stage of development (Action 33)	
	◦ expansion of detox., methadone, under-18s, and needle exchange services across the country (Action 34)	5.2.1–2
	◦ two groups set up to implement recommendations of the 2010 methadone treatment protocol review, including a national data collection, collation and analysis group, and a group to develop clinical guidelines on the treatment of opioid addiction (Action 35)	5.2.2
	◦ guidelines, frameworks and procedures to support the identification and referral of people presenting with drug or alcohol issues, be they adults, under-18s or those in contact with the Gardaí or the Probation Service (Actions 36, 37, 38 & 51)	
	◦ draft strategy for dealing with blood-borne viruses completed (Action 39)	7.3
	◦ national overdose prevention strategy being finalised (Action 40)	7.2
	Action on hold	
	◦ a pilot short-stay respite programme for families of problem drug users, owing to lack	

Pillars	Reported status of actions	Further information in other Sections
	of resources (Action 41);	
	Actions ongoing in relation to specific groups ° expansion of treatment and other health and social services in prison continues (Action 43) ° HSE actively engages with bodies representing minority groups via various social fora and associated governance fora (Action 44) *Actions delayed* ° protocol for seamless provision of treatment services as a person moves between prison and the community in place but lack of community places can present challenges (Action 43) ° problems remain with the remand population as the Irish Prison Service cannot influence releases directed by the Courts (Action 43)	9.8
	Action under way in relation to quality and standards ° quality and standards framework is being rolled out, with 100 projects countrywide being supported in implementing the QuADS (Quality Standards in Alcohol and Drugs Services), and an evaluation phase being piloted (Action 45) *Actions on hold* ° appointment of two additional clinical director posts for addiction treatment in HSE South and HSE West delayed because of moratorium on new staff appointments (Action 45) ° a regulatory framework for counselling services not to be considered until after 2014/2015, when registration of the 12 health and social care professionals listed in the Health and Social Care Professionals Act 2005 will have been completed (Action 46)	
	Actions under way in relation to training and skills and development ° the National Addiction Training Programme (HSE) has developed training based on core principles from the NDRIC Rehabilitation Framework, including modules on key working, care planning and case management, and is piloting this training in 10 sites (Action 47) ° while an 'appropriate educational model' for paramedics, nurses and midwives has not been developed, reviews of the standard of education in these professions have been completed or are under way (Action 48)	
Research and information	*Actions under way or completed* ° work is ongoing in respect of the five key EMCDDA epidemiological indicators and new indicators in relation to harm reduction, public expenditure and drugs and crime (Actions 49 & 50) ° the NACD's Early Warning and Emerging Trends Sub-Group is developing an annual report to support Ireland's full participation in the EU EWS, and a communications protocol for notifying frontline health services, clinicians, drug-related services and the general public about drug use emergencies (Action 54). ° in 2011 the NACD adopted a corporate policy on data management, including procedures for sharing NACD data with third parties (Action 56).	
	Actions on hold ° reform of the Coroner Service owing to insufficient funding (Action 53); ° introduction of a unique identifier in the health system, pending passage of the Health Information Bill (Action 52); and ° drug-related research programme, awaiting the reconstitution of the National Advisory Committee on Drugs (Action 55).	

Source: (Department of Health 2012b)
* Actions under the Co-ordination pillar are discussed in Section 1.3.4 below.

In March 2012 the *Programme for Government: Annual report 2012*, reporting on the coalition government's first year in office, was published (Government for National Recovery 2011–2016 2012).[2] As well as noting the completion of the report of the National Substance Misuse Strategy Steering Group (see Section 1.3.1 above), the document reported progress on the three drug-related 'key priorities' relating to treatment, rehabilitation and harm reduction. Progress in relation to the other eight

[2] See Section 1.3.1 of Ireland's 2011 Report to the EMCDDA Irish Focal Point (Reitox) (2011). 2011 National Report (2010 data) to the EMCDDA by the Reitox National Focal Point. Ireland: new developments, trends and in-depth information on selected issues. Health Research Board, Dublin. Available at http://www.drugsandalcohol.ie/16812/ for a full account of *Towards recovery: programme for a National Government 2011–2016* Fine Gael and the Labour Party (2011). Towards recovery: programme for a national government 2011–2016. pp. 64. Fine Gael, Labour Party, Dublin. Available at www.drugsandalcohol.ie/14795/.

priorities, mainly in the supply reduction and prevention areas, was not reported, although steps have been taken in some of these areas (see Table 1.3.2.2).

Table 1.3.2.2 Progress in implementing drug-related 'key priorities' in *Programme for Government 2011–2016*, March 2012

Key priorities	Update in Programme for Government annual report 2012	Further information in other sections
Review of the Drug Treatment Court programme	The catchment area of the Drug Treatment Court was extended significantly with effect from July 2011. A review of the court commenced in early 2012 with a view to completion by Q3, 2012 (p. 31).	9.6.1
Rehabilitation services including expansion of places across country, provision of services at local level, participation in community employment schemes, and introduction of compulsory as well as voluntary programmes	Clients can usually access methadone provision within one month of assessment in Dublin and there is now a focus on increasing the availability of services outside Dublin. An increased number of detox facilities have also come on stream in a number of locations (p. 31).	8.3
Needle exchange programmes expanded across the country where needed most	A major expansion is taking place in the provision of needle exchange services to over 60 community pharmacies at various locations outside Dublin (p. 31).	
Roadside drug testing	–	1.2.1
Prison sentences versus non-custodial alternatives	–	1.2.1
Mandatory sentencing	–	1.2.2
Supply reduction and criminal assets seizures	–	10.2–3
Reduction of flow of drugs into prisons	–	9.7
Customs controls to combat drug supplies at source	–	–
Budget transparency and accountability	–	1.4
Prevention measures including drug awareness programmes in schools, preventing addiction in schools, and introducing Education Prevention Units in all task forces	–	3.3

(Government for National Recovery 2011–2016 2012)

1.3.3 Other drug policy developments *e.g. government declaration, civil society initiatives*

Government revises poverty targets

In April 2012 the government (Department of the Taoiseach 2012) announced it was abandoning the national ambition to eliminate consistent poverty in Ireland, as set out in the national action plan for social inclusion 2007–2016 (Office for Social Inclusion 2007).[3] This decision was made following public consultation, engagement with key stakeholders, and an EU peer review on the setting of national poverty targets, which Ireland hosted in June 2011, and which was attended by nine member states, the European Commission and European stakeholders. Table 1.3.3.1 summarises the change in ambition.

Table 1.3.3.1 Targets for reduction of consistent poverty, Ireland, 2007 and 2012

Target Level for Consistent Poverty	2012	2016	2020
National Action Plan for Social Inclusion 2007–2016	2–4%	0%	–
National Reform Programme for Ireland: 2012 Update	–	4% max.	2% max.

Sources: (Office for Social Inclusion 2007); (Department of the Taoiseach 2012)

[3] 'Consistent poverty' is defined by the Social Inclusion Division in the Department of Social Protection (www.socialinclusion.ie) as' the proportion of people, from those with an income below a certain threshold (less than 60% of the median income), who are deprived of two or more goods or services [an 11-item index] considered essential for a basic standard of living'.

Explaining the change, the government stated that between 2008 and 2010, ' …numbers in consistent poverty rose from 186,000 to 277,000, representing an increase of almost 50% on the 2008 figure … the rise in the numbers in consistent poverty over that period reflects the impact of the economic and fiscal crisis in Ireland, and in particular almost a trebling of the unemployment rate, from 4.5% in 2007 to 13.6% in 2010. There was also an effect from the programme of fiscal consolidation on social welfare adult and universal child payment rates' (p. 15).

The policy approach to meeting the poverty target remains that set out in the national action plan for social inclusion 2007–2016, based on three inter-connecting themes of income support, activation and services. The government also asserts that improving the position of vulnerable groups, including children, lone parents, people with disabilities, and jobless households, will remain critical to the achievement of the national poverty target.

Government prioritises child welfare and protection

Following a commitment in its programme for government, in March 2011 the new coalition government appointed a Minister for Children and Youth Affairs and established a Department of Children and Youth Affairs (DCYA).[4] The new Minister, Frances Fitzgerald TD, and her department have completed the following initiatives relevant to the drugs issue.

In 2011 the revised *Children first: national guidance for the protection and welfare of children* (Department of Children and Youth Affairs 2011) and the supporting *Child protection and welfare practice handbook* (Health Service Executive 2011b) were published. They include discussion of the risks arising for children of drug-using parents and approaches to addressing the risks (see Section 12.4.2 of Ireland's 2011 Report to the EMCDDA (Irish Focal Point (Reitox) 2011) for detailed description).

In October 2011 the NACD, HSE and Alcohol Action Ireland hosted a one-day seminar, attended by policy makers and service providers, at which a report, *Parental substance misuse: addressing its impact on children* (Horgan 2011), was launched. Having reviewed all the major international research on the impact of parental substance misuse on children, author Dr Justine Horgan, senior researcher with the NACD, identified five priority areas for policy makers, service providers and researchers to consider:

- *Consequences of parental substance misuse for child development*: substance misuse during pregnancy can have harmful effects on the baby.
- *Consequences for parenting and family life*: the stress owing to parental substance misuse combined with the increased likelihood of the child being in care and/or suffering homelessness, results in these children being at a high risk of emotional isolation and/or social marginalisation.
- *Impact on child outcomes*: for many affected children, the effect continues into their adult lives; for some, the impact can be multifaceted and persist not only into adult life but even into the lives of the next generation.
- *Response to parental substance misuse*: more integrated working between addiction services, children's services and medical professionals is needed to help reduce the negative impact of parental drug and alcohol misuse on children and the wider family.
- *Future research and data needs*: five research areas are identified that would help to fill gaps in Ireland's research, statistics and information regarding children of parents who misuse drugs.

Key recommendations included:

- Additional research and data collection to properly estimate the number of children whose parents have substance misuse problems.

[4] Prior to March 2011, children and youth affairs policy had been handled by the Office of Children and Youth Affairs located in the Department of Health and Children.

- The HSE *Children First* guidelines to be used by all services and organisations working regularly with children who experience parental substance misuse and with their parents.
- Assess the extent to which adult alcohol and drug treatment services are supporting parenting and liaise with child support and other relevant services.
- Assess the extent to which professional education and training in areas such as youth work, psychology, addiction support, guidance, counselling and childcare can address children affected by parental substance misuse.
- Educate women on the adverse effects of consuming alcohol and drugs during pregnancy and train medical professionals so that they can raise awareness among their patients of the risks of consuming these substances.
- Consider appropriate interventions and ways of working for primary health care staff who are involved in the early stages of children's lives such as public health nurses, GPs and community mothers.

In June 2012 the report of the Independent Child Death Review Group (ICDRG) was published (Shannon and Gibbons 2012).[5] The review group investigated the deaths (between 1 January 2000 and 30 April 2010) of 196 children and young people who were in care, in receipt of aftercare or known to the child protection services in Ireland at the time of their death. Of the 196 deaths, 112 were due to non-natural causes. The breakdown of deaths over the ten-year period was as follows:

Children (aged 4–17 years) in care: 36 deaths
- 19 deaths from natural causes
- 17 deaths from non-natural causes

Children and young people (aged 18–23 years) in aftercare: 32 deaths
- 5 deaths from natural causes
- 27 deaths from non-natural causes

Children (aged <1–17 years) known to the HSE: 128 deaths
- 60 deaths from natural causes
- 68 deaths from non-natural causes

The ICDRG examined the files and reports of the HSE in respect of all 112 children and young people who died of non-natural causes and provided a comprehensive case summary for each individual, together with summaries of good practice and causes for concern in each case.

The ICDRG reported that the examination of the files showed that 17 of the 112 children and young people had a history of problem alcohol use and 29 a history of problem drug use. Thirty (27%) of the 112 non-natural deaths were directly drug-related:
- children (aged 4–17 years) in care: 5 (29%)
- children and young people (aged 18–23 years) in aftercare: 14 (52%)
- children known to the HSE (aged <1–17 years): 11 (16%)

The review group did not give details as to which drugs caused the deaths. The other causes of non-natural death were:
- 28 (25%) due to suicide;
- 17 (15%) due to road traffic collisions;
- 16 (14%) were unlawfully killed; and
- 21 (19%) due to other accidental or unknown causes.

Many of the children also lived with problem alcohol use (n=37) or problem drug use (n=19) in the home. The ICDRG noted the HSE was aware of drug and alcohol misuse problems among the families:

[5] The ICDRG had been established by the previous Fianna Fáil–Green Party coalition government in March 2010.

> … the HSE was aware of drug and alcohol abuse within a number of families, in particular by parents, which must as a natural consequence have given rise to concerns as to the welfare of the children, yet the HSE closed their files in a number of these cases despite the drug and alcohol abuse continuing. Children are vulnerable by their very nature and not to continue to attend to these issues and the implications for their welfare is to expose them to too great a risk of harm. Risk indicators such as this were not followed up adequately, or at all, by the HSE in a number of the files. In some cases no social worker was assigned to these families. (p. xxiii)

The ICDRG made the following recommendations with regard to how social workers should involve drug and alcohol services, and conversely how drug and alcohol services should work with the child welfare and protection services:

> In a significant number of cases, it was evident that drug and/or alcohol abuse by parents was having a very damaging effect on their ability to consistently parent their child. Indeed, in some cases, drug and/or alcohol abuse was the key factor in the child/young person being referred to the HSE or being taken into care. This is a problem which has to be tackled. When a Social Worker comes into contact with a family where drug/alcohol abuse is significantly disrupting familial life, it is essential that such abuse is addressed in a robust manner. The effect on the children has to be recognised and the parents must be made aware of the support and treatment options that are available. Parents must be encouraged and enabled to take up those supports.
>
> Furthermore, drug and alcohol services must be actively integrated into the child protection system. These services have the capacity to alert Social Workers to potentially devastating events happening between parents with drug and/or alcohol problems and their children often before the children are ever referred to the HSE. There must be open channels of communication between drug and alcohol services and the child protection system so that where these services become aware of child protection concerns, this information is quickly conveyed to the child protection system. The planning around these children and families must actively engage each part of the system. (p. 409)

Other child-related initiatives relevant to the drugs issue currently under way include:[6]

- A Child and Family Support Agency (CFSA) is due to be established in early 2013. In July 2012 a task force reported to the Minister for Children and Youth Affairs, setting out recommendations with regard to governance, organisation structure, scope of services and service mode. Its overall approach is summarised as follows: 'It is crucial that certain services for children are now realigned from across a number of agencies into a single comprehensive, integrated and accountable agency for children and families' (Department of Children and Youth Affairs 2012): p. vii). Under the direction of the DCYA, this agency should 'provide leadership' to relevant statutory and non-statutory agencies to ensure that the conditions needed for children's well-being and development are fulfilled.
- The Children First Bill, introduced in 2012, will strengthen the child protection framework set out in the *Children first: national guidance for the protection and welfare of children* (Department of Children and Youth Affairs 2011). Organisations coming within the meaning of the Bill, including drug-related services, will have a statutory obligation to report a concern or an allegation of child abuse to the HSE.
- A Children and Young Peoples Policy Framework, to cover the period from 2012 to 2017, is being developed by the DCYA in a holistic way to comprehend the continuum of the life course from infancy, through early and middle childhood, to adolescence through to early adulthood. It will bring together policies of relevance to children and young people, including those relating to prevention and early intervention initiatives, early childhood education, breaking the cycle of

[6] If not otherwise indicated, the following information was taken from the website of the Department for Children and Youth Affairs www.dcya.ie on 14 June 2012.

disadvantage through area based approaches to address child poverty, addressing youth homelessness and aftercare provision, and addressing issues around anti-social behaviour (Fitzgerald 2012, 15 May-b).

- Funding has been secured to end the practice of sending under-18s to St Patrick's Institution over the next three years and the end of the practice of sending 16-year-olds to St Patrick's has already been announced (Fitzgerald 2012, 15 May-a).[7]

Parliamentary activity

Established in June 2011 by the new coalition government, the Joint Committee on Health and Children in the 31st Dáil decided that an early priority would be to consider the issues surrounding the misuse of alcohol and other drugs. In the course of its discussion on the misuse of drugs, committee members asked whether it was time to consider the drug policy options preferred by Portugal and the Netherlands, i.e. eliminate criminal sanctions for illicit drug users (Dowds 2011, 22 September), and whether it was time to consider allowing people with a complete physical and chemical dependence on heroin or morphine to get their heroin or morphine in well-supervised, clean, incorruptible circumstances, i.e. establish safe injecting facilities (Crown 2011, 15 September).

In January 2012 the Joint Committee on Health and Children published its conclusions in a report on the misuse of alcohol and drugs (Joint Committee on Health Children 2012). The committee's overarching aim was to highlight the prevalence of alcohol and other drugs in society and to emphasise the misuse of alcohol in particular. The report was based primarily on published research on the issue of alcohol and drug misuse, submissions made to the committee by stakeholders (including some 20 or so groups from the statutory and voluntary sectors), and transcripts of the committee's discussions.

The Joint Committee formed the opinion that no single measure will solve the problem of alcohol use and that a package of measures is needed to change attitudes, as well as behaviours, regarding the consumption of alcohol. With regard to the misuse of illicit drugs, the committee made recommendations with regard to the following aspects:

- *Supply reduction:* In light of the spread of grow houses in Ireland, legislation is needed criminalising the importation of cannabis seeds. Stricter controls are needed in relation to the importation and prescription of benzodiazepines.
- *Prevention and education*: The government should consider how a programme of new, preventative, educational initiatives, aimed at the general public, could be devised to highlight the implications and dangers of alcohol and drug misuse, and to influence prevailing cultural attitudes, particularly with regard to the use of alcohol.
- *Treatment and rehabilitation*: There should be renewed emphasis on the implementation by the HSE of the four-tier model, and more resources should be allocated to drug rehabilitation services, to significantly increase the number of dedicated inpatient detoxification beds, and to reduce waiting times to access drug services across the country.

Although the Joint Committee discussed evidence regarding four population sub-groups at greater risk of drug and alcohol misuse than the general population, it only made a recommendation with regard to two of these groups – early school leavers and young people – in relation to whom it recommended that youth work and peer support be considered as an integral part of any strategy aiming to divert children away from substance misuse. The committee did not make any recommendations regarding substance misuse in the lesbian, gay, bisexual and transgender (LGBT) community, or in the Traveller community. The committee also did not consider the wider issue of the

[7] According to the website of the Irish Prison Service, www.irishprisons.ie, accessed on 25 June 2012, St Patrick's Institution is 'a closed, medium security place of detention for males aged 16 to 21 years', accommodating both remand and sentenced prisoners.

relationship between socio-economic disadvantage and deprivation and substance misuse.

In March 2012, during a discussion with the Joint Committee on Health and Children on the report of the steering group on the national substance misuse strategy, the Minister of State at the Department of Health, with responsibility for Primary Health (including the NDS), Róisín Shortall TD, acknowledged the report of the Joint Committee, stating: 'We have two very comprehensive reports which will form the basis of future early action in this area' (Shortall, Róisín 2012, 15 March).

Civil society initiatives

Civil society organisations (CSOs) were active throughout the reporting period, hosting conferences to disseminate information on evidence-based practice, and publishing documents or organising events to promote particular practices or to influence policy. Two innovative mechanisms for seeking to develop and influence policy included the assembling of a 'strategic response group', a cross-city inter-agency group, formed under the auspices of the Lord Mayor of Dublin and the Dublin City Local Policing Forum, and the formation of a 'drug policy alliance' of CSOs, spearheaded by the CityWide Drugs Crisis Campaign.

Conferences

In October 2011 Kerry Life Education, in partnership with the Southern Regional Drugs Task Force, hosted its eighth annual national conference on substance and alcohol misuse for local authorities, the public service and drug/alcohol service providers, in Killarney. The title of the conference was 'Getting a grip 2011: substance misuse – a health or criminal justice issue?'

In November 2011 the Irish Needle Exchange Forum, which exists to actively develop, support, and sustain a network of high quality, comprehensive needle exchange and other harm reduction services across Ireland, hosted its second annual National Drugs Conference of Ireland (NDCI). The conference theme was 'Drug interventions: what works?' (Mongan and Nelson 2012).

Two inaugural conferences were organised during the year, one focusing on young people and mental health and one on neuroscience and addiction recovery:

- In October 2011 a special interest group within the *Association for Child and Adolescent Mental Health (ACAMH)*, Youth Mental Health, held its first national research conference, 'Emerging evidence on youth mental health: multi-disciplinary perspectives'. One session focused entirely on research on substance use among young people (Dunne, Mary 2012a).
- In November 2011 the first international *NEAR (Neuroscience and addiction recovery)* conference took place in Ireland. The purpose was to explore the latest neurological developments on potential causes and treatments, and to educate delegates about the latest evidence based recovery practices and their application (Dunne, Mary 2012b).

Publications

In October 2011 Barnardos and the Family Support Agency (FSA) launched a resource for children, teenagers and their parents to support them in understanding and dealing with difficulties that can result from a parent's problem drug or alcohol use (Barnardos 2011). November 2011 saw Ballymun Youth Action Project (BYAP) launch two reports on substance misuse to mark the final event celebrating its 30th year (McGuire 2012). The first report, *Seen but not heard?* (Ballymun Youth Action Project 2011), highlights the need for all agencies working in the drugs field to adopt a more integrated approach in addressing the drugs problem, while the second report, *Fact or fiction?* (Herbert and Fennelly 2011), looks at young people's attitudes to drugs and alcohol-related issues.

Several papers have been published calling for radical changes to Ireland's criminal justice and penal systems. In September 2011 Fr Peter McVerry SJ wrote an article in *Working Notes*, the magazine published by the Jesuit Centre for Faith and Justice (JCFJ), calling for a radical appraisal of current approaches to dealing with illegal drug use (McVerry 2011). Noting that 'drug policy' encompasses both policies to deal with the supply of drugs and policies to deal with demand, he says that addressing supply absorbs by far the greater share of public expenditure. Yet, despite successes in intercepting supplies, the inflow of drugs continues, with powerful criminal gangs controlling this trade. He suggests that the findings and recommendations of the 2011 Global Commission on Drug Policy provide some useful guidelines for the much-needed public and political debate on the issue. In relation to policies to control demand, McVerry highlights the importance of addressing demand among those who are habitual users or who are addicted to drugs. He emphasises the need for a comprehensive range of detoxification, rehabilitative and after-care services, and says that it is essential that these be accessible without undue delay.

In February 2102 the Irish Penal Reform Trust (IPRT) published a paper highlighting the causative connection between social exclusion, deprivation and crime (Irish Penal Reform Trust 2012). The paper argued that marginalised communities are more heavily policed and that people from these communities receive more severe punishment than those from more affluent communities. It also argued that cuts to community-based services would exacerbate crime rates (see Section 9.5 for more detail). In March 2012, the JCFJ published a report calling on the government to radically reform its approach to imprisonment and bring an end to what it describes as 'the bankrupt policy of recent decades' (Jesuit Centre for Faith and Justice 2012). The report provides a detailed analysis of research into the links between imprisonment and socio-economic deprivation, which include poor education, unemployment, homelessness, and the incidence of mental illness and substance misuse among prisoners (see Section 9.7 for more detail).

In June 2012 the report of a Strategic Response Group (SRG) on public substance misuse and perceived anti-social behaviour in Dublin city centre was published (Strategic Response Group 2012) (see Sections 9.5, 9.6.1, and 12.3 for more detail). Formed under the auspices of the Lord Mayor of Dublin and the Dublin City Local Business Policing Forum, the SRG comprised a cross-city/inter-agency group whose objective was to develop ways to build sustainable street-level drug services and address related public nuisance.

Events

In December 2011 the Dales Centre in co-operation with CityWide Drugs Crisis Campaign hosted a seminar in Dublin, inquiring how changing patterns of drug use had impacted on individuals, communities and treatment services (Bellerose 2012). Chairperson of the Dales Centre, Declan Andrews, stated that the shift in Dublin from what had been a heroin problem to what was now an increasingly complex problem of multiple substance use had put a lot of pressure on services, especially when funding cuts were having a dramatic impact on the delivery of such services.

In February 2012 the Family Support Network (FSN) held its 13th annual service of commemoration and hope, entitled 'Growing Strong Together', in remembrance of those lost to drugs and related causes and to publicly support families living with the devastation that drug use causes (Lynn 2012). In her address to the gathering, Sadie Grace of the FSN highlighted current issues involving the FSN, including: recommendations to government from the FSN bereavement group, the setting up of a bereavement support group, nationwide training within family support groups, working with gardaí to assist victims of intimidation and working on a regional response to Garda harassment. The growth of family support groups throughout Ireland was evident at the service, with over 100 groups from across the island of Ireland represented.

In February 2012 CityWide Drug Crisis Campaign, along with SIPTU (Services, Industrial, Professional and Technical Union),[8] voluntary organisations, community drug services, church organisations, members of the artistic community and others, launched a broad-based drugs policy alliance to give a renewed impetus to the response to the drugs crisis in Ireland. Speaking in advance of the launch, Fergus McCabe of CityWide said:

> Citywide and the communities we represent have always tried to cooperate with Government in the promotion and implementation of the national drugs strategy. But over the past few years this has become more and more difficult. Government are moving away from a partnership approach and this is undermining the delivery of the strategy. We are confident that our coming together as an alliance will help strengthen the voice of the NGO drug sector and will locate the drugs issue squarely back on the political agenda. (CityWide Drugs Crisis Campaign 2012, 17 February).

This was backed up by Joe O'Flynn, general secretary of SIPTU, who said:

> SIPTU are fully committed to supporting this new initiative. We need to ensure that our national drugs strategy is being defended across all departments. The principles of partnership cannot be abandoned simply because of our economic problems. It's at times like these that we need effective partnership - not less partnership. (CityWide Drugs Crisis Campaign 2012, 17 February).

In September 2011 Tony Geoghegan, director of Merchants Quay Ireland (MQI) and a community and voluntary sector representative on the steering committee that drew up the NDS and on the steering group that examined integrating alcohol into the drugs strategy, had already highlighted the concerns of the voluntary sector with regard to the demise of the partnership approach:

> The core of the national drugs strategy was the bringing together of the statutory, voluntary and community sectors directly to solve problems in a collaborative way. The decision-making has now been pulled back from that forum into the Department. Certainly that is how it appears as a member of the voluntary sector and I am aware that the community sector holds the same belief. The greatest step I would take to try to address and make a success of the strategy would be to ensure that decision making is collaborative and that the community and voluntary sectors are directly involved. It is all the more necessary in a time of reducing resources to involve the community and voluntary sectors in such decisions rather than imposing decisions from a central source. (Geoghegan, Tony 2011, 15 September-b)

Announcing the drug policy alliance, CityWide also launched a policy statement containing an eight-point agenda for action (CityWide Drugs Crisis Campaign 2012):

1. make partnership work;
2. improve protection, reporting and prosecution of debt intimidation;
3. systematically tackle gang activity;
4. support families, children and young people most at risk;
5. build community resilience;
6. strengthen information and harm reduction messages;
7. direct ‘profits’ from problem drug use (i.e. funds seized by the Criminal Assets Bureau) and introduce a social responsibility levy (on drinks industry); and
8. debate decriminalisation.

[8] SIPTU represents over 200,000 workers from virtually every category of employment across almost every sector of the Irish economy.

1.3.4 Co-ordination arrangements

The NDS contains six actions under the Co-ordination pillar. An update on implementation of these actions was included in the 2011 progress report (Department of Health 2012b). It shows activity with regard to all actions (Table 1.3.4.1).

Table 1.3.4.1 Progress in implementing Co-ordination actions in NDS, December 2011

Action	Reported status
57. Establish an Office of the Minister for Drugs (OMD) with the roles and responsibilities outlined in chapter 6 of the NDS.	The OMD role was subsumed into the Department of Health in May 2011 and is now undertaken by the Drugs Policy Unit and the Drugs Programmes Unit.
58. Establish the Oversight Forum on Drugs (OFD) with the terms of reference set out in chapter 6 of the NDS.	The OFD has been established
59. Develop an overall performance management framework for the NDS across all departments and agencies to assess and monitor progress.	Performance is being managed by the Department of Health through the operation of the Oversight Forum on Drugs (OFD) and through the monitoring of progress on the actions of the NDS. Annual reports monitoring progress on the actions in the NDS will be published on the Department of Health website.
60. Continue to develop engagement with specifically identified at risk groups, including: ° Travellers ° new communities ° LGBTs ° homeless ° sex workers at the appropriate national/regional/local level in the design and planning of interventions under the NDS.	A dedicated sub-group of the Drugs Advisory Group (DAG) produced a report identifying a range of measures to help progress the implementation of this action and Actions 41, 42, and 44. The implementation of this report will be monitored by the DAG.
61. Develop protocols between relevant departments and agencies to ensure that a more co-ordinated approach is put in place to support Ireland's international role and responsibilities in relation to problem drug use.	Protocols between relevant departments and agencies have been agreed. The International Drugs Issues Group, involving relevant departments and agencies, meet on an ongoing basis. In the context of Ireland's Presidency of the EU (Jan-Jun 2013) an Irish EU Presidency Drugs Steering Group has been established.
62. Review and renew the participation and commitment of members of the drugs task forces (DTFs). Revise the DTF Handbook to take account of the new structural arrangements. Review DTF boundaries. Examine the optimum structure for the employment arrangements of DTF personnel.	A review is being undertaken of DTFs and the associated national structures which underpin the NDS. Having regard to the outcome of the review, measures will be developed to implement reforms in this area.

Source: (Department of Health 2012b)

With regard to Action 62, the new coalition government has initiated two separate reviews that will impact on the structure and functions of the country's 24 DTFs. Neither review has been completed but interim reports have been published and are summarised below. It is anticipated that the recommendations from these reviews, when taken in conjunction with the recommendations expected from concurrent public expenditure reviews (see Section 1.4 below), will most likely lead to:

- revamped national co-ordinating structures;
- revised funding arrangements, with statutory agencies playing a greater role;
- an enhanced role for local authorities; and
- a reduced number of drugs task forces, and consequent changes in their composition and roles.

Concerns expressed by researchers and civil society organisations regarding the current functioning of co-ordinating mechanisms are also reported in this section

Review of structures underpinning the NDS

In September 2011 the Minister of State in the Department of Health with responsibility for Primary Care, Róisín Shortall TD, informed the Cabinet Committee on Social Policy that she was initiating a review of DTFs, focusing on the role and composition of drugs task forces and the national structures under which they operate, the funding arrangements, and where appropriate transferring responsibility for funding to relevant

statutory agencies, and overhauling the accountability and reporting arrangements of the drugs projects that continue to be supported by the DTFs.

In October a consultation process was initiated with government departments and statutory bodies, with community and voluntary bodies, and with the DTFs , and in February 2012 an interim report summarising the responses from these three groupings to six 'key questions' was released (Drugs Programmes Unit 2012). With regard to the first question – 'how can national structures be improved to provide better engagement with task forces?' – there was a general consensus that the co-ordinating structures set up under the NDS 2009–2016 needed to be improved. Various approaches were suggested.

A review of roles and responsibilities of the existing structures was called for, including:

- clarification of the relationship between the OFD and the DAG and the relative authority and terms of reference of each;
- consolidation and enhancement of the role of the Drugs Programmes Unit (DPU) in the Department of Health in managing operational DTF issues and in overseeing and monitoring the delivery of the NDS, through introducing clear governance protocols in relation to commissioning services, quality standards and clinical governance;
- review of the fitness for purpose of the DTFs, following the expansion of their remit to include alcohol; and
- a cost-benefit analysis of the task forces, focusing on their interagency work, governance and their relationship with projects.

New structures were proposed, including:

- a dedicated Minister for Drugs with super junior status;
- a national implementation group led by the departments of Health and of Justice to drive and support the implementation of the NDS;
- a national implementation body (NIB), a cross-departmental team constituted as a partnership between the statutory, community and voluntary sectors, to drive the implementation of the NDS, with the OFD having a monitoring role only. The proposed NIB would ensure that lead agencies include prioritised NDS actions in their work plans and support drugs task forces; would have oversight and decision-making powers; liaise with the HRB on the evidence base; and include representatives of the Department of the Taoiseach, YPFSF, NACD, and NDRIC.
- a reduction in the number of DTFs, based on an assessment of what constitutes a 'viable' task force; and
- a review of DTF boundaries, with local development companies becoming involved in implementing the NDS.

Processes also need to be reviewed, including:

- an annual meeting between the DTFs and the Minister for Justice to discuss agreed agenda items and with the DPU/DAG on their annual report;
- the DTF Chairs networks to meet more regularly with the DAG group or subgroup;
- quarterly reports by DTFs to the DAG on the implementation of the NDS; and
- involvement of the liaison personnel on the DAG in the strategic direction of the DTFs.

The final report and recommendations with regard to the role and composition of DTFs and governance and funding arrangements have yet to be published. The Cabinet Committee on Social Policy advised the Minister of State that her review should link in with, take cognisance of, a separate review regarding the alignment of community and local government structures, which is described next.

Alignment of local government and local development and community development

At the same as the review of DTF structures was announced, the Minister for Environment, Community and Local Government, Phil Hogan TD, established a high-level alignment steering group to review the role of local government in local and community development. This initiative was launched on foot of a commitment in the Programme for Government to review the delivery of services at local level in order to reduce the duplication of services, provide more efficient and effective local services, and ensure greater democratic accountability in decision-making at a local level. In December the Steering Group completed an interim report to the Minister, setting out its conclusions regarding the existing roles of local authorities and the local and community development sector in the provision of local and community development services (Local government / local development alignment steering group 2011).

In this interim report to the Minister, the steering group identified the following core guiding principles:

- the absolute requirement for services to be delivered to optimum standards and targeted at those who need them most;
- the importance of a strong community ethos and meaningful engagement by local community groups in the provision of services;
- the need for democratic accountability by structures and bodies who deliver the services; and
- the need for accountability and integrated oversight of the local disbursement of public funds.

Noting that existing arrangements for local development are administratively burdensome and do not lend themselves to joined-up, integrated service delivery, that the multiple structures set up by central government for service delivery at local level have, to a large extent, by-passed local government and undermined the democratic process at local level, and finally that there is considerable variation in approach, skills and standards of service delivery across both local authorities and local development companies, the steering group outlined the preferred 'way forward':

- a more co-ordinated and integrated approach to local service provision, based on an enhanced role for local government in planning, decision-making, oversight and, where appropriate, delivery of local development programmes within agreed structures;
- meaningful community engagement and involvement within this planning and decision-making framework as well as in the delivery of services;
- a strong national oversight role to ensure consistency of standards and approaches across the country;
- a more integrated and targeted approach to all the programmes funded and managed by all departments and agencies and delivered locally, through provision of joined-up services based on a comprehensive cross-programme and cross-government alignment; and
- central government priorities should allow greater flexibility at local level to customise programmes and policy initiatives to local needs and priorities, while the policy making role at national level should also be informed by delivery and practice at local level.

The steering group's final report to the Minister, containing detailed recommendations on structures and mechanisms, was due to be completed in early 2012. It has not yet been published.

Concerns regarding co-ordination and partnership processes

In awaiting the outcome of the two reviews described above, observers in the research and NGO sectors have expressed concerns about the perceived decline of co-ordination mechanisms and the partnership approach to the drugs issue.

In an article on the recent report on a national substance misuse strategy, academic researcher Shane Butler described the abandonment since 2009 of the cross-cutting model of management of illicit drug problems (see Section 1.3 above for more detail).

Appearing before the Joint Committee on Health and Children of the Oireachtas (Houses of Parliament) in September 2011, Tony Geoghegan, director of Merchants Quay Ireland (MQI) and a community and voluntary sector representative on the steering committee that drew up the NDS and on the steering group that examined integrating alcohol into the drugs strategy, highlighted the concerns of the voluntary sector with regard to the demise of the partnership approach:

> The core of the national drugs strategy was the bringing together of the statutory, voluntary and community sectors directly to solve problems in a collaborative way. The decision-making has now been pulled back from that forum into the Department. Certainly that is how it appears as a member of the voluntary sector and I am aware that the community sector holds the same belief. The greatest step I would take to try to address and make a success of the strategy would be to ensure that decision making is collaborative and that the community and voluntary sectors are directly involved. It is all the more necessary in a time of reducing resources to involve the community and voluntary sectors in such decisions rather than imposing decisions from a central source. (Geoghegan, Tony 2011, 15 September-b)

At the launch of the broad-based drug policy alliance in the NGO sector in February 2012 (see Section 1.3.3 above), the perceived collapse of the partnership approach continued to be a concern. Fergus McCabe of CityWide said:

> Citywide and the communities we represent have always tried to cooperate with Government in the promotion and implementation of the national drugs strategy. But over the past few years this has become more and more difficult. Government are moving away from a partnership approach and this is undermining the delivery of the strategy. We are confident that our coming together as an alliance will help strengthen the voice of the NGO drug sector and will locate the drugs issue squarely back on the political agenda. (CityWide Drugs Crisis Campaign 2012, 17 February).

This was backed up by Joe O'Flynn, general secretary of SIPTU, who said:

> SIPTU are fully committed to supporting this new initiative [the drug policy alliance]. We need to ensure that our national drugs strategy is being defended across all departments. The principles of partnership cannot be abandoned simply because of our economic problems. It's at times like these that we need effective partnership – not less partnership. (CityWide Drugs Crisis Campaign 2012, 17 February).

1.4 Economic analysis

Before summarising the most recent data on drug-related public expenditure in Ireland, a short account is given of the outcomes of various reviews of the nation's public expenditure system, initiated in response to the continuing economic downturn being experienced in Ireland, in order to offset any reductions in expenditure by corresponding increases in efficiency. Final decisions on the way forward have yet to be announced, but it is expected that a simpler, more streamlined regime of government funding of services, including drug-related services (described in Section 1.1) will be introduced. An independent study of the operation of a government funding scheme supporting national-level voluntary and community bodies, including drug-related bodies, found evidence of serious deficiencies in the quality of the administrative system.

In 2011 the government established the Department of Public Expenditure and Reform 'to manage public expenditure at more sustainable levels in a planned, rational and balanced manner in support of Ireland's economic performance and social progress [and] to have public administration and governance structures that are transparent, efficient, accountable and responsive.' In August 2011 the Central Expenditure Evaluation Unit (CEEU) in the new department published a paper on rationalising multiple sources of funding for the not-for-profit sector (Central Expenditure Evaluation

Unit 2012). The research for this paper included a case study of funding for third-sector organisations in one local area – Blanchardstown in Dublin. Among the 16 state sources of funding for projects in the Blanchardstown area, the authors listed three drug-related bodies – the Blanchardstown Drug Education Resource Centre, the Blanchardstown LDTF and another, unspecified DTF. The authors reported:

- Fifteen different organisations received funding of €7.7 million in 2008 and €7.45 million in 2009.
- The amounts received from the 16 state organisations identified by the authors closely matched the total income of the supported organisations so they were in effect 100% state funded.
- A number of the supported organisations received their funding from multiple sources – four organisations from 6–8 sources; six organisations from 2–4 sources, and five organisations from 1 source.
- Seven of the 15 supported organisations received funding, totalling €0.68 million in 2008 and €0.76 million in 2009, from one or more of the three drug-related funding sources.
- Nine of the 15 supported organisations were located in a very small geographical area, i.e. within a perimeter of 4.3 km. This is, however, a densely populated area.

The authors of the paper observed:

- The total amount of funding identified was not the issue so much as the way the funding was provided and distributed.
- Nearly all of the organisations supported were small in scale with an annual income of €0.5 million or less.
- Some of the organisations seemed to have a very similar brief in the same geographical area and were funded by the same group of state providers, e.g. in the Blanchardstown area, the Blakestown and Mountview Youth Initiative received c. €0.75 million per annum from the HSE, the Drugs Task Force, Fingal County Council, the Department of Social and Family Affairs (DSFA),[9] the Dublin County Vocational Education Committee (VEC) and Pobal, while the Blakestown and Mountview Neighbourhood Youth Project Ltd received c. €1.3 million per annum from the HSE, the Drugs Task Force, the DSFA, the Dublin County VEC and Pobal.
- When the number of sources exceeds three or four, some sources were only providing small amounts which were probably for very defined purposes.

The interim report of the review of DTFs (Drugs Programmes Unit 2012), described in Section 1.3.4 above, which summarised the feedback received from statutory bodies, the voluntary and community sectors, and DTFs, in the consultation process, revealed a general consensus that both funding mechanisms for and financial accountability of DTFs need to be overhauled. In line with the conclusions of the CEEU paper just described, respondents viewed the current funding arrangement, with funding flowing to projects through 'channels of funding', as unduly complex. A more simplified and standardised approach, with accountability and monitoring arrangements built in, was widely favoured. Specific suggestions included:

- a centralised system via a lead agency/central office which would provide enhanced accountability and management of the funding of projects on a national scale, or via the Department of Health and the DTFs;
- mainstreaming as an avenue to simplify the current arrangements;
- clarification of the roles and responsibilities of DTFs in relation to the oversight of funding;
- DTFs to have no role in the management of funding, which should be centralised through the HSE and other statutory bodies;
- alternatively, DTFs to have flexibility and local autonomy in relation to expenditure, while RDTFs act as advisory and monitoring bodies;
- a standardised service level agreement to ensure the integrity of the funding system;

[9] Disbanded in 2011 and replaced by the Department of Social Protection

- financial procedures issued to guide DTFs and a biannual review of projects undertaken; and
- given the multiplicity of funding sources, an integrated audit for all channels of funding.

Regarding financial planning and budgeting, it was suggested that DTFs should not have an automatic entitlement to their operational budget, which should be assessed annually and any savings passed on to front-line services. Moreover, in order to access interim funding, interim funded projects should have to declare all sources of funds, the conditions of their allocations and the amounts involved. At local level, it was suggested that county and city development boards (CDBs) could have a role, with DTFs submitting an annual report, detailing income and expenditure, to the relevant CDB. At DTF level, it was suggested that co-ordinators should be accountable and effectively line-managed by their employer (the HSE); DTF chairpersons should not be members of funded projects. One respondent observed that there is currently a lack of financial expertise among DTF members; up-skilling of staff on financial monitoring and control, particularly at task force and project level, would be beneficial.

In June 2012 the Minister for Social Protection, Joan Burton TD, confirmed that she had received a copy of a review of the Community Employment (CE) scheme, commissioned by her when the CE scheme transferred from FÁS to her Department in January 2012 (Burton 2012, 12 June). The terms of the review were to examine the income and funding of sponsoring organisations in terms of their ability to continue the programme with reduced funding from the Department of Social Protection. Within the overall scheme, which provides some 23,000 placements, 1,000 places are ring-fenced for recovering drug users.

Echoing the findings of the CEEU paper described above, the Minister reported that the review had taken much longer than expected partly because there were almost one thousand schemes, and although there were ten or twelve main types, no two were the same, and partly because community and voluntary sponsoring organisations receive funding from a multiplicity of state agencies.

With regard to the current financial year, the Minister outlined the government's continuing support for the CE scheme: 'There will also be no decrease in the number of CE places allocated in 2012. While no final allocation of materials and training grants has been made pending completion of the financial review, the existing commitment in relation to the financial support of schemes will continue to apply. No schemes have been earmarked for closure. The Government is committed to supporting the CE participants and the sponsors in continuing the valuable contribution the programme makes to individuals and communities'. Looking to savings in future years, she stated that one of the most important outcomes of the review was the identification of 'very serious savings that could be made in areas such as administration in respect of insurance charges, and audit and accountancy charges. In the case of a number of CE schemes, it is also clear that rental savings may be possible'.
In April 2012 the European Anti-Poverty Network Ireland (EAPN Ireland) and OPEN published a case study of how the Irish government allocated grants to non-statutory organisations (Harvey 2012a). The author analysed the documentation held by the Department of the Environment, Community and Local Government with regard to the operation of a funding scheme supporting national organisations in the voluntary and community sector, which is being delivered in two phases, 2008–2010 and 2011–2013. He found evidence of serious deficiencies in the quality of the administration of the review, assessment and appeals processes, details of which are reflected in his recommendations, including:

- adopt a collegial approach among officials within the department to review, assessment and appeal;
- undertake structured, strategic consultation with voluntary and community organisations;

- improve the knowledge base, so that assessment and appeal officials are familiar with key governmental, academic and research texts on the profile, topography and *modus operandi* of the voluntary and community sector;
- introduce guidelines for assessing concepts such 'disadvantage', 'key services', 'coalface services', and 'added value';
- introduce mechanisms such as a technical assistance facility and/or a screening round to address the problem of poor applications;
- use external advisers to assist in the assessment process;
- apply the principles of administrative justice to the assessment and appeals system, including:
    - appellants to given the original assessment sheets as a basis for appeal;
    - reasons given for rejecting an appeal should be those used when making the original decision;
    - an independent system of quality control to verify both the assessment and appeals process;
- re-open the decision in *Shaping a healthier future* (Department of Health 1994) about the core funding of voluntary organisations working in the health field, to be followed by a 'trialogue' between the Department of the Environment, Community and Local Government, the Department of Health, and the voluntary and community sector, with a view to the Department of Health re-accepting its responsibilities for funding voluntary organisations and the Department of Social Protection supporting a scheme that will effectively fund national anti-poverty networks;
- reinstate 'advocacy' as a factor for marking up the funding applications of voluntary organisations in the next round.

1.4.1 Public expenditures

Public expenditure on the drugs issue in 2008–2011 is reported here, together with two reports on the impact of the public expenditure cuts on drug-related services in the voluntary and community sectors. In Table 1.4.1 the significant changes in expenditure from year to year and between Departments and Agencies were as a result of revised Department functions and responsibilities.

Table 1.4.1 Expenditure and allocations directly attributable to drugs programmes 2008–2011

Department/Agency	2008 Expenditure €m	2009 Expenditure €m	2010 Expenditure €m	2011 Expenditure €m
Department of Health (Previously Office of the Minister for Drugs**)**	**65.207**	**39.377**	**34.992**	**32.876**
Department of Health (formerly Dept Health and Children)	**1.033**	**0.949**	**0.763**	**0.704**
Department of Children and Youth Affairs (Formerly OMCYA)	**0.000**	**28.501**	**25.740**	**25.000**
Department of Education and Skills	**12.386**	**3.643**	**2.461**	**0.411**
Health Service Executive	**101.867**	**104.867**	**105.400**	**91.149**
Department of Social Protection (previously FÁS area)	**18.800**	**18.800**	**18.000**	**14.934**
Department of Environment, Community & Local Government	**0.496**	**0.461**	**0.461**	**0.400**
Department of Justice & Equality	**12.340**	**14.801**	**14.478**	**18.681**
Irish Prison Service	**5.000**	**5.000**	**5.200**	**5.200**
An Garda Síochána	**44.400**	**45.004**	**44.500**	**45.014**
Revenue's Customs Service	**14.900**	**15.867**	**15.797**	**15.470**

Department/Agency	2008 Expenditure €m	2009 Expenditure €m	2010 Expenditure €m	2011 Expenditure €m
Total:	**276.429**	**277.240**	**267.792**	**249.839**

Source: Drug Policy Unit in the Department of Health (unpublished data)

In September 2011, appearing before the Joint Committee on Health and Children, Tony Geoghegan, director of Merchants Quay Ireland (MQI), described the impact of the economic recession and the cuts in public expenditure on MQI as follows (Geoghegan, Tony 2011, 15 September-a):

> We have seen an impact from the recession. It is not so much that I have seen new presenters arriving in directly through our drug services but where we have probably seen it most is in our homeless services and with people attending our food services. We open early in the morning for breakfast and that is where we have seen the biggest spike. There is a huge enmeshment between drugs and homelessness once people get caught in homelessness. We know many people become homeless because of using drugs but, equally, people who become homeless often commence using drugs by association with people who are there and also as a mechanism for coping with being homeless and having to deal with the issues around that. Both are wrapped up in each other.
>
> In terms of how it impacts on our service provision, I cannot remember the last time the Merchants Quay Project got an increase in any of its budget lines. We receive funding from various State agencies, from the Department of Justice and Equality to FÁS to the Department of Health and the HSE. In the last five years, each budget has been reduced incrementally, by 5% one year, followed by a further 10% the next year etc. Ms Casement is our head of communications and fund-raising, a new venture for us to be involved in. We had to do it to continue to provide the level of services we provide. Without voluntary income we would not be able to provide them. None of our services, from our homeless food service to the detox and residential services, is 100% funded by the State. We are dependent on voluntary income in that regard.

In February 2012 the Community Sector Committee of the Irish Congress of Trade Unions launched a report examining the cumulative impact of the cuts in spending on the voluntary and community sector in Ireland between 2008 and 2012, focusing on their effect on employment (Harvey 2012b). According to the author, the voluntary and community sector had, at the start of the financial crisis in 2008, a value of €6.5 billion, received about €1.89 billion in state funding and employed 53,098 people (full-time equivalents). The government's budgets for 2008–2012 show that over the five years, total government spending on current services fell by 2.82%. Using this reduction as the 'benchmark', the author finds that government funding for the voluntary and community sector has fallen during the same period by substantially greater amounts:

- Health services: between 4.5% and 29%
- Voluntary social housing: 54%
- National supports: 48%
- Local Community Development Programme: 35%
- Initiatives against Drugs: 29%
- Family support projects: 17%
- Dormant accounts: 87%

The author states that, in response, voluntary and community organisations have sharply reduced their spending, their last options being the dismissal of staff and the closure of services. Such a dramatic fall in funding is estimated, based on a contraction in the order of 35%, to lead to a loss of employment in the voluntary and community sector of 11,150 jobs by the end 2013 and employment in the sector may be down to 36,638 by the end of 2015.

1.4.2 Budget

Budget 2012 saw cuts to directly drug-related funding under two Votes – Education and Health (see Table 1.4.2.1). Current funding for education-related projects will drop by €132,000 (24%), while funding for pilot projects in drugs task force areas across the country, funded under the Drugs Initiative, will decrease by just over €2.5 million (7%). Against the trend, capital funding under the Drugs Initiative will increase by 38%.

Table 1.4.2.1 Budget for drug-related services under Vote Education and Vote Health, 2011–2012

Vote: Subhead	2011 Estimate (€000)			2012 Estimate (€000)			Change 2012 over 2011
	Current	Capital	Total	Current	Capital	Total	
Education: Funding of Projects in Drugs Task Force Areas	543	-	543	411	-	411	-24%
Health: Drugs Initiative	33,044	623	33,667	30,475	1,000	31,375	-7%

Source: (Department of Finance 2011)

In 2010, in anticipation of a decline in its funding, one regional DTF commissioned an independent study to evaluate the efficiency and effectiveness of the 30 projects it had funded in 2008 and 2009, to undertake a needs assessment with regard to substance misuse in the region, to score the capacity of the evaluated projects to meet these needs, and to prepare a roadmap to ensure it continued to use its resources in the most effective way possible (Comiskey, Catherine*, et al.* 2011). Using the Rapid Assessment Response (RAR) method promoted by the World Health Organization (WHO) and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), the researchers who undertook the three-month study concluded that it is a useful approach for service planners and policy makers 'who often have difficult funding decisions to make in short time frames and under competing pressures'.

A mix of quantitative and qualitative methods was used to gather data relevant to both the needs assessment and the performance evaluation:

- analysis of existing data sources on the prevalence and nature of the drug problem, to inform a retrospective needs analysis;
- the administration of a standardised needs assessment questionnaire to each service, to provide the basis for a prospective needs analysis;
- one-to-one qualitative interviews with service providers;
- consultations with regional stakeholders; and
- analysis of data collected relevant to service efficiencies, and of each service's financial and monitoring data for the previous year.

The roadmap was developed in round-table discussions by the three researchers, based on triangulation and constant comparing of all the data gathered in the course of the study. This ensured that any inconsistencies in the data could be identified, and that the most relevant and efficient projects for the region emerged.

The main recommendations of the roadmap were as follows:

Strategic priorities: A short regional drugs strategic plan should be developed, adapting and localising the NDS by prioritising the national pillars of the strategy in line with the region's needs and by setting clear measurable targets and outcomes for each pillar. The researchers proposed placing the pillars in the following order of local priority: (1) Treatment, (2) Rehabilitation and (3) Prevention.

Treatment: The roadmap proposed three targets – a drug substitution service for opiate users that ensured access to 100% of opiate users, comparability of local service provision to Dublin's range of services, and availability of mental health services to substance misusers within one month of referral.
Rehabilitation: The researchers recommended that the region should engage closely with the National Drug Rehabilitation Implementation Committee (NDRIC) on how to localise its recommendations, and in preparation for shared care planning, it should implement a unique identifier system for clients in the region.

Prevention: Although the region had prioritised prevention among projects funded, the RAR revealed that work methods and approaches to the delivery of preventative education were uneven. The researchers suggested that the task force and regional service providers should examine the quality standards framework developed by the National Drug Education Workers Forum (DEWF). They also suggested that resources should be focused on those most 'at risk' , and to this end, 'targeted' and 'selected' interventions should be prioritised while other 'more generic' approaches could be delivered by organisations working with the regional population as a whole.
Funding: Table 5 in the published report shows how funding allocations could be made in accordance with the local strategic priorities; thus, funding to projects aligned with the top priorities should continue to be funded, funding to other projects should continue but their relevance or efficiency be further reviewed; and funding to other projects should be suspended, because the project is not of sufficient strategic importance or relevance, or the need could be met by some other means.

With regard to research, the roadmap recommended that the task force should form 'a strategic alliance with an educational institute in the region in order to assist the development of the research pillar for the region'. In response to needs identified by services in relation to processes and support for projects (including the need for enhanced information sharing, the development of common working methods and the provision of training), the roadmap recommended a review of data collection methods and the appointment of a half-time monitoring and evaluation position for the region.

1.4.3 Social costs

See National Report 2009 for most recent information (Alcohol and Drug Research Unit 2009)

2. Drug Use in the General Population and Specific targeted-Groups

2.1 Introduction

Drug prevalence surveys of the general and school-child population are important sources of information on patterns of drug use, both demographically and geographically, and, when repeated, reveal changes over time. In Ireland such surveys are conducted every three to four years. These surveys increase understanding of drug use, which, in turn, helps in the formulation and evaluation of drug policies. They also enable informed international comparisons, provided countries conduct surveys in a comparable manner. The four main data collection tools in Ireland are described below.

An **All-Ireland Drug Prevalence Survey** was initiated in 2002 by the National Advisory Committee on Drugs (NACD) in Ireland and the Public Health Information and Research Branch (PHIRB), formerly known as the Drug and Alcohol Information and Research Unit (DAIRU), within the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland. The main focus of the survey is to obtain prevalence rates for key illegal drugs, such as cannabis, ecstasy, cocaine and heroin, on a lifetime (ever used), last year (recent use), and last month (current use) basis. Similar prevalence questions are also asked of alcohol, tobacco, and other drugs such as sedatives, tranquillisers and anti-depressants. Attitudinal and demographic information is also sought from respondents.

The questionnaire and methodology for this drug prevalence survey are based on best-practice guidelines drawn up by the EMCDDA. The questionnaires are administered through face-to-face interviews with respondents aged between 15 and 64 normally resident in households in Ireland and Northern Ireland. Thus, persons outside these age ranges, or who do not normally reside in private households, have not been included in the survey. This approach is commonly used throughout the EU and because of the exclusion of those living in institutions (for example, prisons, hostels) this type of prevalence survey is usually known as a general population survey.

The first iteration of this general population drug prevalence survey was undertaken in 2002/3 (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005), and a second iteration in 2006/7 (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008). A series of bulletins reporting the findings of the 2002/3 and 2006/7 iterations have been published and can be found at http://www.nacd.ie/publications/index.html The most recent (third) survey was conducted in 2010/11 and the results are described in Section 2.2.

As with other European surveys, people over the age of 64 are excluded from this survey, as they grew up in an era when both the use and availability of illegal drugs were very limited. Therefore, surveys with older people have, to date, shown very low rates of use even on a lifetime basis. This situation will change over time as the younger population grows older: lifetime prevalence rates are likely to increase for a considerable period of time. When examining the data and comparing results over time, last-year use is the best reflection of changes as it refers to recent use. Last-month use is valuable insofar as it refers to current use.

The **Survey of Lifestyles, Attitudes and Nutrition (SLÁN)** is a national survey of the lifestyles, attitudes and nutrition of people living in Ireland. To date, three surveys have been completed – in 1998 (Friel*, et al.* 1999), 2002 (Kelleher, Cecily*, et al.* 2003) and 2007 (Morgan*, et al.* 2008) – and have examined the health and social status, and related health service use, of adults aged 18 years and older living in private households. SLÁN 1998 and SLÁN 2002 were postal surveys, based on samples from the electoral register, and involved 6,539 respondents in 1998 (62% response rate) and 5,992 in 2002 (53% response rate). SLÁN 2007 interviewed 10,364 respondents face-

to-face in their homes, based on samples from the GeoDirectory (62% response rate). The SLÁN data are not comparable with the results of the 2002/3, 2006/7 and 2010/11 all-Ireland general population drug prevalence survey as the SLÁN survey excludes those aged between 15 and 17 years and includes those aged over 65 years.

The **Health Behaviour in School-aged Children (HBSC)** is a cross-national research study conducted in collaboration with the WHO (World Health Organization) Regional Office for Europe. The study aims to gain insights into, and increase our understanding of, young people's health and well-being, health behaviours and their social context. HBSC was initiated in 1982 and is conducted every 4 years. It is a school-based survey with data collected through self-completion questionnaires administered by teachers in the classroom.

The Health Promotion Research Centre, National University of Ireland, Galway was invited to join the HBSC network in 1994 and conducted the first survey of Irish schoolchildren in 1998 (Friel*, et al.* 1999); the survey has been repeated in Ireland in 2002 (Kelleher, Cecily*, et al.* 2003), 2006 (Nic Gabhainn*, et al.* 2007), and 2010. The results from this latest iteration are described below in Section 2.3.

The **European School Survey Project on Alcohol and Other Drugs (ESPAD)** is a collaborative effort of independent research teams in about 40 European countries. Data on alcohol and illicit drug use among 15–16-year-olds have been collected every four years since 1995, using a standardised method and a common questionnaire. The Swedish Council for Information on Alcohol and Other Drugs (CAN) initiated the project in 1993. Support has been provided by the Pompidou Group at the Council of Europe, the Swedish Ministry of Health and Social Affairs, the Swedish National Institute of Public Health and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The data collections in the individual countries are funded by national sources. The rationale for the survey is that school students are easily accessible and are at an age when onset of substance use is likely to occur. (By definition, early school leavers, a group known to be vulnerable to alcohol and drug use, are not represented.)

The fourth iteration of the survey was conducted in 35 European countries, including Ireland, in the spring of 2007 and the results were published in March 2009 (Hibell*, et al.* 2009). The fourth survey collected information on alcohol and illicit drug use among 15–16-year-olds; 2,249 students from 94 randomly-selected schools participated, which represents a response rate of 78%. Fewer schools and students participated in 2007 than in 2003. The Irish data showed a marked decrease in lifetime use of any illicit drug between 2003 (40%) and 2007 (22%). As the majority of those who had tried any illicit drug had used cannabis (marijuana or hashish), the decrease in illicit drug use was influenced by the considerable decrease in the number of students who had tried cannabis at some point in their lives, from 39% in 2003 to 20% in 2007 (European average 19%). Data were collected for the fifth iteration of ESPAD in spring 2011 and the survey findings are described below in Section 2.3.

2.2 Drug use in the general population (based on probabilistic sample)

On 22 November 2011 the National Advisory Committee on Drugs (NACD) and the Public Health Information and Research Branch (PHIRB) of the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland jointly published the results of the third all-Ireland general population drug prevalence survey (National Advisory Committee on Drugs and Public Health Information and Research Branch 2011) (National Advisory Committee on Drugs and Public Health Information and Research Branch 2012). These surveys are done every four years.

The 2010/11 survey followed best practice guidelines recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The questionnaire, based

on the European Model Questionnaire (EMCDDA 2002), was administered in face-to-face interviews with respondents aged between 15 and 64 years normally resident in households in Ireland. The questionnaire had been revised to include better measures of problematic alcohol and cannabis use, and three questions about new psychoactive substances sold in head shops or online. The detailed results from these new questions will be published in future bulletins. The response options for questions about other opiate-type substances used were increased to include codeine and other commonly used opiates; this may account for the increase in the use of other opiates when compared to the findings in previous surveys. Fieldwork was carried out by MORI MRC during late 2010 and early 2011. Of the household members contacted, 5,134 (60%) agreed to take part. The sample was weighted by gender, age and region to ensure that it was representative of the general population. The main measures of use were lifetime (ever used), use in the last year (recent use) and use in the last month (current use). Last-year use is a more useful measure for policy and service interventions as it is not influenced by the cumulative effect during preceding years.

Use of any illegal drug

Compared with the previous survey in 2006/7, the proportion of adults (aged 15–64 years) who reported using an illegal drug in their lifetime increased by just over three percentage points, from 24.0% in 2006/7 to 27.2% in 2010/11 (Table 2.2.1). The proportion of young adults (aged 15–34 years) who reported using an illegal drug in their lifetime also increased, by just over four percentage points, from 31.4% in 2006/7 to 35.7% in 2010/11. As expected, more men (35.5%) reported using an illegal drug in their lifetime than women (19.0%).

The proportion of adults who reported using an illegal drug in the last year remained reasonably stable at 7.2% in 2006/7 and 7% in 2010/11 (Table 2.2.1). The proportion of young adults who reported using an illegal drug in the last year also remained stable, at 12.2% in 2006/7 and 12.3% in 2010/11. The proportion of young adults who reported using an illegal drug in the last month was 5.3%.

Table 2.2.1 Lifetime, last-year and last-month prevalence of illegal drug use in Ireland, 2002/3, 2006/7 and 2010/11

Illegal drug use*	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Lifetime	18.5	24.0	27.2	23.8	29.5	35.5	13.1	18.6	19.0	25.9	31.4	35.7
Last year	5.6	7.2	7.0	7.8	9.8	10.4	3.4	4.7	3.6	9.8	12.2	12.3
Last month	3.0	2.9	3.2	4.1	4.5	5.3	1.8	1.4	1.1	5.2	5.0	5.3

* Includes amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

Source: (National Advisory Committee on Drugs and Public Health Information and Research Branch 2011)

Cannabis use

Lifetime cannabis use increased over the four years since the 2006/7 survey, but last-year use remained stable (Table 2.2.2). The proportion of adults who reported using cannabis at some point in their life increased from 21.9% in 2006/7 to 25.3% in 2010/11. The proportion of young adults who reported using cannabis in their lifetime also increased, from 28.6% in 2006/7 to 33.4% in 2010/11. The lifetime prevalence rate in 2010/11 was higher for men (33.2%) than for women (17.5%).

The proportion of adults who reported using cannabis in the last year did not decrease significantly in 2010/11 (6.0%) when compared to 2006/7 (6.3%). The proportion of young adults who reported using cannabis in the last year remained reasonably stable over the last two survey periods. The proportion of adults who reported using cannabis in the last month remained stable also, at 2.8%.

Table 2.2.2 Lifetime, last-year and last-month prevalence of cannabis use in Ireland, 2002/3, 2006/7 and 2010/11

Cannabis use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Lifetime	17.3	21.9	25.3	22.2	27.2	33.2	12.3	16.8	17.5	23.8	28.6	33.4
Last year	5.1	6.3	6.0	7.2	8.8	9.1	2.9	3.9	2.9	8.6	10.6	10.3
Last month	2.6	2.6	2.8	3.4	4.1	4.7	1.7	1.2	0.9	4.3	4.3	4.5

Source: (National Advisory Committee on Drugs and Public Health Information and Research Branch 2011)

Cocaine use

Lifetime cocaine use increased in 2010/11 compared to 2006/7, but last-year use remained stable (Table 2.2.3). The proportion of adults who reported using cocaine (including crack) at some point in their lives increased from 5.3% in 2006/7 to 6.8% in 2010/11. The proportion of young adults who reported using cocaine in their lifetime also increased, from 8.2% in 2006/7 to 9.4% in 2010/11. As expected, more men (9.9%) reported using cocaine in their lifetime than women (3.8%).

The proportion of adults who reported using cocaine in the last year remained reasonably stable at 1.7% in 2006/7 and 1.5% in 2010/11. The proportion of young adults who reported using cocaine in the last year did not vary significantly, being 3.1% in 2006/7 and 2.8% in 2010/11. The proportion of adults who reported using cocaine in the last month remained stable at 0.5%.

Table 2.2.3 Lifetime, last-year and last-month prevalence of cocaine use (including crack) in Ireland, 2002/3, 2006/7 and 2010/11

Cocaine use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Lifetime	3.0	5.3	6.8	4.3	7.1	9.9	1.6	3.5	3.8	4.7	8.2	9.4
Last year	1.1	1.7	1.5	1.7	2.3	2.3	0.5	1.0	0.7	2.0	3.1	2.8
Last month	0.4	0.5	0.5	0.7	0.8	0.8	0.0	0.2	0.3	0.7	1.1	1.0

Source (National Advisory Committee on Drugs and Public Health Information and Research Branch 2011)

Ecstasy use

Almost 11% of young adults surveyed in 2010/11 claimed to have tried ecstasy at least once in their lifetime (Table 2.2.4). More young men (15%) reported using ecstasy in their lifetime than young women (6%) as presented in Standard Table 1. The proportion of young adults who used ecstasy in the last year decreased significantly, from 2.4% in 2006/7 to 0.9% in 2010/11. The decrease in ecstasy use may be partly explained by the proportion (6.7%) of young people reporting use of new psychoactive substances sold in head shops and on line ((National Advisory Committee on Drugs and Public Health Information and Research Branch 2011): Table 1.3).

Table 2.2.4 Lifetime, last-year and last-month prevalence of ecstasy use in Ireland, 2002/3, 2006/7 and 2010/11

Ecstasy use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Lifetime	3.7	5.5	6.9	4.9	7.4	10.1	2.6	3.6	3.7	7.1	9.1	10.9
Last year	1.1	1.2	0.5	1.5	1.8	0.6	0.6	0.6	0.3	2.3	2.4	0.9
Last month	0.3	0.3	0.1	0.6	0.5	0.1	0.0	0.2	0.0	0.6	0.6	0.1

Source: (National Advisory Committee on Drugs and Public Health Information and Research Branch 2011)

As already noted in Section 2.1, the increase in the proportions using any illegal drug at some point in their lives between 2006/7 and 2011/12 was influenced by the fact that drug use in Ireland is a recent phenomenon and the population of lifetime and recent drug users is relatively young. Drug use is measured among adults aged 15–64, and those leaving this age group over the next five years are less likely to have been

exposed to drug use than those entering the measurement cohort. The relative stability in last-year use of cannabis and cocaine indicates that the situation with respect to these drugs has stabilised. More detailed data from the general population survey are presented in Standard Table 1.

Drug use among the general population in regional drugs task force areas

Drug use prevalence data by regional drugs task force (RDTF) area, based on findings from the 2010/11 general population survey on drug use, were published in June 2012 (National Advisory Committee on Drugs and Public Health Information and Research Branch 2012). This third iteration of the drug use prevalence survey is described above in discussing the findings with regard to the general population. The following commentary concentrates on the prevalence of drug use by RDTF area in the year prior to the survey (described as 'recent' use) as this is the most useful measure for policy makers and service planners.

Recent (or last-year) illicit drug use among the 15–64-year-old population stabilised or decreased marginally in most RDTF areas between 2006/7 and 2010/11, with no area showing a significant increase (Table 2.2.5). As expected, recent use is higher among men than women and higher among those aged 15–34 years than among their older counterparts.

Table 2.2.5 Proportion of respondents aged 15–64 years reporting lifetime and last-year use of illegal drugs, by RDTF area of residence, 2002/3, 2006/7 and 2010/11

RDTF area of residence	Ever in lifetime %			Year prior to survey %		
	2002/3	**2006/7**	**2010/11**	**2002/3**	**2006/7**	**2010/11**
Ireland	18.5	24.0	27.2	5.6	7.2	7.0
East Coast of Dublin and East Wicklow	25.9	38.4	38.0	6.3	12.4	9.2
North Dublin City & County	29.5	32.2	34.6	8.4	12.8	10.5
South West of Dublin, West Wicklow, and Kildare	24.0	25.6	36.3	7.5	7.4	11.1
South East	18.5	25.5	25.3	6.9	7.9	5.9
North Eastern	18.9	22.1	23.9	6.4	5.4	4.0
Midland	11.0	19.6	19.1	2.8	4.4	4.8
Mid West	12.0	18.0	18.7	3.2	5.8	5.1
Southern	12.1	16.3	24.2	4.7	4.9	6.1
Western	12.5	20.4	23.8	2.9	4.2	5.1
North West	10.6	14.6	16.6	2.6	3.0	2.8

*Incudes amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.
Source: (National Advisory Committee on Drugs and Public Health Information and Research Branch 2012)

Cannabis was the most commonly reported illegal drug used in each of the RDTF areas, with rates of recent use ranging between 2.8% in the North West and 9.4% in North Dublin (Table 2.2.6 and Figure 2.2.1). Rates have stabilised or fallen in six RDTF areas (not statistically significantly) and increased significantly in one area, the Western RDTF area.

Table 2.2.6 Proportion of respondents aged 15–64 years reporting lifetime and last-year use of cannabis, by RDTF area of residence, 2002/3, 2006/7 and 2010/11

RDTF area of residence	Ever in lifetime %			Year prior to survey %		
	2002/3	**2006/7**	**2010/11**	**2002/3**	**2006/7**	**2010/11**
Ireland	17.3	21.9	25.3	5.1	6.3	6.0
East Coast of Dublin and East Wicklow	24.5	35.9	36.2	6.1	11.3	7.7
North Dublin City & County	26.9	28.8	30.2	7.7	11.9	9.4
South West of Dublin, West Wicklow, and Kildare	23.2	24.0	33.4	7.3	6.7	8.7
South East	16.8	23.3	24.2	5.8	5.1	4.1
North Eastern	17.8	19.2	20.5	5.2	4.3	3.3
Midland	10.7	17.0	17.4	2.8	4.1	4.3
Mid West	10.9	17.0	17.9	3.0	4.7	5.0

	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Southern	11.6	15.0	23.3	4.4	4.6	5.5
Western	12.0	18.4	23.0	2.0	3.9	4.9
North West	9.3	13.0	16.1	2.2	3.0	2.8

Source: (National Advisory Committee on Drugs and Public Health Information and Research Branch 2012)

Recent ecstasy use decreased somewhat in all RDTF areas (significantly so in the East Coast area only), with proportions ranging between 0% in the North West and 1.3% in North Dublin (Table 2.2.7). Anecdotal evidence of seizures and adverse events, received through early warning reports, indicate that ecstasy use increased in late 2011 and 2012 (Jean Long, personal communication, 2012).

Table 2.2.7 Proportion of respondents 15-64 years reporting lifetime and last-year use of ecstasy, by RDTF area of residence, 2002/3, 2006/7 and 2010/11

RDTF area of residence	Ever in lifetime %			Year prior to survey %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Ireland	3.7	5.4	6.9	1.1	1.2	0.5
East Coast of Dublin and East Wicklow	5.4	7.6	9.4	2.5	2.3	0.3[ǂ]
North Dublin City & County	6.5	11.2	11.3	1.6	2.9	1.3
South West of Dublin, West Wicklow, and Kildare	5.9	4.1	10.4	1.3	0.5	0.7
South East	4.3	6.5	6.4	1.3	1.9	0.6
North Eastern	2.6	5.2	4.9	0.5	0.8	0.1
Midland	2.0	5.8	3.0	0.9	0.9	0.0
Mid West	1.7	2.9	4.9	0.6	0.8	0.4
Southern	2.8	3.5	5.7	0.9	0.6	0.4
Western	1.8	3.9	3.7	0.3	0.7	0.4
North West	0.3	2.3	3.6	0.0	0.3	0.0

Source: (National Advisory Committee on Drugs and Public Health Information and Research Branch 2012)

Cocaine was the second most commonly used illicit drug in the year prior to the survey (Table 2.2.8). Its use was highest in the North Dublin, South West and East Coast RDTF areas. Recent cocaine use stabilised or decreased somewhat in nine areas and increased significantly in only one, the South West (SW Dublin, W Wicklow and Kildare).

Table 2.2.8 Proportion of respondents aged 15–64 years who reported lifetime and last-year use of cocaine, by regional drugs task force area of residence, 2002/3, 2006/7 and 2010/11

RDTF area of residence	Ever in lifetime %			In year prior to survey %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Ireland	3.0	5.3	6.8	1.1	1.7	1.5
East Coast	6.3	9.1	10.1	2.3	3.1	2.7
North Dublin City & County	5.2	11.0	11.9	1.7	3.3	2.6
South West of Dublin, West Wicklow, and Kildare	5.0	3.8	9.6	1.5	0.8	2.9
South East	2.5	6.7	5.5	1.7	2.4	1.5
North Eastern	1.2	5.4	5.3	0.0	1.4	0.5
Midland	1.3	4.4	4.0	0.3	1.7	0.7
Mid West	1.1	2.9	4.5	0.7	1.0	0.4
Southern	1.9	3.1	4.9	0.7	1.1	1.0
Western	1.7	3.1	5.5	0.7	1.5	0.8
North West	0.0	1.6	2.7	0.0	0.3	0.3

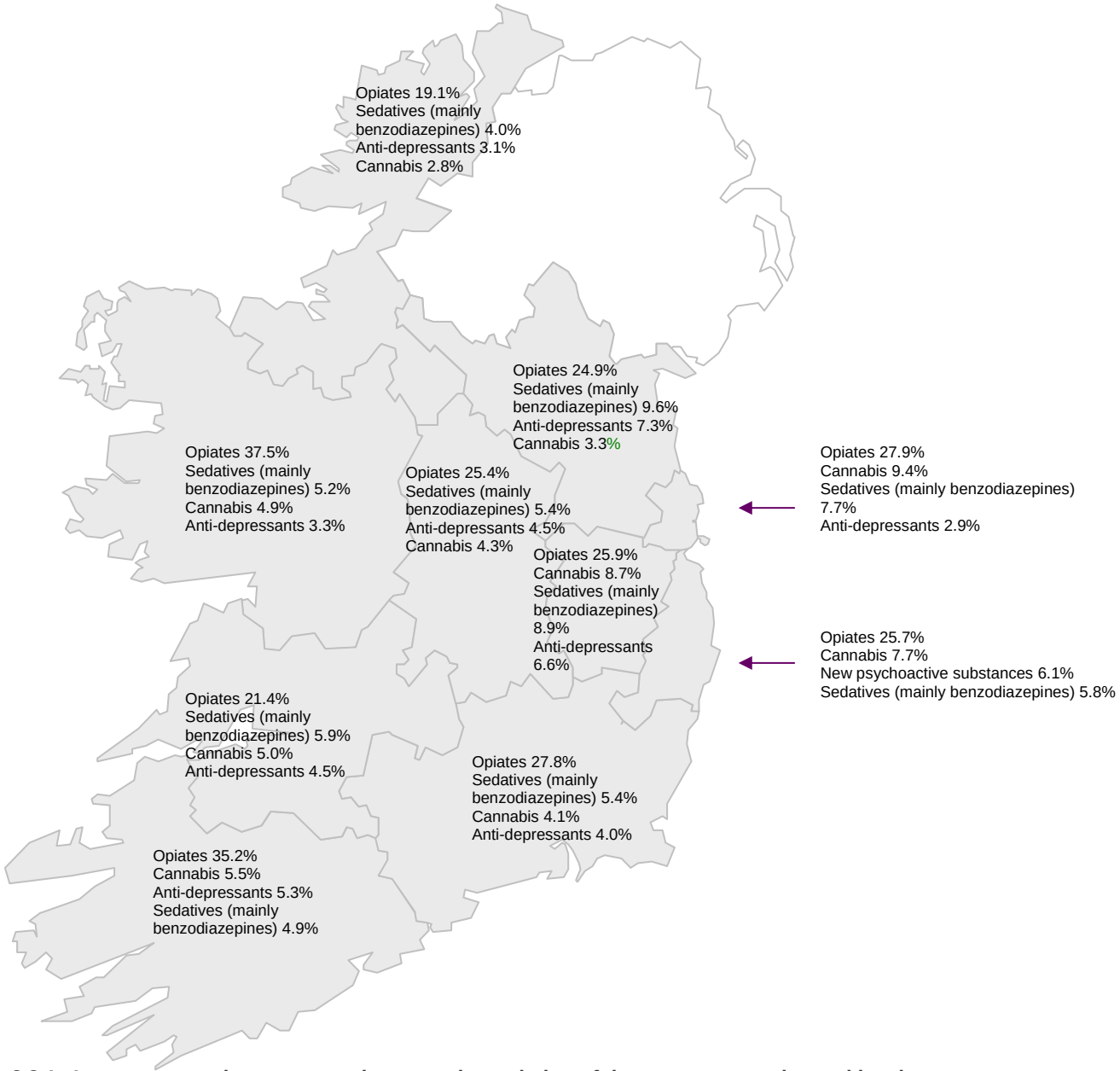
*Cocaine in this context is cocaine powder and crack.
Source: (National Advisory Committee on Drugs and Public Health Information and Research Branch 2012)

Recent use of new psychoactive substances was reported in all RDTF areas. The rate of use was highest in the East Coast RDTF area (6.1%) and lowest in the North West RDTF area (1.5%) ((National Advisory Committee on Drugs and Public Health Information and Research Branch 2012): Tables 9.2 and 13.2). It has been suggested that new psychoactive substances may take the place of other stimulants, which may account for the marginal decrease in cocaine and ecstasy use since 2006/7. Anecdotal evidence, indicating a reduction in the number of adverse events reported since the

introduction of legislation regarding new psychoactive substances, appears to suggest that the use of new psychoactive substances has also decreased.

Recent use of sedatives and tranquillisers (such as benzodiazepines and zopiclone, both prescribed and non-prescribed) has increased significantly in three RDTF areas (North Dublin, South West and North Eastern) and decreased significantly in the North West. Sedatives and tranquilisers are among the four most common drugs used in all RDTF areas (Figure 2.2.1).

The definition of the category 'other opiates' was broadened in successive surveys, to be consistent with the definition used in Northern Ireland, and to include substances that contain codeine (an opiate). Consequently, data from the 2010/11 survey on recent use of 'other opiates' is not comparable with data for that category in previous surveys In 2010/11 the rate of recent use of other opiates is high in all RDTF areas, ranging from 19.1% in the North West to 37.5% in the Western area (Map 2.2.1).



Map 2.2.1 Last year prevalence among the general population of the most commonly used legal and illegal drugs (excluding alcohol) in Ireland, by regional drugs task force area, 20010/1
Source: (National Advisory Committee on Drugs and Public Health Information and Research Branch 2012)

2.3 Drug use in the school and youth population (based on probabilistic sample)

European School Survey Project on Alcohol and Other Drugs (ESPAD)
The European School Survey Project on Alcohol and Other Drugs (ESPAD) has conducted surveys of school-going children every four years since 1995, using a standardised method and a common questionnaire (see http://www.espad.org/). The fifth survey was conducted in 36 European countries during 2010/11 and collected information on alcohol, tobacco and illicit drug use among 15–16-year-old students (Hibell*, et al.* 2012).

The rationale for the ESPAD surveys is that school students are easily accessible and are at an age when onset of substance use is likely to occur. Early school leavers, a group known to be vulnerable to alcohol and drug use, are not represented in this survey, so the results do not indicate the extent of alcohol and other drug use among all 15–16-year-old children. ESPAD survey information is valuable in planning prevention initiatives.

The number of students completing valid questionnaires in the 2010/11 survey conducted in Ireland was 2,207 from 72 randomly selected schools. Fewer schools and students participated in 2010 than in 2007 or 2003.

Four-fifths of the students (80% boys and 81% girls) reported that they had consumed alcohol at some point in their life, and 73% (72% boys and 73% girls) had drunk alcohol in the year prior to the survey. Half (48% boys and 52% girls) had drunk alcohol in the 30 days prior to the survey, a decrease of six percentage points since the 2007 survey (56%). Two-fifths (40%) reported having had five or more drinks on a single occasion in the month prior to the survey. Almost one-quarter (23%) reported that they had had one or more episodes of drunkenness in the 30 days prior to the survey, a decrease of three percentage points since the 2007 survey (26%). Nine per cent of the girls and 13% of the boys had had their first episode of drunkenness at or before the age of 13 years. The 2011 European average for alcohol consumption in the last 30 days was 57% (7 percentage points higher than Ireland), while the European average for drunkenness in the last 30 days was 17% (6 percentage points lower than Ireland).

Beer (40%), spirits (35%) and cider (33%) were the most common types of alcohol drunk in the month prior to the survey. Respondents reported drinking an average of 6.7 centilitres of alcohol on the last alcohol-drinking day prior to the survey, which places Ireland joint (along with the UK) fifth highest. Those who drank alcohol at some point in their life were asked to rate their level of intoxication during the last alcohol drinking day on a scale of one to ten; the average rate for Irish students was 3.8, which places Ireland third highest after the UK and the Faroe Islands.

Eighty-four per cent of the students reported that alcohol was easy or fairly easy to acquire in Ireland. Over one-quarter (26%) had bought alcohol for their own consumption in an off-trade outlet in the 30 days prior to the survey; 37% had done so in an on-trade outlet. Sixty-five per cent reported that they were likely to experience positive consequences from alcohol consumption, while 35% were likely to experience negative consequences. Some of the negative consequences reported were getting into trouble with the police (22%), not being able to stop drinking (20%), and doing something they regretted (48%). Ten per cent of boys and six per cent of girls had experienced ‘delinquency problems’ as a result of their alcohol use in the year prior to the survey. Delinquency problems included being involved in a physical fight (16% boys and 7% girls), being a victim of robbery or theft (4% boys and 3% girls), and being in trouble with the police (11% boys and 8% girls).

The lifetime use of alcohol has decreased by 10 percentage points in 15 years, falling from 91% in 1995 to 81% in 2011, and alcohol use in the month prior to the survey has decreased by 19 percentage points, from 69% in 1995 to 50% in 2011. The proportion

reporting having had five or more drinks on one occasion during the last 30 days has decreased by only four percentage points, from 23% in 1995 to 19% in 2011. The consumption of five or more drinks in the one sitting is an indicator of harmful use of alcohol.

Over two-fifths (43%) of the students (42% boys and 45% girls) reported that they had smoked cigarettes at some point in their life, and 21% (19% boys and 23% girls) had smoked cigarettes in the 30 days prior to the survey. Over one-fifth had had their first cigarette at or before the age of 13 years. Five per cent were smoking daily at or before the age of 13 years. The 2011 European average for smoking cigarettes in the last 30 days was 28% (7 percentage points higher than Ireland), while the European average for smoking cigarettes daily at age 13 or under was 6% (one percentage point higher than Ireland). Three-quarters reported that cigarettes were easy or fairly easy to acquire in Ireland. Over one-fifth thought that people who smoked cigarettes occasionally were at great risk of harming themselves; 67% thought that smoking one or more packs a day constituted a great risk.

The reduction in cigarette use is larger than the reduction in alcohol use, and alcohol is easier to acquire than cigarettes. The rate of lifetime use of cigarettes decreased by 31 percentage points, from 74% in 1995 to 43% in 2011, and use in the month prior to the survey decreased by 20 percentage points, from 41% in 1995 to 21% in 2011. The proportion who reported smoking cigarettes on a daily basis by age 13 years decreased by 13 percentage points, from 18% in 1995 to 5% in 2011.

The Irish data show a fall of 3 percentage points in the rate of lifetime use of any illicit drug between 2007 (22%) and 2011 (19%) (Table 2.3.1). Boys (23%) were more likely than girls (15%) to have used illicit drugs at some point in their life. As the majority of 15–16-year-olds who have tried any illicit drug have used cannabis (marijuana or hashish), the decrease in illicit drug use may be explained by the fall in the number of students who have tried cannabis at some point in their lives, from 20% in 2007 to 18% in 2011 (just above the European average of 17%). Boys (22%) were more likely than girls (15%) to use cannabis at some point in their life. Fourteen per cent of respondents had used cannabis in the year prior to the survey (higher than the European average of 12%). Only two per cent had used ecstasy at some point in their life and the proportion was the same in the year prior to the survey, indicating recent introduction to the use of this drug. In the case of cocaine powder, 3% had used it in their lifetime, just above the European average of 2%. Nine per cent of respondents reported that they had taken prescribed tranquillisers or sedatives at some point in their lives, and a further three per cent had taken them without a prescription. One in twenty had taken alcohol with pills ‘in order to get high’. Lifetime use of solvents/inhalants decreased considerably, from 15% in 2007 to 9% in 2011, and the rate is now the same as the European average (9%).

Forty per cent of the students reported that cannabis was easy or fairly easy to acquire in Ireland, while lower but considerable proportions reported that amphetamines (14%), ecstasy (21%) and sedatives (17%) were easy or fairly easy to acquire. Alcohol and cigarettes are easier to acquire than illicit drugs.

Table 2.3.1 Proportions of school-going children (15–16 years) in Ireland reporting lifetime use of drugs in ESPAD surveys, 1995, 1999, 2003, 2007 and 2011

	1995 %	1999 %	2003 %	2007 %	2011 %
Lifetime use					
Any illicit drug*	37	32	40	22	19
Cannabis	37	32	39	20	18
Inhalants (solvents)	n.a.	22	18	15	9
Ecstasy	9	5	5	4	2
Cocaine powder	2	2	3	4	3
Amphetamines	3	3	1	3	2
Prescribed tranquilisers or sedatives	n.a.	11	10	10	9

	1995 %	1999 %	2003 %	2007 %	2011 %
Non-prescribed tranquilisers or sedatives	7	5	2	3	3

*includes amphetamines, cannabis, cocaine, crack, ecstasy, heroin and LSD or other hallucinogens
n.a. = not available
Source: (Hibell*, et al.* 2012)

Association of cigarette smoking with drug use and risk-taking behaviour in Irish teenagers

Cigarette smoking has been shown in other studies to act as a 'gateway' to cannabis use and further risk taking behaviours. This study aims to establish the prevalence of cigarette smoking and cannabis use in Irish teenagers, to quantify the strength and significance of the association of cigarette smoking and cannabis use and other high risk behaviours and to examine whether the above associations are independent of social networking (O'Cathail*, et al.* 2011).

Adolescent students across five urban, non-fee paying, schools were invited to complete an abridged European schools survey project on alcohol and other drugs (ESPAD) questionnaire. The abridged questionnaire was completed by 370 out of a possible 417 students, giving a response rate of 88.7%. Of these, 228 (61.6%) were girls and 349 (94.3%) were aged 15–16 years.

The proportion who had smoked cigarettes at some point in their life was 48.4% and 18.1% had smoked in the 30 days prior to the survey. Just over 15.1% used cannabis at some stage in their life and 5.7% had used it in the 30 days prior to the survey. A higher proportion of cigarette smokers (29.6%) had used cannabis compared with 1.6% of non-smokers. After controlling for the influence of other factors, hard drug (heroin or cocaine) use was six times more likely among lifetime cigarette smokers compared to non-smokers (adjusted OR=6.0, $p<0.01$); soft drug use (cannabis) was almost five times more common among smokers (adjusted OR=4.6, $p<0.01$); high-risk sex practices were almost 11 times more common among cigarette smokers (adjusted OR=10.6, $p<0.05$); poor examination results were almost three times more common among smokers (adjusted OR=2.9, $p<0.0001$); and being absent from school owing to illness was almost twice as likely among smokers (adjusted OR=1.9, $p<0.01$).

According to the authors, cigarette smoking is prevalent among Irish teenagers and is significantly associated with drug use and other risk-taking behaviours. Specific teenage smoking cessation strategies need to be developed targeting these combined high-risk health behaviours.

Health behaviour in school children: alcohol and cannabis use

The Health Behaviour in School-aged Children (HBSC) survey 2010 was published on 16 April 2012 (Kelly, C*, et al.* 2012). Researchers at the National University of Ireland, Galway, did the survey. Previous iterations of the survey had been undertaken in 2006, 2002 and 1998.

The HBSC survey is a cross-national research study conducted in collaboration with the WHO Regional Office for Europe (www.hbsc.org). The survey runs on an academic four-year cycle, and in 2010 there were 43 participating countries and regions. HBSC collects information on the key indicators of health and health-related attitudes and behaviours (including alcohol and cannabis use) among young people aged 11, 13 and 15 years. In Ireland, the HBSC 2010 survey collected data from children aged 9 to 18 years, and the data analysed on alcohol and cannabis is for children aged 10 to 17 years.

A nationally representative sample of primary and post-primary schools in Ireland was randomly selected and subsequently, within schools, classes were randomly selected. The HBSC questionnaire was developed by the international HBSC research network, administered by teachers and completed by the selected students themselves.

Younger children received a shorter questionnaire. Just over two-thirds (67%) of invited schools and 85% of students participated in the survey. There was a higher representation from social classes 1 and 2 and lower representation from social classes 3, 4, 5 and 6 in the 2010 survey than in the 2006 survey.

Overall, 46% of children (aged 10–17) reported that they had consumed an alcoholic drink at some point in their life, a fall of seven percentage points on the 2006 figure of 53%. Girls (43%) were less likely than boys (48%) to report drinking alcohol, and as children grew older they were more likely to report drinking alcohol.

The proportion of children (aged 10–17) who had consumed alcohol in the 30 days prior to the survey was 21%, a fall of five percentage points on the 2006 figure of 26%. Boys (22%) were more likely than girls (19%) to have consumed alcohol in the last 30 days.

Twenty-eight per cent of children reported having been 'really drunk' at some point in their life, a fall of four percentage points on the 2006 figure of 32%. More boys (29%) than girls (26%) reported this, and the proportion reporting drunkenness increased with age: 4% of 10–11-year-olds, 16% of 12–14-year-olds and 52% of 15–17-year-olds. Children from lower social class groups were more likely to report having been 'really drunk' than those from middle and higher social class groups. The proportion who reported having been 'really drunk' in the 30 days prior to the survey was 18% in 2010 and 20% in 2006, a marginal decrease, which may be explained by sampling variation or the sample representation by socio-economic group.

Eleven per cent of 15-year-old girls and 15% of 15-year-old boys had their first episode of drunkenness at the age of 13 years or under.

Overall, 27% of children (aged 10–17) reported that they had smoked a cigarette at some point in their life, a fall of nine percentage points on the 2006 figure of 36%. Girls (26%) were less likely than boys (27%) to report smoking cigarettes, and as children grew older they were more likely to report smoking. Overall those from the lowest social class were more likely to smoke than those in the middle and higher social classes. The proportion of children (aged 10–17) who had smoked in the year prior to the survey was 12%, a fall of three percentage points on the 2006 figure of 15%.

Eight per cent of children (aged 10–17) reported having used cannabis in the 12 months prior to the survey, a halving of the 2006 figure of 16%. More boys (10%) than girls (6%) reported such use. The proportions increased with age, for example, 1% of 10–11-year-olds compared to 17% of 15–17-year-olds reported such use.

Five per cent of children reported having used cannabis in the 30 days prior to the survey, a fall of two percentage points on the 2006 figure of 7% which may be explained by sampling variation. More boys (7%) than girls (3%) had used cannabis in the month prior to the survey.

Overall, there was a decrease in self-reported alcohol and cannabis use among school children in Ireland in 2010 when compared to 2006. This may represent a true decrease, possibly owing to children having less pocket money in recent years, or it may be the result of sampling variation, or a combination of both factors. These decreases are welcome, but we must note that at least one in ten 15-year-olds has been drunk by the age of 13, and that more than half our 15–17-year-olds have been drunk at some point in their lives.

2.4 Drug use among targeted groups/settings at national and local level (university students and conscript surveys, migrants, music venues gay clubs, gyms)

For most recent research, on substance use among third-level students in Limerick, see (Irish Focal Point (Reitox) 2011).

3. Prevention

3.1 Introduction

Drug prevention is one of the four pillars in the National Drugs Strategy (interim) 2009–2016 (Department of Community Rural and Gaeltacht Affairs 2009). The Strategy states that 'a tiered or graduated approach to prevention and education measures in relation to drugs and alcohol should be developed with a view to providing a framework for the future design and development of interventions' (para. 3.56). It identifies three levels in this framework:

Universal (primary) prevention programmes, aimed at the general population such as students in schools, to promote overall health of the population and to prevent the onset of drug and alcohol misuse. Measures often associated with this type of programme include awareness campaigns, school drug/alcohol education programmes and multi-component community initiatives.
Selected (secondary) prevention programmes, aimed at groups at risk, as well as subsets of the general population including children of drug users, early school leavers and those involved in anti-social behaviour, to reduce the effect of risk factors present in these subgroups by building on strengths and developing resilience and protective factors.

Targeted (tertiary) prevention programmes, for people who have already started using drugs/alcohol, or who are likely/vulnerable to engage in problematic drug/alcohol use (but may not necessarily be drug/alcohol dependent), or to prevent relapse. These programmes are aimed at individuals or small groups and address specific needs.

This framework combines universal, selected and targeted with the old classificatory framework of primary, secondary and tertiary, which is misleading in that it implies that universal prevention is also the primary step in prevention. In Ireland young people and their families are the main target groups for drug prevention activities, which consist mainly of universal and selected prevention, with little focus on targeted prevention.

The NDS identifies as priorities for Prevention, improving the delivery of Social, Personal and Health Education (SPHE) in primary and post-primary schools and co-ordinating the activities and funding of youth interventions in out-of-school settings to optimise their impacts. Drug prevention interventions in schools are delivered through the Social, Personal and Health Education programme. The SPHE programme aims to improve social and personal competencies in students so they can understand and counter the many social influences that are seen as contributing to their use of drugs and alcohol. In the community, prevention programmes are provided in different settings, such as youth clubs and youth cafés, and by means of diversion activities provided by the statutory, voluntary and community sectors.

The NDS calls for a continued focus on orienting educational and youth services towards early interventions for people and communities most at risk. Actions are to be developed to further support the families of drugs users, and community development is acknowledged as an important step in building the capacity of local communities to avoid, or respond to and cope with, drug problems. Early school leavers are targeted through measures such as the School Completion Programme and embedding the government's DEIS (Delivering Equality of Opportunity in Schools) Action Plan, which tackles disadvantage among the school-going population, in schools in LDTF areas. The Department of Education and Skills (DES) has also developed a strategy to tackle educational disadvantage and early school leaving in the Traveller community.

Stand-alone mass media awareness and information campaigns are regarded as less effective than multi-component, multi-level interventions that reflect the complex nature of drug prevention and harm reduction. The NDS proposes that preference be given to the development of timely awareness campaigns targeted in a way that takes

individual social and environmental conditions into account key areas such as third-level institutions, workplaces, sports and other community and voluntary organisations.

3.2 Environmental prevention

3.2.1 Alcohol and tobacco policies

Alcohol taxation

Table 3.2.1.1 includes data on the amount of excise duty that was paid on different alcohol beverages in 2010, which is the most recent data available. Excise duties are paid on beer, wine and cider per hectolitre of volume; a hectolitre equals 100 litres. Excise is paid per single litre on spirits.

Table 3.2.1.1: Excise duty on alcohol beverages, 2010

Alcohol Beverage	Excise paid per alcohol beverage
Beer	Excise paid per hectolitre per cent of alcohol in the beer containing >2.8% alcohol (ethanol): €15.71
Wine	Excise paid per hectolitre of wine containing 5.5–15% alcohol (ethanol): €262.24
Cider	Excise paid per hectolitre of cider containing 2.8–6% alcohol (ethanol): €65.86
Spirits	Excise paid per litre of alcohol €31.13

Source: (Revenue Commissioners 2010)

Blood alcohol concentration allowed for drivers

The following account of the blood alcohol concentration levels allowed for drivers of motor vehicles in Ireland is reproduced from the description provided by (Mongan 2012b). The new blood alcohol concentration (BAC) limit is 50 mg for all drivers, and 20 mg for specified drivers, defined as learner or newly qualified drivers (for a period of two years after passing their driving test) or professional drivers (of buses, goods vehicles and public service vehicles).

A new penalty system has been introduced to deal with offences that come under the new limits. Under the previous system, all drink driving offences were dealt with in the courts and those convicted were automatically disqualified from driving. Under the new system, a driver who fails a preliminary breath test at the roadside will still be arrested and required to provide an evidential breath, blood, or urine specimen at a Garda station. However, if the driver's BAC does not exceed 100 mg and they are not already disqualified from holding a driving licence at the time of detection or have not availed of the administrative fixed penalty notice option in the preceding three years, they will be served with a fixed penalty notice (Table 3.2.1.2). A driver can only avail of the fixed penalty option once in a three-year period.

Table 3.2.1.2: Blood alcohol concentration levels and legal penalties for drivers of motor vehicles in Ireland

BAC Level	Specified drivers (leaners, newly qualified and professional drivers)	All other drivers
20–80 mg*	€200 fine Disqualified for holding a driving licence for 3 months	
50–80 mg		€200 fine Thee penalty points which will remain on a licence record for 3 years. Any driver accumulating 12 penalty points in a 3-year period will be disqualified from driving for a period of 6 months.
80–100 mg		€400 fine Disqualified from holding a driving licence for 6 months.
*If a driver cannot produce their driving licence when required to undergo a preliminary breath test, the lower limit of 20 mg will apply until such time as the driver produces their licence.		

Source: (Mongan 2012b)

Court proceedings will not be initiated if the driver pays the fixed charge and accepts the penalty. If a driver does not accept the fixed penalty notice and goes to court and is unsuccessful in appealing, the penalties are increased; for first offences, where the BAC does not exceed 80 mg, a six-month disqualification period applies, while a one-year disqualification period applies for offences where the BAC is 80–100 mg. Where the BAC detected is above 100 mg, or above 80 mg for a specified person, where the person is not eligible to be served with a fixed penalty notice, or where payment has not been made in respect of a fixed penalty notice, the court penalties relating to disqualification from driving outlined in Table 3.2.1.3 apply on conviction. In addition, the court may apply a fine of up to €5,000 and/or six months in prison.

Table 3.2.1.3: Blood alcohol concentration levels and legal penalties allowed for drivers of motor vehicles in Ireland

BAC Level	1st Offence	2nd Offence
>89 mg (specified drivers only)	6 months	1 year
80–100 mg	1 year	2 years
101–150 mg	2 years	4 years
151+ mg	3 years	6 years

Source: (Mongan 2012b)

Age limits for purchasing (or consuming) alcohol

Under the Intoxicating Liquor Act 2008, it is an offence to sell alcohol to anyone under the age of 18. Anyone found guilty of doing so is liable on summary conviction in a District Court to a class B fine of €3,000 for a first offence and a class A fine of €5,000 for a second and any subsequent offence.

It is an offence to buy alcohol for anyone under the age of 18. It is also an offence to give alcohol to anyone under the age of 18 unless in a domestic home and they have parental consent. If found guilty of any of these offences, a person is liable on summary conviction in a District Court to a class B fine of €3,000 for a first offence and a class A fine of €5,000 for a second or any subsequent offence.

Anyone under the age of 18 is not allowed in licensed premises during extended hours (except in certain circumstances). It is the responsibility of the licence holder to make sure this does not happen.

Anyone aged under 18 cannot legally buy alcohol; neither can they drink it unless they are in a private residence and have their parents' permission. It is also an offence to pretend to be over 18 in order to buy or drink alcohol. If found guilty of these offences, the individual is liable to a class E fine on summary conviction in a District Court.

Children (anyone under the age of 18) are only allowed in licensed premises if they are with a parent or guardian, but this provision carries certain restrictions. For example, if accompanied by a parent/guardian, a child may remain on the premises between the hours of 10.30 am and 9.00 pm (10.00 pm from May to September) (unless the licence holder feels this is injurious to the child's health, safety or welfare). Children aged between 15 and 17 years may remain on the premises after 9.00 pm when attending a private function at which a substantial meal is served. All licensed premises must display a sign to this effect in a prominent place at all times and failure to do so can result in a fine.

If the licence holder is found guilty of allowing unsupervised children in his or her premises, a fine can be imposed on summary conviction in a District Court. Parents and guardians are also guilty of an offence if their children are found in licensed premises without supervision. If the parent or guardian cannot prove that the child was there without his or her knowledge or permission, he or she is liable for a class E fine on summary conviction.

Distribution of alcohol

Regular licensing hours for the on-trade (public house) sale of alcohol are from 10.30 am to 11.30 pm from Monday to Thursday, and 10.30 am to 12.30 am on Friday and Saturday. Trading hours on Sunday are 12.30 pm to 11.00 pm. An additional 30 minutes drinking-up time is permitted at the end of each trading day.

The sale of alcohol products in the off-trade (off-licences, supermarkets, convenience stores) is allowed between the hours of 10.30 am and 10.00 pm from Monday to Saturday, and 12.30 pm to 10.00 pm on Sunday and St. Patrick's Day.

Public policy with regard to alcohol-related nuisance
Under the Criminal Justice (Public Order) Act 1994, it is an offence for a person to be so drunk in a public place that they could reasonably be presumed to be a danger to themself or to anyone around them. If found guilty of this offence, a person is liable to a class E fine and a member of the Garda Síochána may confiscate any alcohol the person is carrying.

It is illegal for a licence holder to sell alcohol in a closed container (i.e. can or bottle) for consumption off the premises but within 100 metres of the premises. If alcohol is purchased in this way, the purchaser is liable for a class E fine.

While there is no national legislation prohibiting drinking in public, each local authority is entitled to pass bye-laws prohibiting the consumption of alcohol in a public place within its area.

Under the Intoxicating Liquor Act 2008, the gardaí have the power to seize alcohol in the possession of anyone under 18 years of age where they have reasonable cause to believe that the alcohol will be consumed by someone aged under 18 years in a public place.

It is now an offence under the Intoxicating Liquor Act 2003 to supply alcohol to a drunken person and to admit a drunken person to a bar. (A 'drunken person' is defined in the Act as 'a person who is intoxicated to such an extent as would give rise to a reasonable apprehension that the person might endanger himself or herself or any other person, and ''drunk'' and ''drunkenness'' are to be construed accordingly'. Any licence holder who allows this to occur on their premises is liable on summary conviction to a class B fine of €3,000 for a first offence and a class A fine of €5,000 for any subsequent offence.

It is also an offence to engage in disorderly conduct on a licensed premise. This means that a person may not behave in a way that constitutes a risk to the health, safety or welfare of anyone else on the premises; neither may they behave in a violent, threatening, abusive, insulting or quarrelsome manner. If requested to leave a licensed premise by the licence holder or a member of the Gardaí, a person must do so. Failure to leave when requested may lead to a class E fine and/or arrest by the Gardaí.

Price of cigarettes and other tobacco products (taxation)
According to the Irish Heart Foundation (Reed 2011), 'The Irish Government increased taxation on cigarettes by more than average price inflation…so that the percentage of the price pack consisting of tax increased from 75.9% in 1995 to 80.1% in 2008…between 1995 and 2009 the price of a pack of cigarettes in Ireland increased by 64% in real terms.' (p. 15)
According to the Revenue Commissioners (Revenue Commissioners 2010), the total tax as a percentage of the price a packet of 20 cigarettes was 79% in 2010. The price for a premium packet of 20 cigarettes as of July 2012 was €9.10.

Smoke-free work and other public places
Enclosed workplaces became smoke-free by law in Ireland on 29 March 2004 under provisions in the Public Health (Tobacco) Acts 2002 and 2004. Two sections in the legislation provide for the banning of smoking in the workplace. Section 46 of the

Public Health (Tobacco) Act 2002, as amended by Section 16 of the Public Health (Tobacco) (Amendment) Act 2004, requires no smoking signs to be displayed in the workplace. Section 47 of the Public Health (Tobacco) Act 2002, as amended by Section 16 of the Public Health (Tobacco) (Amendment) Act 2004, prohibits smoking in the workplace. In effect, this means that it is illegal for persons to smoke cigarettes in offices, shops, factories, bars, restaurants and other enclosed work places. The primary aim of this legislation is to afford protection to workers and members of the public from exposure to second-hand environmental tobacco smoke (ETS).

Since the introduction of the ban, compliance checks within the hospitality industry have been implemented by Environmental Health Officers (EHOs) from the Environmental Health Section of the Health Service Executive (HSE). This work is part of the National Tobacco Control Inspection Programme and is coordinated by the National Tobacco Control Office (formerly the Office of Tobacco Control [OTC]). Compliance is defined as no-one smoking and no evidence of smoking contrary to the law.

From the introduction of the ban in March 2004 to the end of that year, data made available by the OTC showed 94% of premises complying with the legal requirement (see Table 3.2.1.4).

Table 3.2.1.4 National compliance data on smoking ban in the hospitality sector, March– December 2004

Business Type	Inspections	Compliance
Hotel	1,454	93%
Restaurant	6,873	99%
Licensed premises	14,400	90%
Other	12,230	97%
Total	**34,957**	**94%**

Source: (Office of Tobacco Control 2005)

The most recent data available in respect of monitoring compliance with the workplace smoking ban are reported in the OTC's annual report for 2009 (Office of Tobacco Control 2010). During 2009, 25 cases were taken for offences under Section 47 of the Public Health (Tobacco) Acts 2002 to 2009, 18 cases applied to licensed premises, five to taxi companies and one each to a hotel and an amusement arcade. A total of 19 convictions ensued from these convictions.

Age limits for purchasing (or consuming) tobacco products

Since August 2001, it has been illegal to sell tobacco products to anyone aged under 18 years. According to the most recent data available on compliance with this legislation, from a nationally representative sample of 1,209 retail outlets, 68% refused to sell cigarettes to people under 18 years in 2009. This finding compares with a compliance rate of 60% in 2008 and 52% in 2007, derived from similar sized samples (Office of Tobacco Control and TNS mrbi 2009). In 2009, sales to people aged under 18 were highest among 17-year-olds, with almost 48% of this age cohort not refused a sale.

In May 2007 it became illegal to sell cigarettes in packs of less than 20 or confectioneries resembling tobacco products. By increasing the minimum number of units which may be bought, the price barrier was raised for children at the experimental stage. Ireland currently has the highest price for cigarettes in the EU and after Norway, the second highest in Europe. In 2007 the age limit for sale of cigarettes was also raised, from 16 to 18 years.[10]

Advertising and promotion

On 1 July 2009 new legislation came into effect prohibiting all point of sale advertising in retail outlets and requiring the storage of tobacco products out of sight of the

[10] The information in this paragraph was downloaded from http://www.dohc.ie/fact_sheets/tobacco_control_sept2011.pdf on 28 August 2012.

customer. Section 33A of the Public Health (Tobacco) Acts 2002 and 2004 prohibits all advertising of tobacco products in retail premises where tobacco products are sold:[11]

- No tobacco related advertising will be permitted on your premises. This includes both internal and external tobacco display and advertising signage.
- No tobacco related advertising will be permitted either surrounding or on the front of the closed container or dispenser that stores the tobacco product. This includes all in-store advertising or promotional material for tobacco products. For example, gantries (backlit decorative panels featuring particular brands of tobacco products), promotional lighting, clocks, change mats, mouse pads, till covers, decals, pens, wobblers or danglers.
- Tobacco products or reproductions of tobacco products cannot be on display.
- All tobacco products must be kept out of view in a closed container or dispenser only accessible by the retailer and retail staff.
- Only the tobacco product must be out of sight. The closed container may be visible.
- Self-service vending machines are prohibited, except in registered clubs and licensed premises. They must also be free of all tobacco related advertising.
- Selection decals/buttons for dispensing machines and self-service vending machines must not display tobacco product trademarks, emblems, marketing images or logos unless they are out of the view of the customer.

In 2009, 98% of retail stores were found to be compliant with the new legislation banning cigarette advertising in retail premises, and, 97% were storing cigarettes out of sight in a closed container as required by the legislation (Office of Tobacco Control and TNS mrbi 2009). These observations were derived from a nationally representative sample of 1,209 retail stores.

Treatment to help dependent smokers stop

The HSE runs a dedicated website to help people quit smoking. The website www.quit.ie contains comprehensive information and support, and promotes the following methods and treatments for helping people to quit smoking.

Support methods that work

- One-to-one support
- Group support
- Self help

Drug treatments that work

- Nicotine replacement therapy (NRT), e.g. patches, gum, inhaler, lozenge, microtab
- Zyban (bupropion HCl SR)
- Champix (varenicline)

The HSE provides a range of smoking cessation support services, some in community services and some in hospitals.

3.2.2 Other social and normative changes (e.g. nightlife licensing, neighbourhood policies)

No information available.

[11] The following summary was downloaded on 28 August 2012 from http://www.otc.ie/rg-ban-on-point-of-sale-advert.asp

3.3 Universal prevention

3.3.1 School

The Social, Personal and Health Education (SPHE) programme is the main vehicle through which substance use prevention is delivered in both primary and post-primary schools. The SPHE programme is a mandatory part of the primary school and post-primary (junior cycle) curriculum and supports the personal development, health and well-being of students through ten modules including a module on substance use. The themes and content of modules are based around helping students to understand the nature of social influences that impact on their development and decision-making, and helping them to develop adequate life-skills to improve their self-esteem, develop resilience and build meaningful and trusting relationships.

There is a commitment in the current programme for government to 'update the out-dated drugs awareness programmes in schools to reflect current attitudes and reality of recreational drug use amongst teens' (Fine Gael and the Labour Party 2011). To meet this commitment, the Department of Education and Skills (DES) established a working group to examine the materials used in the delivery of SPHE, with particular reference to substance use education (John Moloney, personal communication, DES, 2012). As part of the review of drug education in schools, the group also agreed to:

- review current literature on drug and alcohol education in schools (and centres of education), including documenting interventions by DES to date;
- review the recommendations in previous evaluations of SPHE;
- review the school inspectorate's composite report on SPHE at primary level to see if it might inform practice at post-primary level;
- assess resources currently available to schools for the purpose of adopting a whole-school approach to SPHE; and
- examine how a whole-school approach to SPHE could include the relationship between schools and local communities, including the drugs task forces.

The working group has invited and received a number of presentations from researchers and other stakeholders in the field including the National Focal Point in the Health Research Board. A draft report has been completed and is currently being reviewed and modified by the working group. It is intended to submit a final version of the report to the Minister for Education and Skills later in 2012.

According to the latest report describing the implementation of actions under the Prevention pillar in the NDS (Department of Health 2012b), a number of steps have been taken in relation to the delivery of drug prevention in both primary and post-primary schools. For example, rather than providing dedicated SPHE support services for primary-school teachers, support across a number educational areas, including SPHE, is now provided by multidisciplinary regional teams in the newly formed Professional Development Service for Teachers (PDST). A course on 'Delivering emotional intelligence in order to prevent substance misuse' was funded by the PDST and delivered in six education centres in the summer of 2011. At post-primary level, a dedicated SPHE Support Service (comprising six people) provides training, advice and support to schools. In the school year 2010/11, 3,589 teachers and other staff attended school-based events and 1,124 teachers attended cluster in-service training organised by the SPHE Support Service.

3.3.2 Family

A review of the literature on the impact of parental substance misuse on children was published by the National Advisory Committee on Drugs (NACD) (Horgan 2011). Summarising the key findings from a purposive overview of international and national studies, the review documented the reported impact of pre-natal exposure to parental substance misuse and the associated physical, cognitive and behavioural problems

that can arise in the development of an affected child. Parental substance misuse was also reported to impact adversely on parenting styles and can compromise a parent's ability to provide consistent support and structure to an affected child.

Parental substance misuse is reportedly associated with poor outcomes for affected children. These outcomes may include mental health problems, deficits in social skills, academic under-achievement, and substance use. Horgan also drew attention to the long-tern impact that parental substance misuse can have for a substantial minority of affected children; it is reported that in some cases, the adverse effects continue into the adult lives of the children, and for some, into the lives of the next generation of children.

Horgan's review documented interventions available to prevent and moderate the adverse impact of parental substance misuse on the development and quality of life of children. These include effective treatment for the parent afflicted by substance misuse; effective parenting skills-based programmes; parent and child therapy programmes; and adolescent therapy and community supports.

The findings of the review were discussed at a seminar and workshop event with stakeholders and it is envisaged that the review and outputs from the public seminar will further influence understanding of this area and lead to the provision more effective services to meet the needs of both parents and children likely to be impacted by parental substance misuse.

3.3.3 Community

A Vision for Change, the report of the expert group on mental health policy, which was published in 2006, outlined a framework for the provision of community-based specialist mental health services (Department of Health and Children 2006). The report recommended the establishment of specialist child and adolescent mental health (CAMH) teams providing community, hospital liaison and day hospital services for all children up to 18 years. As at 30 September 2011, there were 61 CAMH teams in operation, 56 based in the community and five in hospital settings (Health Service Executive 2011a). This number fell short of the 99 teams recommended in the 2006 report.

In the period from 1 October 2010 to 30 September 2011, a total of 7,849 new cases were seen by CAMH teams, and 720 (9.2%) were 16–17 years of age (Health Service Executive 2011a). Of the 7,849 new cases seen, that is those who attended an appointment, a total of 1,725 (22%) had previously attended the service and had been discharged. Over the period:

- 46% of new cases were seen within 1 month of referral,
- 69% were seen within 3 months,
- 12% of new cases had waited between 3 to 6 months to be seen,
- 12% had waited between 6 and 12 months to be seen, and
- 8% had waited more than 1 year to be seen.

Eighty-five per cent of the 7,849 new cases seen between October 2010 and September 2011 were closed and discharged to the care of a general practitioner or primary care team.

Table 3.3.3.1: Primary presentation of 7,907 cases recorded by CAMH teams, November 2010

Primary presentation	Number (%) of cases
Hyperkinetic disorders/problems, e.g. ADHD	2,677 (33.9)
Anxiety disorders/problems	1,207 (15.3)
Autistic spectrum disorders/problems	873 (11)
Depressive disorders/problems	792 (10)
Conduct disorders/problems, e.g. oppositional defiant disorder, anti-social behaviour	691 (8.7)
Deliberate self-harm	266 (3.4)
Eating disorders/problems	184 (2.3)

Primary presentation	Number (%) of cases
Developmental disorders/problems, e.g. delay in developing speech and social abilities	152 (1.9)
Psychotic disorders/problems	108 (1.4)
Habit disorders/problems, e.g. sleeping problems, and soiling	91 (1.2)
Substance abuse	70 (0.9%)

Source: (Health Service Executive 2011a)

Youth cafés

Youth cafés have become an established community resource for young people in a number of geographical locations. Although the precise number of youth cafés in operation remains undocumented, it is estimated there are between 20 and 30 providing services to the youth population in general. The establishment and development of youth cafés have been underpinned by a best-practice guide (Forkan*, et al.* 2010b) and an accompanying toolkit (Forkan*, et al.* 2010a).

The key objectives of the youth café model are to provide formal and informal social support to young people in the community; to encourage and promote social attachment by providing young people with a secure base from which to explore talents, interact with peers and develop social skills; to assist young people to develop and maintain resilience; and to encourage and promote civic engagement between young people and the wider community (Forkan 2010).

According to the progress report on the NDS for 2011 (Department of Health 2012b), approximately €1.7m had been available since 2010 for the support of the provision of youth cafés. The funding was designed to provide both completely new youth cafés and support for existing youth cafés in need of assistance to provide additional facilities. Funding is provided through two strands: strand 1 provides a minimum of €5000 and a maximum of €10,000 to upgrade existing youth cafés, and strand 2 provides a minimum of €50,000 and a maximum of €100,000 to develop a new youth café.

3.4 Selective prevention in at-risk groups and settings

3.4.1 At-risk groups

The NDS through actions 28, 44 and 60 identifies the need to improve access to drug and alcohol services for members of the Traveller community (Department of Community Rural and Gaeltacht Affairs 2009). Research using semi-structured interviews and focus groups with members of the Traveller community (n=137) and service providers (n=34) reported that travellers experienced specific problems relating to access to drug services (Fountain 2006). These problems included a lack of awareness within the Traveller community about the existence and types of services available; a lack of formal education which reduced the ability of travellers to comply with treatment requirements such as completing forms and keeping appointments; stigma and embarrassment about revealing their drug use; and a perception that drug services sometimes lack an awareness of the needs of travellers wishing to access drug services. An example of this last problem is travellers' fear that they may be seen by other members of their community and/or that services may breach their desire for confidentiality.

In an attempt to explore the experiences of travellers engaging with drug and alcohol services, semi-structured interviews were undertaken with 30 members of the Traveller community (Cafferty 2011). Eighteen women and 12 men were recruited from services through a mixture of techniques. Based on the learning accrued from this research, the researcher issued a set of 10 best-practice guidelines to assist services to work more effectively with members of the Traveller community. These guidelines are summarised below:

1. staff induction to include a profile of the organisation's service users and information on the organisation's approach to engaging with travellers;
2. staff to be given cultural competency training;
3. the support of a Traveller peer support worker to be offered if Traveller service users are contemplating accessing rehabilitation services;
4. women to be facilitated to attend initial appointments with friends or in family groups;
5. women in particular to be allowed to choose the gender of their key worker/case manager;
6. a user-friendly induction process for service users to be developed;
7. staff to be encouraged to be proactive in asking travellers at regular intervals what their needs are and what can be done to support them;
8. family members to be encouraged to engage in service user care plans;
9. families involved in care plans to be educated in relation to the nature of addiction and recovery; and
10. service user ethnicity questions (as used in the National Drug Treatment Reporting System [NDTRS]) to be asked after confidentiality has been explained

3.4.2 At-risk families

The NDS prioritises the provision of family supports by drugs task forces (Department of Community Rural and Gaeltacht Affairs 2009). The strategy notes that around 60% of projects being implemented in local drugs task force areas include a family support dimension, with many local task forces implementing the Strengthening Families Programme (SFP).

The Ballymun Local Drugs Task Force has been implementing the SFP for 12- to 16-year-olds since 2008. The Ballymun SFP is a 15-week family skills programme which aims to improve parenting and family functioning and to prevent substance abuse and behavioural problems in teenagers. Parents and teenagers come together one evening a week (usually Tuesdays) for dinner and group sessions from 6.00 pm to 8.30 pm (an adult who plays a parenting role with a teen is considered a 'parent'.) Childcare and transport can be provided where either/both may affect attendance on the course. SFP is delivered by a range of community, statutory and voluntary local services in Ballymun.

In 2010, which was year 3 of the programme being implemented, two SFPs were completed in Ballymun – February to May and September to December. Between the two programmes, 23 families started and 20 completed and graduated. Karol Kumpfer and the Lutragroup were commissioned by the Ballymun Local Drugs Task Force to undertake an outcome evaluation of year 3 of the programme (Kumpfer and Lutragroup 2011). Seventeen families, representing 85% of families that graduated from the programme, retrospectively completed both pre-test and post-test questionnaires as part of the evaluation. Analysis of the 17 completed questionnaires revealed the following:

- In all five of the family functioning outcome measures – family organisation, family cohesion, family communication, family conflict and family resilience – there was a statistically significant improvement between pre-test and post-test.
- In all five of the parenting outcome measures – positive parenting, parental involvement, parenting skills, parental supervision and parental efficacy – there was a statistically significant improvement between pre-test and post-test.
- In five of the seven children outcome measures – overt aggression, covert aggression, depression, social skills and competencies and concentration problems – there was a statistically significant improvement between pre-test and post-test.
- Overall cluster outcomes (the average score) for the overall family, parent and child domains showed statistically significant improvements between pre-test and post-test.
- There was a statistically significant reduction in the use of alcohol and drugs among parents between pre-test and post-test.

The author noted the significant improvements in all family and parenting outcomes measured. By way of explaining these larger than expected improvements, the author drew attention to the possibility that the families recruited were in an exceptionally high-risk category, and that the children were already manifesting behavioural problems. In this contest, the author suggested that perhaps the families had more motivation and room to change and improve than might otherwise be expected.

The author was particularly impressed by the improvements in the children's behaviour and noted that 'even by the immediate post-test, the data suggests that the children's behaviours are already showing statistically significant improvements in…risk factors that are important in reducing later substance abuse…these positive outcomes in children's behaviours are larger than other SFP sites nationwide in the United States…' (p. 23).

The Western Region Drugs Task Force commissioned an evaluation of the roll-out of the Strengthening Families Programme (SFP) in five centres in the region (Sixsmith and D'Eath 2011). The evaluators posed seven questions and the main findings of the evaluation in relation to these questions are outlined below.

1. Was the SFP implemented as planned; what, if any, were the deviations from the plan; and what were the reasons for the deviations?
Steering committees comprising multi-agency representation were convened in all five centres as planned. However, levels of participation varied across committees, with several experiencing non-involvement of individuals and agencies. In one of the centres, plans to implement the SFP were abandoned because of inadequate levels of participation on the committee. For some steering committees, the referral system did not work as planned. Referral processes varied across the centres and some did not receive any referrals from the committees.

The steering committees, for the most part, decided the criteria for referral to the SFP. However, these decisions exhibited a lack of clarity and consensus as to the appropriate target groups. Steering groups reported inconsistencies around understanding which risk factors were relevant to determining eligibility for the SFP. For example, groups differed as to whether substance use was a risk factor, and, if it was, how the nature and extent of the risk were to be assessed. These inconsistent views were at variance with the overall aim of the SFP, which, according to the task force, was to reduce substance misuse by both parents and teenagers.

2. What were the perspectives of participating parents and teenagers on the SFP content and delivery?
The delivery of the SFP by a facilitator was valued by participants and the variety of activities, including role play, games and art, contributed to an unexpected fun experience; it was this experience that appeared to engage and sustain involvement. Teenagers seemed to learn more from specific modules, such as substance misuse, sexuality, communication and resolving conflict. On the other hand, parents tended to speak about their learning in general terms.

3. Was the mealtime an important element of the SFP for participants?
Parents, teenagers and service providers considered the mealtime an important component of the SFP. The mealtime preceded each of the 14 weekly sessions and was seen to act as an ice-breaker, providing an opportunity for less formal communication between families and providers and within families. Some families expressed the desire to incorporate this experience into family living.

4. Was the training adequate for facilitators to deliver the SFP, overall and in this setting?
An information seminar and a two-day training session were delivered in each of the four sites that continued with the programme. Overall, there were mixed views on the adequacy of training, with several facilitators saying that the training was only adequate

because of the range of skills they already possessed and that essential skills were neither provided nor tested during the training provided.

5. What alterations to the process and programme (implementation and content) are necessary to ensure successful outcomes in future delivery?
Changes to the referral process and greater clarity about the role of the referral agencies were identified as necessary improvements. In addition, improved clarity in identifying relevant target groups and in recruitment processes were perceived as necessary changes that could improve implementation and impact. Service providers suggested that future programmes could focus on families with children who were younger than the 12–16-year age group stipulated by the current SFP. This suggestion was based on the view that younger children were more amenable to behaviour change, and that some teenage participants in the current SFP exhibited challenging behaviours.

6. Did the SFP impact on participants, and if so what was the impact?
Families were assessed before and after their participation in the SFP, using three domains in the Family Environment Scale (FES): family cohesion, expressiveness, and conflict. According to the authors, the small sample size and poor response rate to some questions interfered with the analysis that was planned; the limited data generated meant that no significant differences between pre- and post-intervention were detected. Interviews with family members suggested that some benefits from participation in the SFP were achieved, such as improved communication within the family unit and enhanced parenting skills.

7. Did the SFP reduce drug and alcohol use among participants?
Parents were invited to answer questions drawn from the SLÁN questionnaire about their alcohol intake and related behaviours, before and after their participation in the SFP. The authors reported that too few participants answered some questions, which interfered with meaningful analysis. From the limited number of questions answered, no measurable impact on alcohol intake or related behaviours was detected.

Teenagers were invited to answer questions drawn from the Health Behaviour in School-aged Children (HBSC) questionnaire about their substance use and related behaviours, before and after their participation in the SFP. The authors reported that the amount and consistency of data generated from the responses were inadequate to allow meaningful statistical analysis. From the data generated, no differences in substance use could be credited to participation in the SFP.
Interviews with parents (n=10), teenagers (n=7) and service providers (n=9) revealed that, for most of the families taking part in the SFP, substance use was not perceived to be a major problem.

The lack of consensus on appropriate target groups and on what constitutes an at-risk family could have been overcome by a thorough needs assessment of potential participants. The lack of clarity between participants and service providers regarding the main objectives of the programme could have been resolved by setting short-term objectives, such as the reduction of identified risk factors, rather than focusing on long-term and perhaps unrealistic outcomes such as the reduction or cessation of substance use. The inclusion of alternative outcomes would have necessitated the selection of alternative data collection instruments. Instead of using modified versions of the SLÁN and HBSC surveys, alternative instruments could have been used to assess the impact of the SFP on participants.

3.4.3 **Recreational settings** (incl. reduction of drug and alcohol related harm)

See National Report 2008 for most recent information (Alcohol and Drug Research Unit 2008)

3.5 Indicated prevention

The Teen Counselling service provided by Crosscare, a voluntary agency working to promote the concept of social justice in the Dublin area, is a dedicated service working with young people who present with behavioural and emotional problems. The aim of the service is to provide a professional counselling service for teenagers and their families, and to inform, support and complement the role of other statutory and voluntary services working in this field. Teen Counselling works in teams of two, mostly a psychologist and a social worker, who initially assess the nature and severity of problems with the parents and teenagers who present. Subsequently, parents and teenagers are provided with individual counselling sessions, and when appropriate, combined sessions are scheduled; a consultant psychiatrist attends on a sessional basis. Teen Counselling publishes an annual report that details the profile and progress of clients for the reporting period; the most recent annual report relates to the year 2010.

In 2010, the total number of families attending the six Teen Counselling centres was 411 (Crosscare Teen Counselling 2011). This number comprised 247 new families and 164 carried forward from 2009. The profile of the new teenage clients (n=247) presenting in 2010 showed that 56% were under the age of 16 and 55% were male; 90% were attending second-level schools. Over two-thirds of referrals to the service were made by parents, usually the mother. Parents can list up to three reasons for referring their teenage children to the service; in 2010, behavioural problems in the home (39%), mood and anxiety problems (34%), family conflict (31%) and behavioural problems at school (30%) were cited as the main reasons for referring teenagers to the service. Drug use (5%) and alcohol use (4%) were also cited. Following their first meeting with teenagers and parents, counsellors make an assessment of what they regard as the most significant problems that teenagers are presenting with. In 2010, counsellors diagnosed family conflict (22%), teenage mood problems (19%), teenage patterns of disruptive behaviour (13%) and teenage problems coping with life changes/transitions (11%) as the most significant problems; substance use/dependency was diagnosed as significant among 4% of teenagers. Difficulties with communication were detected in 50% of families presenting.

The report noted that substance use was cited as a reason for referral for 9% of teenagers. However, when teenagers were later asked to complete a confidential self-report questionnaire about their substance use, 17% (n=42) reported current or past use of the following drugs: hash (88%), cocaine (10%), ecstasy (10%), solvents (7%) and pills (7%). Seventeen per cent cited use of an ‘other’ drug and these mainly included ‘head shop’ substances.

Teenagers were asked to consider their main problem and the severity of its impact on four important areas of their life: School, Home, Friends and Self. On completion they were again asked to rate the severity of the problem and any changes in these four areas. From the sample of teenagers who completed the questionnaires (30%, n=75), 55% reported that their main problem had greatly improved in relation to their self, 40% noted great improvement in their main problem in relation to school and the home, and 29% reported that their main problem had greatly improved in relation their friends.

Parents were also asked at intake and when counselling was completed to rate the severity of the main problems that their teenagers were presenting with and their ability as parents to deal with these problems. From the sample of parents who completed the self-report assessments (31%, n=78), 51% reported that the severity of the main problem their teenagers presented with had greatly improved and a further 38% noted some improvement; 49% reported that their coping ability had greatly improved and a further 45% noted some improvement in coping with their teenagers problems.

Counsellors reported some improvement in 46% of teenagers presenting with behavioural problems and in a further 9% of teenagers the main problems were

deemed to have ceased. Counsellors reported some improvement in 49% of families that presented with underlying problems, e.g. family communication problems, and in a further 7% of families, the main underlying problem was deemed to have ceased.

3.6 National and local media campaigns

Action 27 of the NDS plans to 'further develop a national website to provide fully integrated information and access to a National Helpline' (Department of Community Rural and Gaeltacht Affairs 2009). According to the progress report on the NDS for 2011(Department of Health 2012b), the website www.drugs.ie has now been established as the national resource for drug and alcohol information and support. In 2011 the website received 114,000 unique visits.

There was no national awareness campaign in 2011. The following developments were reported for 2011.

- January–November 2011 drugs.ie reported over 520 news items.
- In 2011 drugs.ie began building its social media presence through a Facebook Page and Twitter Page. Information and video content is now disseminated through these channels.
- Development and dissemination of the drugs.ie eBulletin
- Redevelopment of the drugs.ie multimedia section
- Further development of the features content
- Drugs.ie has now produced and delivered over 50 online videos relating to drugs and alcohol in Ireland.
- Exclusive recording and broadcasting of presentations from two HSE-sponsored seminar/conference: *The National Drug Conference 2011* and *A Family Affair? Supporting Children Living with Parental Substance Misuse.*
- In partnership with the HSE, drugs.ie is at an advanced stage in developing an online alcohol self-assessment tool and video-based brief interventions. This will initially be rolled out on drugs.ie and on the drugs.ie Facebook page.
- Drugs.ie has produced two videos relating to problematic use of codeine and benzodiazepines. These videos are psycho-educational in nature, delivered by health professionals, and are targeted at individuals looking to address problematic use of these substances.

4. Problem Drug Use (PDU)

4.1 Introduction

A PDU is defined in Ireland as an 'injecting drug user or long duration/regular user of opiates, cocaine and/or amphetamines' (EMCDDA 2004).

It is not possible to estimate the number of injecting drug users or PDUs, apart from opiate users, in Ireland as the National Drug Treatment Reporting System (NDTRS) does not use a unique identifier.

A **national 3-source capture-recapture (CRC) study**, to provide statistically valid estimates of the prevalence of opiate drug use in the national population, was commissioned by the National Advisory Committee on Drugs (NACD) and undertaken in 2001 and 2006. The 2006 study (Kelly, Alan*, et al.* 2009) indicated that use had increased since the 2001 survey (Kelly, Alan*, et al.* 2003). There were 11,807 known opiate users in 2006. The major expansion of the national methadone treatment programme between 2001 and 2006 was the main reason for the inflation of the figures. There is some doubt over the estimate produced of a possible further 8,983 opiate users who had not come into contact with any of the drug treatment services, hospital in-patient services or the Gardaí.

The following were among the trends (2001–2006) seen in the study results:
- the rate of opiate use among females and males aged 15–24 decreased, indicating a significant reduction in the number of young people commencing opiate use,
- an increase in opiate use outside of Dublin, and
- a higher proportion of opiate users in treatment in Dublin than elsewhere, reflecting the more recent spread of opiate use outside Dublin and the later development of treatment services.

Projects initiated in recent years to improve knowledge with regard to PDUs in Ireland include a study of methods and data sources which can be used to estimate the number of problem opiate and cocaine users and the prevalence of problematic opiate and cocaine use in Ireland (see Section 4.2.1); the drafting of legislation to allow for a 'unique identifier' (see Section 4.2.1); and questions in the general population survey on drug use to estimate the number of people dependent on cannabis (see Section 4.4.2).

4.2 Prevalence and incidence estimates of PDUs

See Section 4.2 of the 2011 National Report (Irish Focal Point (Reitox) 2011) for a full account of the results of the 2006 CRC study, the results of which are outlined in Section 4.1.

4.2.1 Indirect estimates of problem drug use

The NACD commissioned a study team (Maria Gannan and Gordon Hay) to investigate and report on methods and data sources which can be used to estimate the number of problem opiate and cocaine users and the prevalence of problematic opiate and cocaine use in Ireland. The objectives of the study were to:
- determine indirect statistical approaches to estimating numbers and rates of problematic opiate and cocaine users in Ireland,
- identify statistical or practical adaptations that would improve the reliability of the current CRC estimate,
- identify all data sources in Ireland, which can be used in the estimation of the prevalence of problematic opiate and cocaine use and, using a systematic approach, evaluate their potential for use, and
- design pilot studies to test the preferred approaches.

The study team made the following recommendations for estimating the prevalence of opiate/cocaine use in Ireland (Gannon*, et al.* 2011):

A combination of estimation methods should be used to calculate the prevalence of opiate use, with 4-sample CRC being the main method. A 4-sample CRC analysis should be carried out in all 26 counties; where it is not possible to calculate an estimate using CRC, either multiple indicator method or multiplier methods should be used. The study team favour a 4-sample CRC analysis as this produces more robust estimates than a 3-sample analysis. The four suggested samples are CTL, HIPE, PULSE and Probation Service data.[12] If this approach were used, each county would have a local estimate, and estimates could be produced for other geographical areas of interest such as HSE region or Probation Service area.

A pilot study using the recommended approach would not be an effective use of time and resources. Studies using the CRC method to estimate opiate prevalence generally comprise two phases – a data access and collection phase and an analysis phase. The first phase needs the most time and resources. The time and effort are not related to the amount of data being collected, so piloting data collection for only a few areas would not significantly reduce the time or cost involved. While a pilot study could investigate issues relating to the data, any possible issues could only be investigated once the data had been collected and the analysis begun; thus, a pilot study would still require the same amount of time and effort as a full study but without the benefit of comprehensive results.

A geographical unit of analysis needs to be identified in order to carry out a successful study. In order for the CRC method to be successful, analyses need to be carried out at a sufficiently 'local' level; stakeholders such as data providers would find local-level estimates useful for planning purposes. It is also important that the data refer to area of residence and not area of contact; for example, Garda (police) data should record the area of residence of the offender not the area where the offence was committed. Following round-table discussions with a group of prospective data providers (excluding Dublin and Tipperary), county level was identified as the preferred geographical area. These county estimates could be combined to give estimates at the level of HSE region or Garda region, or to give a national estimate. Administrative geography indicates that Tipperary should be broken in two - into north and south ridings; the unit of analysis for Dublin requires further analysis taking into account the River Liffey and HSE local health office, drugs task force and local authority area boundaries.

In order for the study to be timely, cost effective and successful, research governance needs to be improved. The data required to match successfully across sources in a CRC analysis are an individual's initials, date of birth, and gender. Encryption can be used to transform this data into an unrecognisable code prior to transfer from data provider to researcher. However, as with any research of this nature, ethical approval is required. The different data providers will also need information on data security and the procedures for safe disposal of the data once the study is completed. Previous CRC studies in Ireland have involved numerous ethics applications to access HIPE data from different hospitals around the country. This has led to significant delays and was a waste of time and resources. The study team recommend that the NACD together with data providers investigate streamlining research governance. Moreover, prior to any future prevalence work, a concerted effort should be made to raise awareness among stakeholders about the nature of prevalence estimation, the data required and the benefits of the resulting estimates.

Use a different method to estimate cocaine prevalence. Owing to the nature of powder cocaine use and the fact that cocaine users can be identified through current Irish data

[12] See Section 6.1 for a description of CTL and HIPE. PULSE (Police Using Leading Systems Effectively) is the Garda Síochána's computerised information system.

sets, the study team recommend a different method of prevalence estimation than that suggested for opiate use. For example, a heroin user who appears in PULSE data is in the same cohort as an opiate user appearing in the HIPE data, but the same cannot be said of a user of powder cocaine. As a result, CRC cannot be used to produce a valid estimate of cocaine users. The study team recommend using a combination of large household survey data and data from a longitudinal study of substance misuse, to model the different levels of powder cocaine use within the Irish population.

Health Information Bill

In June 2008 the Department of Health and Children (DoHC) launched a public consultation on a health information bill. The DoHC prepared a thematic synopsis setting out the main points raised. With regard to public opinion on a unique personal identifier for individual health records and health-related information systems, there was general support but many commentators (including the Data Protection Commissioner) recommended that this identifier should not be the PPSN used for taxation and social welfare purposes. It was also recommended that confidentiality and privacy be protected in any new system (Department of Health and Children 2009, 09 January). As part of its commitment to the consultation process and in line with the philosophy of engaging with individuals in Your Service, Your Say,[13] the DoHC in conjunction with the Health Service Executive (HSE) and the Health Services National Partnership Forum, held a consultative workshop on 20 January 2009. Once again there was general support for a unique identifier in health-related records but many people had reservations about the use of the PPSN (without specific protections) as the identifier, principally because of linkages fears.

The new government elected in early 2011 included a health information bill in its legislative programme; this bill is due to be published by the end of 2012.[14]

4.2.2 Estimates of incidence of problem drug use

There are no estimates of the incidence of problem drug use in Ireland.

4.3 Data on PDUs from non-treatment sources (police, emergency, needle exchange etc)

4.3.1 PDUs in data sources other than TDI

For most recent information, see 2011 National Report (Irish Focal Point (Reitox) 2011).

4.4 Intensive, frequent, long-term and other problematic forms of use

4.4.1 Description of the forms of use falling outside the EMCDDA's PDU definition (in vulnerable groups)

In May 2011, the South Inner City Drugs Task Force commissioned research 'to assess the prevalence of drug misuse in South Inner City Dublin' (Giaquinto 2011). The results and methods indicate that they described the patterns of drug use and explored peoples' current experience of drug use rather than estimating its prevalence. The research was based on focus groups, individual interviews with service users attending some of the drugs task force projects and information obtained from existing literature.

[13] The Office of Consumer Affairs has responsibility for developing and implementing best-practice models of customer care within the HSE and promotes service user involvement throughout the organisation through the concept of 'Your Service Your Say'.

[14] See Section B of the Government Legislation Programme at www.taoiseach.ie , accessed on 5 September 2012. The purpose of the bill as stated in the Government Legislation Programme is 'to provide a legislative framework for the better governance of health information so as to enhance individual patient care and safety and achieve wider health service goals and to provide for a streamlined structure for multi site health research ethics approval'.

Twenty-six service users agreed to participate in either a personal interview or a focus group. They were asked four questions:

1. their own previous or current drug use,
2. their perception of the prevalence of drug misuse in the in south inner city,
3. the nature of drug dealing in the area, and
4. young people's use of drugs.

The results indicated that people were asked about drug use in Ireland as well as in the south inner city.

When the data were analysed and considered alongside existing information, the following pattern emerged for 2011:

- All drugs, regardless of their legal status, were readily available in Ireland. The findings of a 2011 Flashbarometer survey (The Gallup Organization 2011) suggested that all drugs, including heroin, were easier to obtain in Ireland than in most EU countries.
- According to the same Flashbarometer report, the use of' legal highs' and other drugs by young people was higher in Ireland, at 16%, than elsewhere in the EU.
- Father Peter McVerry, of the Peter McVerry Trust, which is committed to reducing homelessness, drug misuse and social disadvantage among young people through its provision of housing and support services, was reported as saying that young people were at high risk of adverse effects from using 'legal highs', alcohol and tablets, either used alone or in combination with one another.
- Reports at the time of the study indicated that crystal meth was beginning to emerge as a new drug in Dublin's south inner city.
- According to interviewees, drugs in Ireland contained an increasing level of impurities.
- There was a very large amount of prescription drugs on the market and also locally-manufactured tablets which might contain dangerous substances.
- There was a decrease in the numbers attending opiate detoxification or substitution treatment, from 979 in 2008 to 963 in 2010. The number of women attending opiate detoxification or substitution treatment in the south inner city decreased between 2008 and 2010, from 330 to 228, while the number of men increased, from 649 to 675. Between 2008 and 2010 there was a 3% increase in clients aged forty-years or over attending opiate detoxification or substitution treatment.
- The HRB NDTRS recorded 420 adults entering treatment in the south inner city area in 2010. Of these, over two-fifths (62%) reported an opiate as their main problem drug, and 32% reported alcohol as their main problem drug. Only 4% were treated for cocaine as their main problem drug and 2% for cannabis. None were treated for benzodiazepine use as a main problem drug.
- Seventy per cent reported they had problems with one or two additional drugs, and 30% reported problems with three or more additional drugs.
- Forty-four per cent reported they had injected, and 47% reported they had first injected before the age of 19 years. Sixty-five per cent said they had shared injecting equipment.

4.4.2 Prevalence estimates of intensive, frequent, long term and other problematic forms of use, not included in the PDU definition

The NACD will be able to use data from the general population survey on drug use 2010/11 to estimate the number of people dependent on cannabis in the year prior to the survey (Jean Long, NACD committee member, 2012). The questionnaire has two measures of cannabis dependency, the MCIDI based of clinical diagnosis and the SDS used in a number of studies on treatment.

5. Drug-related treatment: treatment demand and treatment availability

5.1 Introduction

Two broad philosophies underlie the approaches to drug-related treatment in Ireland: medication-free therapy and medication-assisted treatment. Medication-free therapy uses models such as therapeutic communities and the Minnesota Model, though some services have adapted these models to suit their particular clients' needs. Medication-assisted treatment includes opiate detoxification and substitution therapies, alcohol and benzodiazepine detoxification, and psychiatric treatment. Various types of counselling are provided through both philosophies of treatment and independent of either type of treatment. Alternative therapies, such as acupuncture, are provided through some community projects.

The **Health Service Executive (HSE)**, which manages Ireland's public health sector, provides an addiction service, including both illicit drugs and alcohol, delivered through Social Inclusion Services, which is part of its Integrated Services Directorate. Addiction treatment services are provided through a network of statutory and non-statutory agencies. Under the Community Pharmacy Contractor Agreement, the HSE can agree with individual pharmacies to dispense methadone mixture DTF1mg/ml to opiate dependent persons in their local areas on a special methadone prescription form. The involvement of community pharmacists in the dispensing of methadone also ensures that a large number of opiate dependent persons may be treated in their own local areas.

Merchants Quay Ireland (MQI) is a voluntary organisation, based in South Inner City Dublin, which provides a wide range of services to homeless people and drug users.

In 1998 a **Methadone Treatment Protocol (MTP)** was introduced, to ensure that treatment for opiate misuse could be provided wherever the demand exists. New regulations pertaining to the prescribing and dispensing of methadone were introduced, and a joint Health Board/Irish College of General Practitioners (ICGP) committee was formed to provide training, ongoing education and regular audit for general practitioners (GPs) taking part in the programme. Under this protocol, any GP wishing to take part in the provision of treatment services to drug users, must undertake training as provided by the ICGP. Under the MTP, GPs are contracted to provide methadone treatment at one of two levels – Level 1 or Level 2. Level 1 GPs are permitted to maintain methadone treatment for misusers who have already been stabilised on a methadone maintenance programme. Each GP qualified at this level is permitted to treat up to 15 stabilised misusers. Level 2 GPs are allowed to both initiate and maintain methadone treatment. Each GP qualified at this level may treat up to 35 misusers. Practices where two Level 2 GPs are practising are permitted to treat up to 50 misusers. Locally-based methadone treatment for opiate misusers is now provided through drug treatment clinics, satellite clinics or through GPs in the community.

The **Progression Routes Initiative,** located in Anna Liffey Drug Project's premises in north inner-city Dublin, seeks to improve service delivery to those attending drugs services. It does this by working with multiple agencies to formulate and implement strategic interagency solutions to identified barriers to progression.

Data on drug treatment in Ireland are collected through two national data collection tools – the National Drug Treatment Reporting System and the Central Treatment List.

The **National Drug Treatment Reporting System (NDTRS)** is a national epidemiological database which provides data on treated drug and alcohol misuse in Ireland. The NDTRS collects data from both public and private outpatient services, inpatient specialised residential centres and low-threshold services. For the purposes of the NDTRS, treatment is broadly defined as 'any activity which aims to ameliorate

the psychological, medical or social state of individuals who seek help for their substance misuse problems'. The NDTRS is a case-based, anonymised database. The NDTRS is co-ordinated by staff at the Health Research Board (HRB) on behalf of the Department of Health and Children. The number of drug treatment services participating in the NDTRS continues to increase (Standard Table TDI 34). Although treatment is provided within the Irish Prison Service, it was only in 2009 that counsellors working in the prison service began to return information to the NDTRS.

The **Central Treatment List (CTL)** was established under Statutory Instrument No 225 following the *Report of the Methadone Treatment Services Review Group 1998* (Methadone Treatment Services Review Group 1998). This list is administered by the Drug Treatment Centre Board on behalf of the HSE and is a complete register of all patients receiving methadone (for treatment of opiate misuse) in Ireland and provides all data on methadone treatment nationally.

The **Research Outcome Study in Ireland (ROSIE)** was the first prospective study of treatment outcomes for opiate users to be conducted in Ireland. The objective was to evaluate the effectiveness of treatment and other intervention strategies for opiate use. The study recruited 404 opiate users entering treatment between September 2003 and June 2004. Three treatment modalities, provided through both inpatient and outpatient settings, were the focus of attention – methadone maintenance, structured detoxification, and abstinence-based treatment programmes. In addition, a sub-sample of individuals was recruited from needle exchange interventions. Participants were interviewed at treatment intake, or as soon as possible thereafter, and again at 6 months, 12 months and 3 years after the baseline interview. Data were collected by means of a structured interview. The interview instrument contained a comprehensive set of outcome measures detailing the social and psychological characteristics of the cohort, and a range of treatment process factors in relation to treatment outcomes. Between September 2006 and October 2008 seven papers in the ROSIE Findings series, concentrating on particular aspects of the study, were published; in June 2009 a report on outcomes at 1-year and 3 years for the whole population and the 'per protocol' population, i.e. participants who completed all three interviews, was published (Comiskey, Catherine *, et al.* 2009). In 2010 six further papers reporting on the data were published including analyses of the effects of treatment settings, treatment pathways and use of additional drugs on treatment outcomes for opiate users.

5.2 General description, availability and quality assurance

5.2.1 Strategy/policy

The HSE's National Service Plan 2012 (NSP) set out the HSE's plans for 2012 (Health Service Executive 2012). In his introduction to the plan, the CEO of the HSE pointed out that this was the third consecutive year in which the organisation had taken a cut in its annual budget. Unlike previous years, expenditure cuts in 2012 would begin to impact directly on frontline services.

The CEO outlined how the HSE planned to minimise this impact by 'fast-tracking new, innovative and more efficient ways of using a reducing resource' and by moving to models of care which 'treat patients at the lowest level of complexity and provide services at the least possible unit cost'. Services in the drugs and alcohol area were not to be exempt from these new approaches.

The strengthening of 'multidisciplinary complex care', including the development of protocols signposting referral pathways between specialist addiction/homeless/traveller services and primary care services, was listed as a 'key result area' under Primary Care, Demand-Led Schemes and Other Community Schemes (p. 26).
In the delivery of addiction services (Table 5.2.1.1), which continued to be co-located with homelessness, intercultural health, Travellers' health, and lesbian, gay, bisexual and transgender (LGBT) health services under Social Inclusion Services, it was planned to monitor treatment outcomes and to analyse methadone waiting lists and

exits from the Central Treatment List (CTL) on a quarterly basis. These actions are noteworthy when set against the performance activity report for 2011 (p. 70), which showed that the target of 100% substance misusers over the age of 18 years commencing treatment within one month of assessment was not achieved. The HSE also intended to review the operation of the national drugs rehabilitation framework and identify hindrances to care planning/case management at the systemic and individual client level.

Table 5.2.1.1 Addiction services, deliverable outputs 2012

Addiction services	Deliverable outputs 2012	Target completion
National Drugs Strategy (NDS) 2009–2013 – implement recommendations from HSE *Opioid Treatment Protocol*	• Establish a national data collection, collation and analysis group to maximise the use of current data, identify new data, and develop a brief outcome monitoring process for individuals.	Q1
	• Develop joint clinical guidelines on the treatment of opioid addiction across the full range of drug services by the ICGP, ICP, PSI and the HSE. The guidelines will include an implementation plan for the move to less urine testing and a greater clinical focus on the use of the results of drug testing samples.	Ongoing
	• Produce a quarterly analysis report on methadone waiting lists.	Ongoing
	• Produce a quarterly analysis report on exits from the Methadone Treatment List.	Q2–Q4
Report of the Working Group on Residential Treatment and Rehabilitation 2007 and *HSE National Drugs Rehabilitation Framework 2010*	Conduct an analysis of the HSE's *National Drug Rehabilitation Framework* for usefulness for the following groups: service users, case managers, key workers within other disciplines and service managers.	Q4
	Measure client care plan progression over the course of 2012.	Q4
	Identify the barriers that hinder care planning / case management at the systemic and individual client level.	Q4
Prioritise and implement HSE actions in the *National Substance Misuse Strategy* (following its publication)	Develop an annual training plan which targets emerging trends in addiction and reflects best practice via the HSE National Addiction Training Programme.	Q1
	Implement Quality Standards (Quality in Addiction and Drug Services, QuADS) in both the statutory and voluntary-managed addiction services.	Ongoing
	Conduct an effectiveness review exercise on all current forms of needle exchange provision currently funded by the HSE.	Q4
	Launch an Alcohol Public Education / Awareness Campaign.	Q1
	Further develop web-based information and awareness systems for addiction.	Q4
	Develop a national drug and alcohol service directory to include in-depth information on treatment and rehabilitation and geo-mapping for staff and service (linked with HSE Health Intelligence Unit and Health Atlas).	Q3

Source: (Health Service Executive 2012) pp. 68–69.

5.2.2 Treatment systems

Notwithstanding the budget cuts, new initiatives were flagged for 2012:

- In line with recommendations in the revised HSE Opioid Treatment Protocol, implementation of new clinical guidelines were flagged (see Section 5.2.2.1).
- Following publication of the anticipated National Substance Misuse Strategy, the HSE would adopt a new addiction training plan, implement quality standards across all addiction services, and develop a series of new information and awareness initiatives.
- Needle exchange was another new focus for the HSE: as well as reviewing the effectiveness of all currently funded needle exchange provision, the HSE would aim to recruit 90 pharmacists to provide the needle exchange programme.
- The target set in the 2011 service plan, to complete an analysis of addiction services for children nationwide based on best practice by year's end, was not met and was moved out to Quarter 3 of 2012 (p. 60). This action was identified in response to Recommendation 3 in the *Report of the commission to inquire into child abuse* (Ryan 2009), on the provision of counselling and educational services for children, which called on the HSE and the drugs task forces to establish addiction services for children nationwide based on best practice by June 2011.

5.2.2.1 Organisation and quality assurance

Development of clinical guidelines for opioid treatment
A group has been set up to review and develop clinical guidelines for the treatment of opioid addiction in Ireland. This group was instigated as a result of a recommendation arising out of the review of the MTP (Farrell and Barry 2010). The group consists of representatives of the Irish College of General Practitioners (ICGP), the College of Psychiatry of Ireland, the Pharmaceutical Society of Ireland and the HSE. The 2011 progress report for the NDS stated, 'It is envisaged that these guidelines will include an implementation plan for the move to less urine testing and a greater clinical focus on the use of results of drug testing samples.' (Department of Health 2012b) p. 16

Addendum to best-practice guidelines on treatment for opiate users
The ICGP issued an addendum to its best-practice guidelines *Working with opiate users in community based primary care* (Irish College of General Practitioners 2008). The addendum clarifies four items in the guidelines:

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- To the sentence 'Increments should be no greater than 10 mg at a time' is added '*total dose increases should not exceed 20–30 mg in one week'*.
- The sentence 'Patients usually stabilise on doses between 60 mg to 80 mg' is changed to '*Patients usually stabilise on doses between 60 mg to 120 mg'*. The ICGP stated that this change was in line with international best practice, but they recommended that 'this statement is read in the context of the complete section on commencing doses'.
- The sentence starting 'Higher doses of methadone (>80 mg) may be required…' is changed to '*Higher doses of methadone may be required...*'. The ICGP stated: 'It is not intended to suggest that >80 mg would be interpreted as a high dose.'

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- A similar rationale relating to dosage applies to the sentence starting 'If a patient requires a dose >80 mgs and you have limited experience ...' , which is now changed to '*If a patient requires a higher dose and you have limited experience ...*'.

These changes were made to the on-line version of the guideline document only, as the new national guidelines on opioid treatment were still being developed (see above).

Community detoxification protocols
The Community Detoxification Protocols were originally developed in response to a number of identified needs, including queries from some service users who found it difficult to access outpatient detoxification, and from medical professionals who noted some challenges in providing an outpatient detoxification in the absence of structured community support (Lyons, S 2008b) (Dermody and Lyons 2012).

To address these issues, the Progression Routes Initiative brought together in 2007 an interagency group, including members from the medical and community/voluntary sectors and service user representatives, to develop protocols. The protocols outline the minimum standards for delivery of interagency support for outpatient detoxification. This includes medical support provided by prescribing doctors and psycho-social supports provided by key workers. A key person is nominated as the local 'broker' to raise awareness of the protocols and to support engagement of local professionals in community detoxification. The protocol was piloted in Dublin's north inner city in 2008 and 2009.
The evaluation of the pilot revealed a successful initiative with promising retention rates and stakeholder satisfaction. In November 2010, the Community Detoxification Steering Group reconvened and was expanded to include representation of service user groups, research bodies, and medical, community and voluntary service

providers. The group reviewed and strengthened many aspects of the protocols, incorporating lessons learnt from the pilot (Irish Focal Point (Reitox) 2010).

One of the main changes was the division of the protocol into two separate sets of guidelines, one for methadone detoxification and one for benzodiazepine detoxification (Progression Routes Initiative 2011b, Progression Routes Initiative 2011a). The protocols contain a structured, step-by-step detoxification process and clarify the roles of each stakeholder (service user, doctor and key worker) in the process {Progression Routes Initiative, 2011 #1938; Progression Routes Initiative, 2011 #1939. They include guidelines on psycho-social supports and information to support prescribers to work under these protocols.

While the minimum supports remained largely unchanged following the pilot (weekly relapse prevention, care planning and regular medical appointments), certain areas of the protocols have been bolstered to support the professionals working in line with them. For example:

- Separation of protocols: differences in risks, processes and structural contexts for benzodiazepine prescription and detoxification and for methadone prescription and detoxification are now reflected in two separate sets of protocol documents, one for each substance.
- The detoxification process has been divided into four simple, logical steps with clear roles and responsibilities for each stakeholder in the process: brokering, preparation, detoxification, and aftercare.
- Roles of the service user, key worker, doctor and broker clarified, with a comprehensive guide to the role of the local broker being provided.
- Additional guidelines, information and resources for prescribing doctors.
- Comprehensive FAQ section which includes information on common queries, blocks and challenges encountered during community detoxification.
- Comprehensive, service-user friendly information on risks involved in detoxification are incorporated in to an agreement form which is included in the protocols.

Owing to interest from a number of areas in implementing the protocols and increasing numbers of referrals from outside the north inner city, a National Community Detoxification Pilot 2012 was launched at the National Drugs Conference of Ireland 2011. The sites for the national pilot are Cork/Kerry, the South East Regional Drugs Task Force (SERDTF), the North Eastern RDTF, the Midlands RDTF, and the Bray, Ballymun, Ballyfermot, North Inner City Dublin and South Inner City Dublin LDTFs.

Individuals from a variety of professions were nominated by each local or regional drugs task force to be trained in the role of 'broker' for their area. Progression Routes delivered training in October 2011 and provide an ongoing programme of support for independent brokers in the pilot areas. During 2012/13 an evaluation will be conducted with the support of the evaluation sub-group.

Audit of GPs providing methadone

The terms of reference for the Joint HSE/ICGP Audit Review Group (ARG) have been revised {Connolly, 2012 #2097}. The purpose of the committee is to 'provide support through advice, education, training and audit, to Level 1 and Level 2 GPs, involved in treating people with substance misuse problems, so that the care provided meets the standards set out in national and international best practice guidelines'. The functions of the committee are to:

- devise and maintain a system of annual audit of GPs participating in the MTP;
- have a representative from the ARG who will sit on and report to the Methadone Implementation Committee;
- issue certification on completion of satisfactory audit;
- accept and process applications for level 2 accreditation; and
- provide ongoing review of audit and training requirements.

5.2.2.2 Availability and diversification of treatment

Waiting lists for methadone treatment

Newly published data from the HSE[15] show a reduction in the number of people waiting for methadone treatment in Ireland between March 2011 and April 2012. At the end of April 2012 there were 187 people waiting for treatment, compared to 230 in March 2011.

Most of the 48 clinics listed reported a reduction in waiting times and also in the number of people waiting for treatment; 22 centres reported no waiting list. The average waiting time was 0.8 months. These figures include data from new clinics in Kilkenny, Tullamore and Wexford that were set up in 2011. The clinic in Portlaoise reported the longest waiting list, with 24 people waiting for treatment at the end of April 2012, and an average waiting time of 5.7 months.

In a press release on publication of the new data, Minister of State Róisín Shortall TD stated: 'At a time of cut-backs, HSE management and frontline staff deserve credit for making good progress and for doing more with less. … With the data now available we can assess more accurately the areas where treatment provision needs to be boosted further and I will work to address these needs over the coming months' (Shortall, R 2012, 25 July).

MQI annual review 2010

The MQI annual review for 2010 noted the development of a number of important new initiatives in 2010 (Merchants Quay Ireland 2011). These initiatives were the extended day service, developed in association with Focus Ireland; New Communities Support Service; Midlands Traveller Specific Drugs Project; Aftercare Housing, in conjunction with Respond Housing Association; Drug Free Day Programme; and Easy Access Education for Homeless People.

The review also provided additional information that is not fully reflected in the treatment figures recorded by the NDTRS.

MQI's needle-exchange service recorded approximately 25,000 client visits in 2010, a 20% decrease on 2009 figures. The report highlighted a continuing high level of demand for homeless services, with 57,840 meals provided in 2010. The number of health care interventions provided increased by 15%, to 3,685 in 2010.

In 2010 MQI successfully tendered to provide the national prison-based addiction counselling service to 13 prisons. In excess of 13,000 counselling hours were provided during 2010. This service was provided by 23 counsellors, each with an average caseload of 550 prisoners.

MQI in association with the Midland Regional Drugs Task Force administers the Midlands Family Support and Community Harm Reduction Service, providing outreach and working with families of those actively using drugs in that task force region. The family support service provided services to 237 new clients across the region during 2010. The harm reduction service provided needle-exchange services to an average of 124 clients each month during 2010. The services offered by MQI and the numbers of people accessing them in 2010 are shown in Table 5.2.2.2.1.

Table 5.2.2.2.1 Services offered by MQI, 2010

Service	Type of intervention	No. of participants	Outcomes
Needle-exchange and health-promotion services	Promotes safer injecting techniques HIV and hepatitis prevention	4,308 used needle-exchange services, of whom 575 were new	

[15] Data on the waiting list can be accessed at: http://healthupdate.gov.ie/wp-content/uploads/2012/07/Summary-NWL-April-12-v-March11.pdf

Service	Type of intervention	No. of participants	Outcomes
	Safe sex advice Information on overdose Early referral to drug treatment services	clients 1,617 safer injecting workshops	
Stabilisation services	Methadone substitution Supportive day programmes Gateway programme Counselling	19 78 (monthly average)	
Settlement service	Assists service users to access interim and long-term accommodation	74 (quarterly average)	45 clients were resettled.
Integration programmes	Access to transitional accommodation Ballymount House Group and one-to-one therapeutic sessions	3 (annual average)	
Training and work programmes	FÁS Community Employment scheme	90	Of the 26 who completed FÁS placements at Merchants Quay, 6 secured permanent employment, 2 moved to further education.
High Park	17-week, drug-free residential programme including individual counselling, group therapy, educational groups, work assignments and recreational activities	62 (of whom 13 were admitted for detoxification)	10 clients completed detox
St Francis Farm	Therapeutic facility offering a 6–12-month programme.	34	11 clients completed three months or more

Source: (Merchants Quay Ireland 2011).

Parental responsibilities and drug treatment outcomes

A recently published analysis of data from the ROSIE study aimed to establish whether having children in their care at intake affected the treatment outcomes of opiate users (Comiskey, Catherine *, et al.* 2009).

Of the 404 opiate users recruited in 2003/4 to the ROSIE study, 212 (53%) had children aged 17 or under (a total of 370 children). Ninety-two of these participants had primary responsibility for one or more of their children. Women were significantly more likely than men to have primary responsibility for their children, 59% compared to 15.2%. At one-year follow-up, completed questionnaires were obtained from 74 of the original 92 clients with children in their care at intake and 213 of those not caring for children at intake.

This study compared the groups at intake, and the outcomes at one year, rather than those at three years, based on evidence that 'in general the greatest changes in outcome occur early in treatment, and that longer term outcomes do not exhibit further improvements'. The author pointed out that limitations of the study were that a proportion of the participants were recruited through prisons or residential rehabilitation centres, and therefore could not have had children in their care, and also, participants were not randomly allocated to the different treatment modalities which may have also affected the results.

At intake there was no significant difference in drug use between the two groups, with the exception of the rate of benzodiazepine use, which was lower among the group of participants with children in their care.

At one-year follow-up, significantly fewer of the group with responsibility for children were using heroin, benzodiazepines or cannabis. This group were also using heroin on significantly fewer days compared to the group without responsibility for children. However, regression modelling revealed that having responsibility for children was a significant and positive predictor for using other opioids. Having responsibility for children was also a positive, but non-significant, predictor of use of alcohol, illegal methadone and tobacco.

While both groups had experienced a reduction in psychological symptoms at one year, a greater number of significant reductions were experienced by the group who did not have responsibility for children. The analysis also showed that the group with responsibility for children experienced significantly more panic attacks.

The author concluded that having responsibility for children significantly improved the outcome of a client's treatment for heroin use. The results did suggest some worrying trends, including the use of alcohol and other opioids among the group with responsibility for children, which may indicate that this group had been substituting other substances for heroin. While the effects of parental substance misuse on children have been studied, the ways in which having custodial care of one or more children may affect a client's drug treatment outcomes has not been widely researched. The author recommended that further research in this specific area would improve the effectiveness of drug and alcohol treatment and provide the maximum benefit to both the parent and the child.

Unmet needs and benzodiazepine misuse among people on methadone maintenance

Many problem opiate users in treatment also misuse other substances. This presents a challenge to addiction services as often one single service cannot address their often complex needs of such clients. A study carried out in the Drug Treatment Centre Board examined clients' perceptions of unmet needs and the association between misuse of non-prescribed benzodiazepines and extent of unmet needs (Apantaku-Olajide*, et al.* 2012).

The authors used the Camberwell Assessment of Need Short Appraisal Schedule – Patient-rated version (CANSAS–P) as the measurement tool for this study.

CANSAS–P provides scores based on the client's ratings of 22 items in terms of total needs, unmet needs and met needs. Unmet needs can be used as a predictor of perceived quality of care. The authors believed this was the first study to use this tool to assess unmet needs among clients of addiction services.

Clients who were opiate dependent and receiving methadone for at least three months were eligible to participate in the study. Clients with acute or end-stage medical problems were excluded. Over half (107, 56%) of 191 eligible clients took part. There were no statistically significant differences between the sociodemographic characteristics of those who took part and those who did not.

Of the 107 participants, 52 (49%) reported using non-prescribed benzodiazepines in the previous month. Of these, only one reported both oral and intravenous use. The mean number of days on which benzodiazepines were used was 14, and 90% had benzodiazepine-positive urine samples in the previous month. The group who misused benzodiazepines had statistically more frequent use of both cocaine (mean 2.4 days versus mean 1.6 days) and heroin (mean 12.3 days versus mean 5.3 days) compared to the group who did not misuse benzodiazepines. Table 5.3.1.1 shows the mean number of met and unmet needs in both groups.

Table 5.3.1.1 Mean number of client needs, met and unmet, and association with benzodiazepine use

	Benzodiazepine misuse (n = 52)	No benzodiazepine misuse (n = 55)	
Mean number of needs	7.8	6.4	$p = 0.02$
Mean number of met needs	1.8	1.6	$p = 0.53$
Mean number of unmet needs	5.9	4.7	$p = 0.02$

Source: (Apantaku-Olajide*, et al.* 2012)

The highest proportions of unmet needs related to the following items in the assessment tool:

- substance misuse treatment,

- daytime activities,
- social company,
- money budgeting and benefits,
- psychological distress, and
- physical health.

There were statistical differences between the two groups in relation to substance misuse and daytime activities. Needs that were generally rated as met included accommodation, food, telephone access, self-care, childcare and transportation.

Multivariate linear regression showed that a higher number of days of benzodiazepine misuse was significantly associated with a higher unmet needs rating. The authors stressed that this was a study of needs assessment and that it 'does not propose that fulfilling unmet needs will necessarily alter benzodiazepine misuse among opioid users'. They recommended a more formal and active assessment of the needs of clients on methadone treatment and rapid access to evidence-based treatment for benzodiazepine misuse.

5.3 Access to treatment

5.3.1 Characteristics of treated clients (TDI data included)

See section 5.3.2. Please note there is no TDI data for 2011.

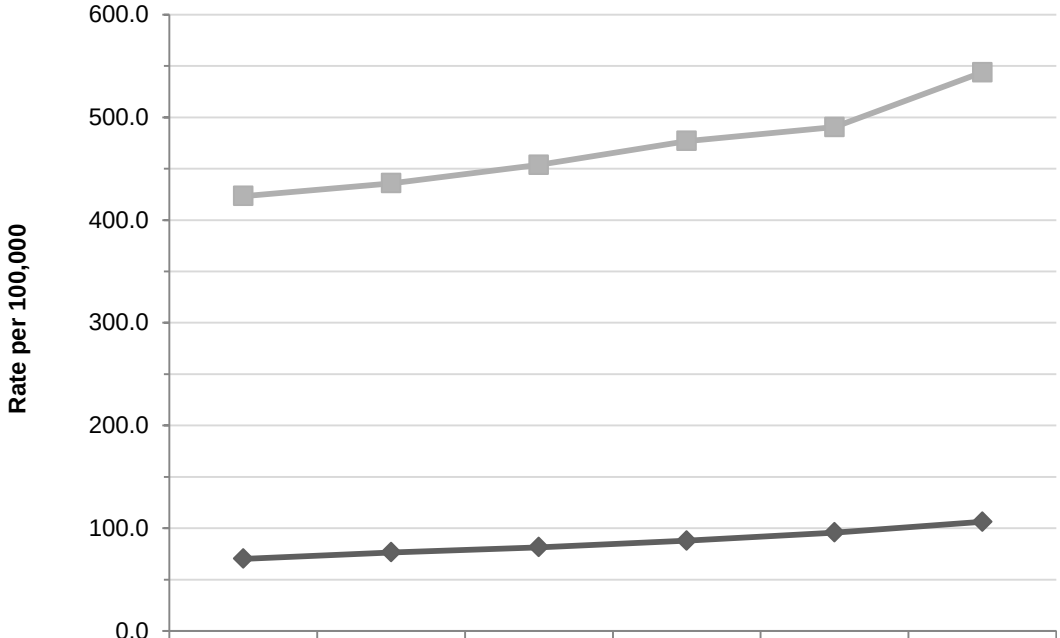
5.3.2 Trends in treated population and treatment provision (incl. numbers)

Trends in treated problem drug use in Ireland 2005–2010
The most recent data from the NDTRS describes trends in problem drug use in Ireland between 2005 and 2010 (Bellerose*, et al.* 2011). It is important to note that each record in the NDTRS database relates to a treatment episode (a case), and not to a person. This means that the same person could be counted more than once in the same calendar year if he/she had more than one treatment episode in that year.

The number of cases entering drug treatment each year and reported to the NDTRS increased by 52%, from 5,176 in 2005 to 7,878 in 2010. The increase in the total number of people requiring drug treatment services, including previously treated cases returning to treatment is a strong indication that problematic drug use remains a pressing issue, and presents complex and multiple challenges to those providing treatment. The clear spread and increase in treated drug use throughout the country reflect not only the extent of problem drug use but also an increase in treatment availability and compliance with the NDTRS.

Figure 5.3.2.1 presents the rates for the incidence (new cases) and prevalence (all cases) of treated problem drug use for the years 2005–2010, expressed per 100,000 of the population aged 15–64 years, based on census figures for 2005 and 2006 and Central Statistics Office (CSO) estimated figures for 2007 to 2010.The incidence increased consistently each year, rising from 70 cases per 100,000 in 2005 to 106 cases in 2010. The number of new cases entering treatment is an indirect indicator of recent trends and points to an increase in drug use over the six-year period.

The prevalence also increased consistently during the reporting period, rising from 423 cases per 100,000 in 2005 to 544 cases in 2010. This indicates that problem drug use is a chronic, recurring health condition that requires repeated episodes of treatment over time.

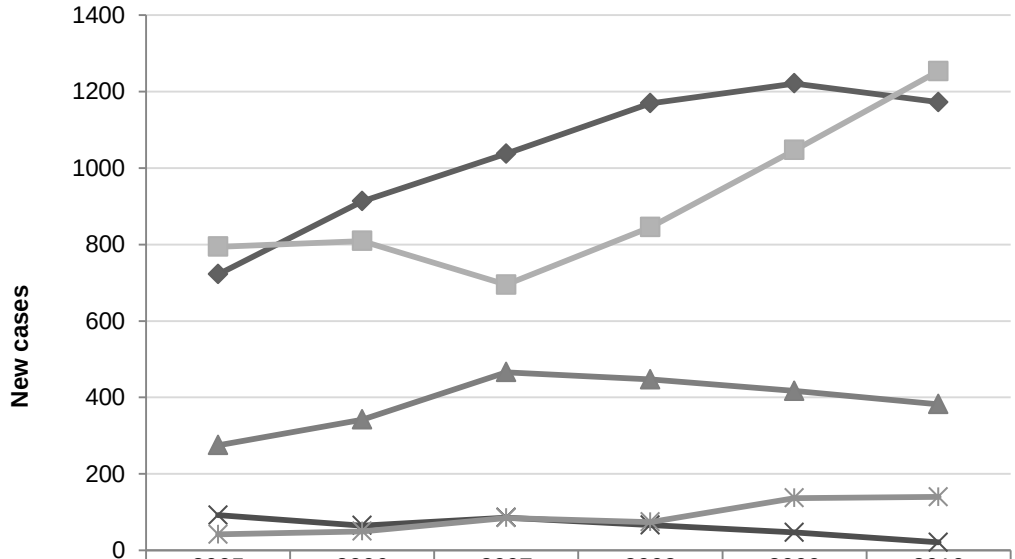


	2005	2006	2007	2008	2009	2010
Incidence (new cases)	70.3	76.5	81.5	87.9	95.7	106.2
Prevalence (total cases)	423.2	435.7	453.7	476.8	490.4	543.8

Figure 5.3.2.1 Incidence and prevalence of treated problem drug use per 100,000 15–64-year-olds, NDTRS 2005–2010
Source: (Bellerose, *et al.* 2011)

Opiates (mainly heroin) were the most common problem drugs reported for all years, with the proportion of opiate users remaining stable between 2005 and 2008 but decreasing slightly in the following two years. The number of cases reporting cannabis as their main problem substance increased significantly over the reporting period, from 1,039 in 2005 to 1,893 in 2010. Following a steady increase to a peak in 2007, the number of cases reporting cocaine as their main problem substance decreased every year thereafter.

Head shop compounds were reported as a main problem substance for the first time in 2009 (17 cases), with the number increasing significantly to 213 cases in 2010, when it exceeded the numbers reporting amphetamines, ecstasy and volatile inhalants. Among new cases, benzodiazepines accounted for the highest proportional increase among the five most commonly reported problem substances (Figure 5.3.2.2). In 2010, cannabis became the most common main problem drug reported by new cases, ahead of opiates for the first time since 2005.



	2005	2006	2007	2008	2009	2010
Opiates	722	913	1037	1169	1221	1172
Cannabis	794	809	695	845	1047	1253
Cocaine	275	342	466	447	417	382
Ecstasy	92	65	86	66	47	21
Benzodiazepines	42	50	85	74	137	140

Figure 5.3.2.2 Main problem drug reported by new cases entering treatment, NDTRS 2005–2010
Source: (Bellerose, *et al.* 2011)

The increase in the number of cases reporting cannabis as a main problem drug is likely in part to be influenced by the proportion of the Irish population who use cannabis. The 2010/11 general population prevalence survey found that lifetime use of cannabis had increased from 21.9% in 2006/07 to 25.3% in 2010/11 (National Advisory Committee on Drugs and Public Health Information and Research Branch 2011). However, the proportion of adults who reported using cannabis in the past year remained stable between the two iterations of the survey.

The number of cases treated for problem opiate use (mainly heroin) reduced slightly in 2009 and 2010. There has been a drop in the number of seizures of heroin reported since 2007, but it is not possible to say if this reflects a decline in heroin use or is due to a change in law enforcement practices or some other unknown (Irish Focal Point (Reitox) 2011). While opiates were implicated in more deaths owing to poisonings than any other drug or substance, in 2010 the number of deaths where heroin was implicated fell for the first time since 2005 (see Section 6.4.1).

While the number of cases treated for problem cocaine use has fallen every year since 2007, the lifetime use reported in the most recent general population prevalence survey has increased from 5.3% in 2006/07 to 6.8% in 2010/11 (National Advisory Committee on Drugs and Public Health Information and Research Branch 2011). The survey found that use in the past year remained stable between the two iterations, although the proportion of young adults did decrease slightly. The trends in drug-related deaths followed a similar trend to treatment in 2010 as the number of deaths owing to poisoning where cocaine was implicated also decreased (see Section 6.4.1). Questions about mephedrone and legal highs were asked in the general population prevalence survey for the first time in 2010/11. While no comparisons can be made, the survey found that the lifetime use of mephedrone was 2.0% and the lifetime use of 'legal highs' ('head shop' drugs) was 2.4% (National Advisory Committee on Drugs and Public Health Information and Research Branch 2011). Among young adults, lifetime use of 'legal highs' was 4.8%. Therefore, while the numbers seeking treatment in 2010 for' legal highs' was small, it is likely that these figures may increase in the future. Only six deaths owing to poisonings had a 'head shop' drug implicated in 2010 (see Section 6.4.1).

The use of more than one problem substance continues to present a challenge to the treatment services. The vast majority (68%) of cases treated between 2005 and 2010 reported problem use of more than one substance. Cannabis, alcohol, cocaine and benzodiazepines were the most common additional problem drugs reported by all cases entering treatment. The very large number of cases reporting alcohol as an additional problem substance highlights the strong links between alcohol and illicit substance use. This mirrors trends among drug-related deaths where 68% of deaths owing to poisonings involved more than one drug (see Section 6.4.1).

The profile of cases entering drug treatment remained stable between 2005 and 2010; in general, problem drug users were male and in their twenties. Half of the new cases entering treatment during the reporting period started drug use at or before the age of 15. The proportion of new cases aged less than 18 has increased since 2007, reaching 16% in 2010. This finding highlights the need for prevention measures and initiatives specially targeting young teenagers.

Data show a decline in injecting and, among new injectors, an increasing interval between starting drug use and starting injecting. The increase in harm reduction services and practices over the reporting period is likely to have influenced this progress.

The data also show that employment rates among drug users declined significantly, from 22% in 2005 to 9% in 2010, most likely reflecting the current economic climate. These findings outline the continued importance of social and occupational reintegration interventions as part of the drug treatment process.

The growing demand for treatment for problem use of substances other than heroin, combined with the high proportion of cases using multiple problem substances, remains a constant challenge for service providers, as drug users often require multiple treatment interventions, which in turn require a high degree of co-operation between services. This inter-agency approach to treatment and rehabilitation was highlighted as one of the priorities in the NDS (Department of Community Rural and Gaeltacht Affairs 2009). Supported by the drugs task force structure, many services are participating to an increasing extent in local inter-agency initiatives in order to provide a wide range of interventions and a continuum of care for clients, for example, through the development of case management and key working strategies.

Trends in treated problem alcohol use

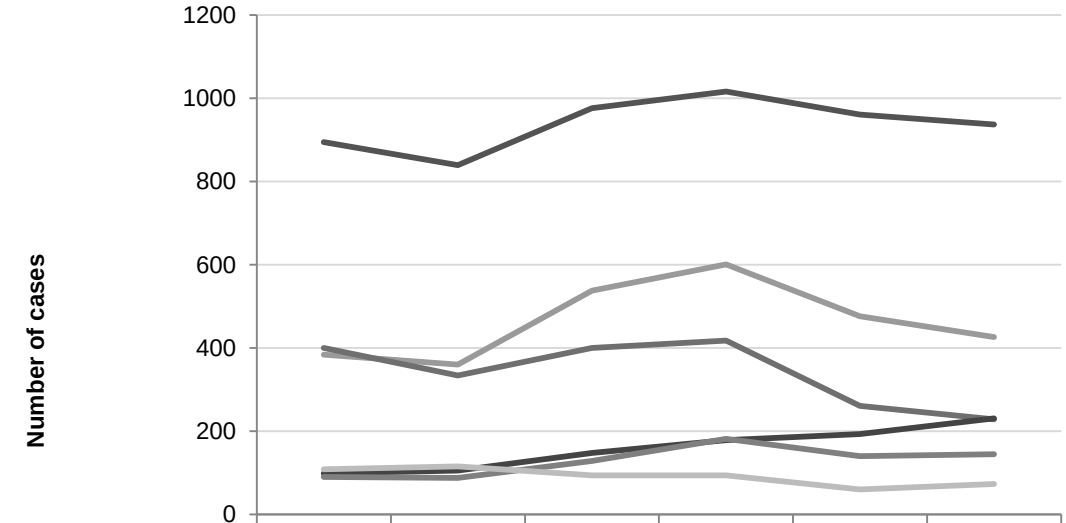
A recent addition to the HRB Trends Series, *Treated problem alcohol use in Ireland 2005 to 2010,* was published in November 2011 (Carew*, et al.* 2011). It was based on data reported to the NDTRS. It is important to note that the NDTRS collects data on episodes of treatment, rather than the number of individual people treated each year. This means that individuals may appear more than once if they attend more than one treatment service in a year, and may reappear in subsequent years. The main findings of the paper are summarised below.

In the period 2005–2010, a total of 42,333 cases presented with alcohol as a main problem substance, accounting for more than half (52.7%) of all cases treated for problem substance use during that period.

The incidence of such cases increased from 109.9 per 100,000 of the 15–64-year-old population in 2005 to 133.2 per 100,000 in 2010. The prevalence increased from 187.6 per 100,000 in 2005 to 251.6 per 100,000 in 2010. This is an indication that problem alcohol use is a recurring addiction that requires repeated treatment over time. These increases in incidence and prevalence may be explained by a true increase in problem alcohol use in the population, an increase in reporting to the NDTRS, or a combination of both.

Almost one in five of those treated for alcohol as a main problem substance also reported using at least one other substance. In 2010, the most common drugs used in

conjunction with alcohol were cannabis, cocaine, benzodiazepines and ecstasy (Figure 5.3.2.3). This reflects a minor change since 2008, when opiates were the fourth most common additional drug. Use of more than one substance increases the complexity of cases and results in poorer outcomes for the patient. Information about combinations of substances used is important in terms of individual clients' care plans.



	2005	2006	2007	2008	2009	2010
Cannabis	895	839	976	1016	961	937
Cocaine	384	360	538	601	476	426
Ecstasy	400	334	400	418	261	229
Benzodiazepines	99	106	148	179	193	231
Opiates	90	88	129	182	140	145
Amphetamines	109	116	94	94	60	73

Figure 5.3.2.3 All cases treated for problem alcohol use as main problem substance: additional problem substances, NDTRS 2005–2010
Source: (Carew, *et al.* 2011).

Half of those treated for alcohol as a main problem substance was aged 40 years or under. The age profile of cases remained similar throughout the reporting period. The median age for all treated cases was 39 years; the median age for new cases continued to be lower (36 years). While the proportion of cases aged less than 18 years remained small, the number of new cases in that age group rose by 151.9% in the reporting period.

The socio-demographic characteristics of cases, both new and previously-treated, remained similar throughout the reporting period. The majority of cases were male, with low levels of employment. The proportion of cases in employment fell in the years 2008 to 2010, most likely reflecting the current economic climate. The proportion of cases that were homeless fell slightly between 2008 and 2009, but rose again in 2010: new cases from 2.4% to 1.5% to 2.3%, and previously-treated cases from 6.9% to 5.0% to 6.5%. Those who used other substances as well as alcohol were more likely to be unemployed and to live in unstable accommodation.

Trends in drug admissions to in-patient psychiatric facilities
See section 6.3.2.

6. Health Correlates and Consequences

6.1 Introduction

Problematic drug use can be associated with a number of other health conditions or lead to a range of health consequences, including drug-related infectious diseases, drug-related overdoses, a range of chronic illnesses and acute conditions, and psychiatric comorbidity. Information on these various health correlates and consequences is collected in a variety of information systems, which are described below.

The **Central Treatment List (CTL)** was established under Statutory Instrument No 225 following the *Report of the Methadone Treatment Services Review Group 1998* (Methadone Treatment Services Review Group 1998). This list is administered by the Drug Treatment Centre Board on behalf of the HSE and is a complete register of all patients receiving methadone (for treatment of opiate misuse) in Ireland and provides all data on methadone treatment nationally.

The **General Register Office (GRO)** is the central civil repository for records relating to births, deaths and marriages in Ireland.

Headstrong is the national centre for youth mental health, a non-profit organisation supporting young people's mental health in Ireland. It works with communities and statutory services to empower young people to develop the skills, self-confidence and resilience to cope with mental health challenges. It also works with the government, media and direct community outreach to change the way Ireland thinks about youth mental health.

The **Health Protection Surveillance Centre (HPSC)** is Ireland's specialist agency for the surveillance of communicable diseases. Part of the Health Service Executive (HSE), and originally known as the National Disease Surveillance Centre, the HPSC endeavours to protect and improve the health of the Irish population by collating, interpreting and disseminating data to provide the best possible information on infectious disease. The HPSC has recorded new cases among injecting drug users of HIV since 1982, hepatitis B since 2004, and hepatitis C since 2006.

The **HIPE (Hospital In-Patient Enquiry)** is a computer-based health information system, managed by the Economic and Social Research Institute (ESRI) in association with the Department of Health and the HSE. It collects demographic, medical and administrative data on all admissions, discharges and deaths from acute general hospitals in Ireland. It was started on a pilot basis in 1969 and then expanded and developed as a national database of coded discharge summaries from the 1970s onwards. Each HIPE discharge record represents one episode of care; each discharge of a patient, whether from the same or a different hospital, or with the same or a different diagnosis, gives rise to a separate HIPE record. The scheme, therefore, facilitates analyses of hospital activity rather than of the incidence of disease. HIPE does not record information on individuals who attend accident and emergency units but are not admitted as inpatients.

Established in 2005, the **National Drug-Related Death Index (NDRDI),** which is maintained by the HRB, is an epidemiological database which records cases of death by drugs poisoning, and deaths among drug users in Ireland, extending back to 1998. The NDRDI also records data on alcohol-related poisoning deaths, deaths among those who are alcohol dependent, extending back to 2004.

The **National Psychiatric In-Patient Reporting System (NPIRS),** administered by the Health Research Board (HRB), is a national psychiatric database that provides detailed information on all admissions to and discharges from 56 inpatient psychiatric services in Ireland. It records data on cases receiving inpatient treatment for problem drug and

alcohol use. NPIRS does not collect data on the prevalence of psychiatric comorbidity in Ireland. The HRB publishes an annual report on the data collected in NPIRS, entitled *Activities of Irish psychiatric units and hospitals.*

The **National Registry of Deliberate Self-Harm** is a national system of population monitoring for the occurrence of deliberate self-harm, established at the request of the Department of Health and Children, by the National Suicide Research Foundation (National Parasuicide Registry Ireland 2004). Since 2006/07 the Registry has achieved complete national coverage of hospital-treated deliberate self-harm. The Registry defines deliberate self-harm as 'an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences'. All methods of deliberate self-harm are recorded in the Registry, including drug overdoses and alcohol overdoses, where it is clear that the self-harm was intentionally inflicted. All individuals who are alive on admission to hospital following a deliberate act of self-harm are included. Not considered deliberate self-harm are accidental overdoses, e.g. an individual who takes additional medication in the case of illness, without any intention to self-harm; alcohol overdoses alone, where the intention was not to self-harm; accidental overdoses of street drugs (drugs used for recreational purposes), without the intention to self-harm; and individuals who are dead on arrival at hospital as a result of suicide.

The National Suicide Research Foundation (NSRF) is a multi-disciplinary research team with contributions from a broad range of disciplines, including epidemiology, psychology, psychiatry and biostatistics. It is recognised by the Department of Health as an official research unit contributing to the prevention of suicidal behaviour in Ireland.

There are two centres in Ireland from which information on poisons is accessible 24 hours a day: the **Poisons Information Centre of Ireland** in Dublin, and the **Regional Medicines and Poisons Information Service** in Belfast. These centres are supported by a consultant toxicologist advisory service. The Poisons Information Centre of Ireland (Tel. +353-1-8092566) offers a telephone information service for healthcare professionals on a 24/7, 365-days-a-year basis. Enquires are answered by poisons information officers between 8.00am and 10.00pm; calls outside of these hours are automatically diverted to the UK National Poisons Information Service at no extra charge. The public poisons information service (+353-1-8092166), also based in the Poisons Information Centre of Ireland, is for the general public, in particular parents and carers of young children. This service is available between 8.00am and 10.00pm daily. Outside of these hours the general public should contact their general practitioner or a hospital emergency department.

First piloted in Cork between 2008 and 2011, the objectives of the **Suicide Support and Information System (SSIS)** are to provide better support to bereaved family members, to identify and better understand the causes of suicide, to identify and improve the response to clusters of suicide and extended suicide, to describe the incidence of and explore patterns of suicide in Ireland, and to identify individuals who present for medical treatment owing to deliberate self-harm and who subsequently die by suicide. It operates a two-step approach, including (i) pro-active facilitation of support for family members bereaved by suicide, and (ii) obtaining information from the different sources who had been in contact with the deceased in the year prior to death or at the time of death, including coroners' records, family informants and medical professionals.

Toxbase, an online clinical toxicology database in the United Kingdom, has been available to Irish health professionals since 2001. Since then it has become the main source of information on poisons, with usage increasing annually. It is available to

health professionals in emergency department and intensive care units; 99% of queries come from emergency departments. Toxbase is not available to laboratory staff.

6.2 Drug-related infectious diseases

6.2.1 HIV/AIDS and viral hepatitis

HIV surveillance in 2011

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1985. According to the most recent report of the HPSC, at the end of 2011 there were 6,287 diagnosed HIV cases in Ireland, of which 1,485 (24%) were probably infected through injecting drug use (O'Hora and O'Donnell 2011). Figure 6.2.1.1 presents the number of new cases of HIV among injecting drug users reported in Ireland, by year of diagnosis; data from 1982 to 1985 are excluded as these four years were combined in the source records. There was a fall in the number of HIV cases among injecting drug users between 1994 and 1998, with about 20 cases per year, compared to about 50 cases each year in the preceding years. There was a sharp increase in the number of cases in 1999 (69 new cases), which continued into 2000 (83 new cases). Between 2001 and 2010 there was an overall decline in the number of new injector cases when compared to 2000. It was difficult to interpret the trend owing to the relatively small numbers diagnosed each year, so a smoother curve (grey plot line in Figure 6.2.1) was calculated using a rolling centered three-year average. This curve presents a declining trend since 2006 and a return to low number of cases in the mid-nineties.

Of the 16 new HIV cases reported in 2011, 13 were male and three were female, and the median age among intravenous drug users (IDUs) was 37 years (range 22–48 years). Eight cases (36.4%) were born in Ireland and another three (36.4%) in central and eastern Europe and two in Africa. Nine new cases were Irish, eight cases were not Irish and five cases had no country of origin recorded. At the time of HIV diagnosis in 2011, 85% of IDUs for whom CD4 count was reported were classified as diagnosed late (CD4 count <350 cells/mm3), three had AIDS and two had an acute HIV infection.

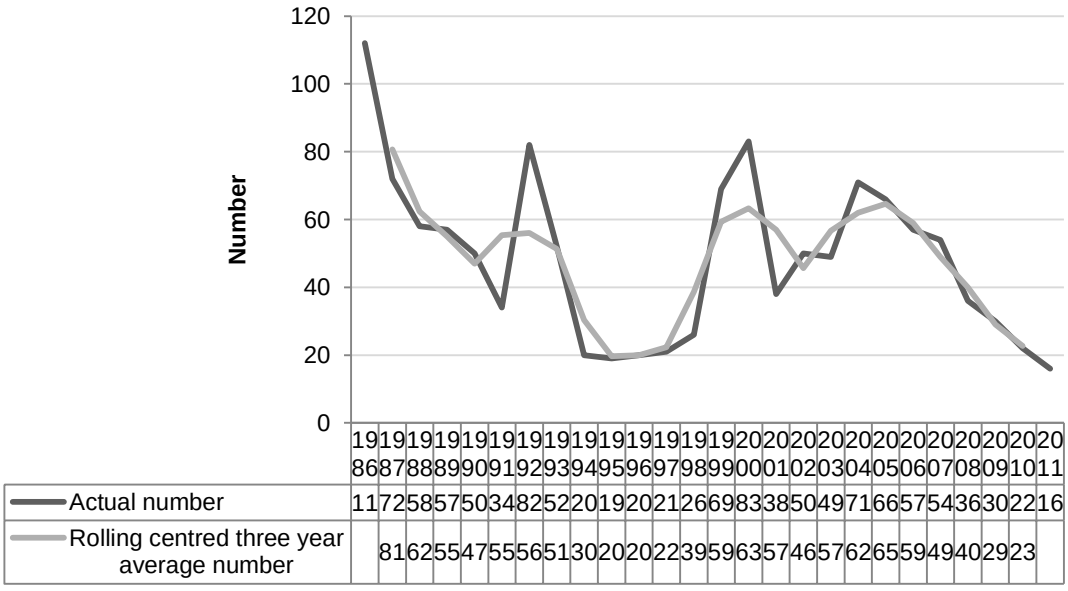


Figure 6.2.1.1 Actual number and rolling average number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland, 1986–2011

Source: Unpublished data reported to Department of Health and Children, National Disease Surveillance Centre and HPSC.

Hepatitis B and hepatitis C notifications, 2011

Hepatitis B notifications in 2011 were 19% lower than in 2010, continuing the downward trend since 2008 (Murphy and Thornton 2012) (Table 6.2.1.1). The number of hepatitis B notifications had increased dramatically between 2000 and 2008,

coinciding with increasing numbers of people immigrating to Ireland from hepatitis B endemic countries. The falling numbers of immigrants in recent years is likely to have contributed to the current decreasing trends in hepatitis B notifications, particularly in relation to cases of chronic infection. The number of notifications of cases of acute hepatitis B remains relatively low and sexual transmission continues to be the predominant mode of transmission of these.

Table 6.2.1.1 Acute and chronic hepatitis B cases reported to the HPSC, by risk factor status, 2008–2011

	2009			2010			2011		
Hepatitis B status	Acute No. (%)	Chronic No. (%)	Unknown No. (%)	Acute No. (%)	Chronic No. (%)	Unknown No. (%)	Acute No. (%)	Chronic No. (%)	Unknown No. (%)
Total number of cases	78	681	44	49	554	42	45	460	20
% of cases by status	9.7	84.8	5.5	7.6	85.9	6.5	8.6	87.6	3.8
Cases with reported risk factor data	60	361	4	41	261	6	44	183	5
% of cases with risk factor data	76.9	53	9.1	83.7	47.1	14.3	97.7	39.8	25
Of which:									
Injecting drug users	1 (1.7)	12 (3.3)	0	0	4 (1.5)	0	0	1 (0.6)	0
Cases without reported risk factor data	18	320	40	8	293	36	1	277	15
% of cases without risk factor data	23.1	47	90.9	16.3	52.9	85.7	2.3	60.2	75
Total		803			645			525	

Source: Unpublished data from the HPSC

Hepatitis C surveillance in 2010

Hepatitis C is one the most common blood-borne viral infections among injecting drug users and is transmitted through contact with the blood of an infected person. The main routes of transmission are mother-to-baby, unsafe injections, transfusion of blood and blood products, and unsterile tattooing and skin piercing. There were 1,236 cases of hepatitis C reported to the HPSC in 2010 (Table 6.2.1.2), compared to 1,257 cases in 2011.

The number of notifications of hepatitis C continued at a very high rate in 2011 (Table 6.2.1.2). Where risk factor data were available, 82% were injecting drug users (Table 6.2.1.3). Most cases occurred in middle-aged adults and males (Table 6.2.1.4). The majority of cases were notified in the eastern region of Ireland.

Table 6.2.1.2 Hepatitis C cases and notification rates per 100,000 population, 2004–2011

Year	n	Notification rate
2004	1119	26.4
2005	1403	33.1
2006	1210	28.6
2007	1541	36.5
2008	1511	35.8
2009	1240	29.3
2010	1236	29.2
2011	1257	29.6

Source: Unpublished data from the HPSC

Table 6.2.1.3 Hepatitis C cases reported to the HPSC, by risk factor status, 2007–2011

Risk factor status	2008 n (%)	2009 n (%)	2010 n (%)	2011 n (%)
Total number of cases	1511	1240	1236	1257
Cases *with* reported risk factor data	574 (37.9%)	801 (65.0%)	728 (58.8)	753 (59.9)
Of which:				
Injecting drug users	441 (76.8)	607 (75.2)	550 (75.5)	616 (81.8)
Recipients of blood/blood products	24 (4.2)	34 (4.2)	19 (2.6)	19 (2.5)
Other risk factors	77 (13.4)	134 (16.6)	143 (19.6)	106 (14.1)
No known risk factor identified by patient or doctor	32 (5.6)	32 (4.0)	16 (2.2)	12 (1.6)
Cases *without* reported risk factor data	942	434	511	504

Source: Unpublished data from the HPSC

Table 6.2.1.4 Hepatitis C cases who reported injecting drug use as a risk factor, by age, gender and place of residence, 2007–2010

	2008 n (%)	2009 n (%)	2010 n (%)	2011 n (%)
Total number of known injector cases	441	607	550	616
Gender				
Male	315 (71.4%)	438 (72.2%)	409 (74.4%)	419 (68)
Female	123 (27.9%)	169 (27.8%)	140 (25.5%)	196 (31.8)
Gender not known	3 (0.7%)	0 (0.0%)	1 (0.1%)	1 (0.2)
Age				
Mean age	33.2	34.5	35.8	35.4
Median age	32	33	34	34
Under 25 years	45 (10.2%)	48 (7.9%)	32 (5.8%)	45 (7.3)
25 to 34 years	230 (52.2%)	314 (51.7%)	247 (44.9%)	269 (43.7)
Over 34 years	162 (36.7%)	244 (40.2%)	271 (49.3%)	300 (48.7)
Age not known	4 (0.9%)	1 (0.2%)	0 (0.0%)	2 (0.3)
Place of residence				
Dublin, Kildare or Wicklow	375 (85.0%)	537 (88.5%)	466 (84.7%)	538 (87.3)
Elsewhere in Ireland	66 (15.0%)	70 (11.5%)	84 (15.3%)	78 (12.7)

Source: Unpublished data from the HPSC

The natural history of injecting drug use: a 25-year longitudinal study of a cohort of injecting drug users in inner city Dublin.

Injecting drug use is associated with increased morbidity and mortality. This is the first longitudinal study to examine the natural history of injecting drug use in a community in Dublin, Ireland and was conducted by FD O'Kelly and CM O'Kelly (O'Kelly and O'Kelly 2012).

Injector cohort

Eighty-two heroin injectors were recruited over the summer months of 1985 and the 25 still alive and traced were re-interviewed in 2010.

Eighty-two questionnaires were completed, out of a possible 103, by face-to-face interviews in 1985. The study was commenced prior to the availability of HIV (human immunodeficiency virus) testing. In 1985, the age range of respondents was 16–37 years, with 67 (82 %) aged between 20 and 29 years. Sixty-two (76 %) of the respondents were male, 62 (76 %) were single, 55 (87 %) were unemployed and 63 (77 %) had been in prison. Fifty-three (65 %) of the cohort had started to inject by age 19, the youngest being 10 years of age. All respondents gave a history of polydrug use. The most commonly used groups of drugs in addition to heroin were benzodiazepines and alcohol.

Deceased members of the injecting cohort
Between 1985 and 2010, 52 (63%) of the cohort tested positive for HIV and 58 (71 %) for hepatitis B. Fifty-one (63%) of the cohort had died between 1985 and 2010. The cause of death for the cohort can be summarised into four main groups: (i) HIV related (26) (ii) opiate overdose (9) (iii) accident or violence (5) and (iv) medical non-HIV related (11). The mean age of death was 35.9 years of age (± 4.1 years). The median survival time for those with a positive HIV status was 17 years (95% CI 14.0–20.0) and for those with a positive hepatitis C status, 21 years (95% CI 15.5–26.5).

Surviving members of the injecting cohort
In 2010, 31 individuals, of the original cohort, were either known to be still alive, or did not have a death certificate in the records of the GRO. The majority of them are now aged between 45 and 54 years. Of the original 82 in the cohort (62 males, 20 females), 16 males and 9 females were still alive in 2010. Twenty-five were re-interviewed and six were not found (81 % response rate). In 2010, none of the surviving cohort were currently using drugs by injection, however, 11 (44 %) were currently registered with the Central Treatment Services and on a methadone programme. Eight (32 %) were HIV-positive, all of whom were currently receiving anti-retroviral therapy (ART) and attending a hospital-based HIV clinic. Fifteen (60 %) of the cohort members re-interviewed were HBV positive and ten (40 %) were HCV positive. All reported regular engagement with primary and secondary care services.

Comparison cohort
A comparison cohort of age-matched non-opiate users from the same community setting was retrospectively drawn from the author's practice records in 1995. The comparison cohort was made up of all the non-opiate users, within the same age range as the index cohort from Merchants Quay F Ward who had attended the author's practice in 1985. This number was 201 and represented 20% of the Ward population between the ages of 15 and 34 years who were known to the author's practice in 1985. The majority of both groups had an address in the only local authority flat complex in the Ward and therefore shared the same socio-demographic profile. The comparison cohort was analysed in 1995 and 2010 for death rates and HIV status similarly to the study cohort, using the author's clinical records, the General Register Office and the Genito-Urinary Medicine services at St. James Hospital, Dublin.

Eleven persons of the comparison cohort of 201, that is 5.5%, are known to have died. Two members of the comparison cohort are HIV-positive. These mortality rates are in line with census figures for the area and much lower than that experienced by the injector cohort.

Conclusions
The participants in the injector cohort were 63 times more likely to be diagnosed with HIV than the members of the comparison cohort indicating the excess risk of acquiring HIV when one injects drugs. The injector cohort were 11 times more likely to die that the comparison cohort indicating the excess risk of drug use, HIV infection and the violent nature of the drug users world.

The lifestyle of injecting drug users, as demonstrated by the experience of this cohort, has hazardous consequences resulting in high-levels of morbidity and mortality. A

relatively stable picture of HIV associated with IDUs is now emerging in Ireland, as is the case throughout most of the EU. HIV is a more manageable chronic disease though surviving injecting drug users are ageing and now have other chronic diseases, posing challenges for health services in its treatment.

Blood-borne viral status among a population attending a Dublin maternity hospital by exposure to methadone

Cleary and colleagues (Cleary*, et al.* 2011) examined the relationship between methadone maintenance treatment and maternal characteristics, including blood-borne viral status. This was a retrospective cohort study of 61,030 singleton births at a large maternity hospital from 2000 to 2007, based on antenatal, delivery and postnatal records and the Central Treatment List (of clients prescribed methadone). Of the 61,030 singleton births, 618 (1%) were to women who were prescribed methadone at delivery. A higher proportion of methadone-exposed women were likely to test positive for hepatitis B, hepatitis C and HIV when compared to non-exposed women (Table 6.2.1.5).

Table 6.2.1.5 Blood-borne viral status in 61,030 singleton births at a large Dublin maternity hospital, 2000–2007, by exposure to methadone

	Exposed to methadone* n (%)	Non-exposed* n (%)
Hepatitis B positive serological status	20 (3.5)	326 (1.0)
Hepatitis C positive serological status	275 (48.2)	193 (0.6)
HIV positive	35 (5.8)	171 (0.3)

*The total number tested in each group is not presented in the paper.
Source: (Cleary, *et al.* 2011)

6.2.2 STI's and tuberculosis

The surveillance data available in Ireland does not identify drug use as a risk factor for these infections.

6.2.3 Other infectious morbidity (e.g. abscesses, sepses, endocarditis, wound botulism)

Four people, three men and one woman, with local tissue injury were admitted to an acute general hospital in Dublin between February and March 2010 (Dorairaj*, et al.* 2012). All four reported injecting cathinone powders. Three were already diagnosed with hepatitis C, one had a history of schizophrenia and one had a history of self-harm. The four individuals had visible signs of cellulitis and on further examination three had developed abscesses and one had phlebitis. Three of the four had high white cell counts (sign of infection) and one case had a normal white cell count because he had already commenced antibiotic therapy.

All four individuals were treated with intravenous antibiotics, three had their wound surgically debrided to remove dead, damaged, or infected tissue, and one required a skin graft. The causative organisms were commensal organisms from the skin.

6.2.4 Behavioural data

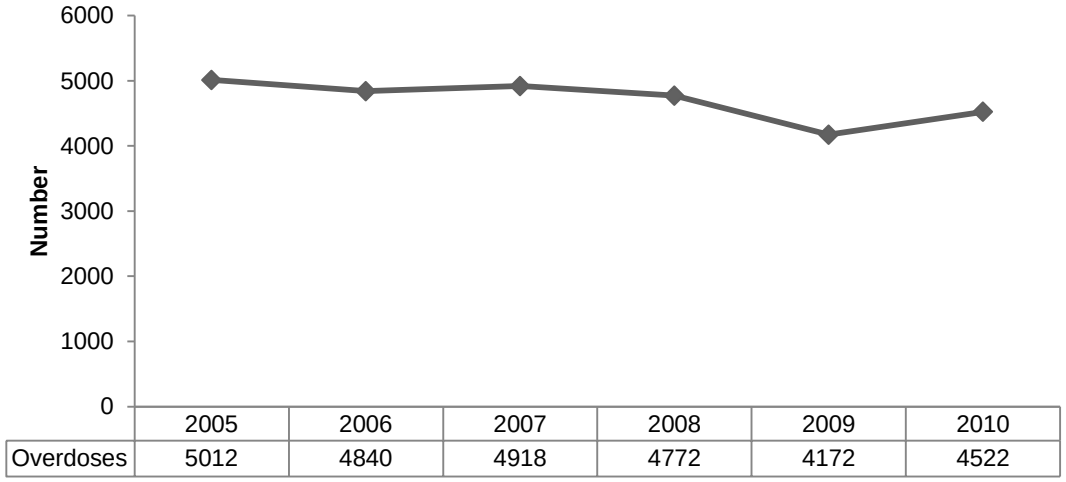
There are no routine collections of behavioural data in Ireland. For the most recent information, see study presented in Section 6.2.3 and Table 6.2.3.2 of the 2011 National Report (Irish Focal Point (Reitox) 2011).

6.3 Other drug-related health correlates and consequences

6.3.1 Non-fatal overdoses and drug related emergencies

Non-fatal overdoses discharged from Irish hospitals, 2010

Data extracted from the Hospital In-Patient Enquiry (HIPE) scheme were analysed to determine trends in non-fatal overdoses discharged from Irish hospitals in 2010. There were 4,562 overdose cases in that year, of which 40 died in hospital. The 4,522 discharged cases were included in this analysis. The number of overdose cases increased by 8% between 2009 and 2010, following a decrease of 13% between 2008 and 2009 (Figure 6.3.1.1).

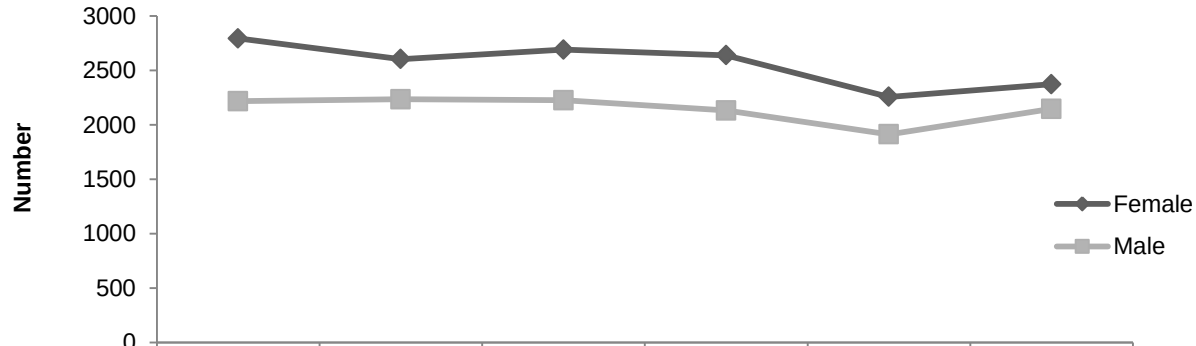


	2005	2006	2007	2008	2009	2010
Overdoses	5012	4840	4918	4772	4172	4522

Figure 6.3.1.1 Overdose cases, 2005–2010 (N=28,236)
Source: Unpublished HIPE data

Gender

In the years 2005–2010 there were more overdose cases among females than among males (Figure 6.3.1.2), with females accounting for 53% of all overdose cases in 2010.

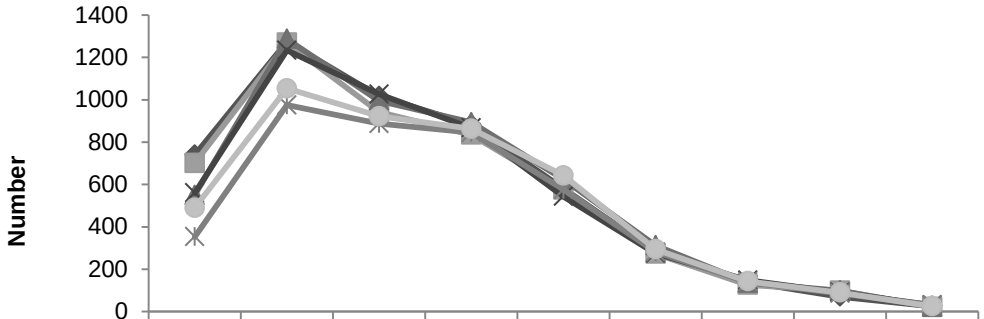


	2005	2006	2007	2008	2009	2010
Female	2794	2605	2691	2640	2258	2374
Male	2218	2235	2227	2132	1914	2148

Figure 6.3.1.2 Overdose cases by gender, 2005–2010 (N=28,236)
Source: Unpublished HIPE data

Age group

One quarter of all overdoses between 2005 and 2010 occurred in those aged 15–24 years, with the incidence of overdose decreasing with age (Figure 6.3.1.3). However, the number of under-25s was lower in both 2009 and 2010 than in previous years. In 2005, 40% of cases were aged under 25 years, compared to 34% in 2010.



	0-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
2005	740	1275	1017	882	581	282	140	70	25
2006	701	1269	942	835	575	273	126	98	21
2007	550	1287	995	893	624	312	136	99	22
2008	560	1233	1026	867	543	274	148	90	31
2009	353	975	887	845	576	281	140	85	30
2010	490	1053	922	863	642	294	143	90	25

Figure 6.3.1.3 Overdose cases by age group, 2005–2010 (N=28,236)
Source: Unpublished HIPE data

Area of residence

In 2010 there were 1,003 (22%) overdose cases among people resident in Dublin (city and county), 3,492 (77%) cases among people resident outside Dublin, and 77 cases recorded as having no fixed abode or being resident outside Ireland.

Drugs involved

Table 6.3.1.1 presents the positive findings per category of drugs and other substances involved in all cases of overdose in 2010. Non-opioid analgesics were present in 34% (1,552) of cases. Paracetamol is included in this drug category and was present in 27% (1,129) of cases. Psychotropic agents were taken in 22% (1,000) and benzodiazepines in 24% (1,086) of cases. There was evidence of alcohol consumption in 12% (561) of cases. Cases involving alcohol are included in this analysis only when the alcohol was used in conjunction with another substance.

Table 6.3.1.1 Categories of drugs involved in overdose cases, 2010 (N=4,522)

Drug category	Positive findings per drug category*	
	n	%
Non-opioid analgesics	1552	34.3
Benzodiazepines	1086	24.0
Psychotropic agents	1000	22.1
Narcotics and hallucinogens	588	13.0
Anti-epileptic / sedative / anti-Parkinson agents	563	12.5
Alcohol	561	12.4
Other chemicals and noxious substances	282	6.2
Cardiovascular agents	152	3.4
Systemic and haematological agents	147	3.3
Anaesthetics	118	2.6
Hormones	115	2.5
Autonomic nervous system agents	99	2.2
Systemic antibiotics	96	2.1
Gastrointestinal agents	67	1.5
Diuretics	56	1.2
Topical agents	37	0.8
Muscle and respiratory agents	36	0.8
Other gases and vapours	33	0.7
Anti-infectives / anti-parasitics	22	0.5
Other and unspecified drugs	945	20.9

*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.
Source: Unpublished HIPE data

Overdoses involving narcotics or hallucinogens

Narcotic or hallucinogenic drugs were involved in 13% (588) of overdose cases in 2010. Figure 6.3.1.4 shows the number of positive findings of drugs in this category among the 588 cases. The sum of positive findings is greater than the total number of cases because some cases involved more than one drug from this category. Opiates were used in 80% of the cases, cocaine in 16% and cannabis in 8%.

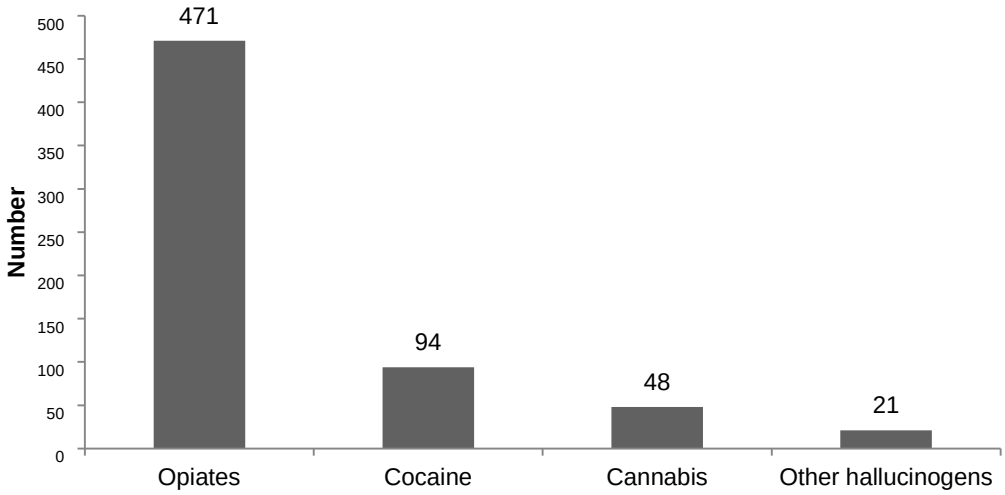


Figure 6.3.1.4 Narcotics and hallucinogens involved in overdose cases, 2010 (N=588)
Source: Unpublished HIPE data

Overdoses classified by intent

In 67% of cases the overdose was classified as intentional (Figure 6.3.1.5).

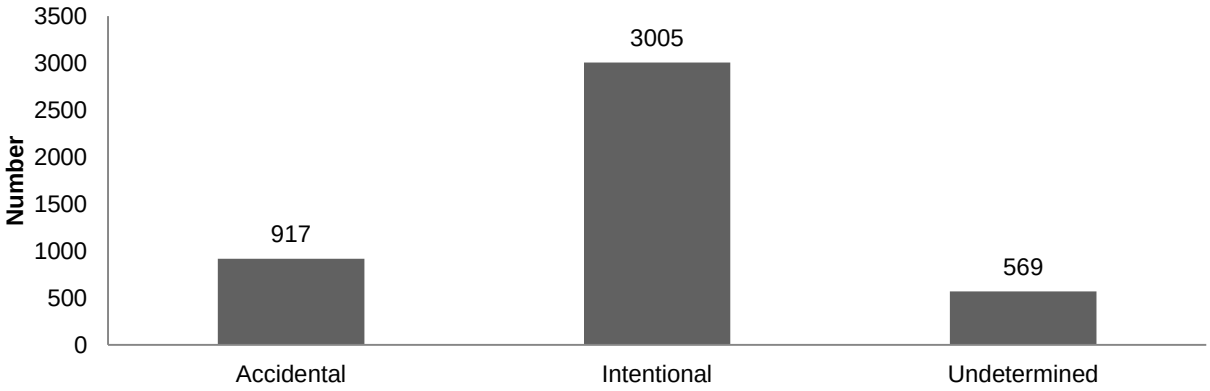


Figure 6.3.1.5 Overdose cases classified by intent, 2010 (N= 4,491)
Source: Unpublished data from HIPE

Table 6.3.1.2 presents the positive findings per category of drugs and other substances involved in cases of intentional overdose in 2010. Non-opioid analgesics were involved in 42% (1,258) of cases, benzodiazepines in 28% (832) and psychotropic agents in 27% (820).

Table 6.3.1.2 Categories of drugs involved in intentional overdose cases, 2010 (N=3,005)

Drug category	Positive findings per drug category*	
	n	%
Non-opioid analgesics	1258	41.8
Benzodiazepines	832	27.7
Psychotropic	820	27.3
Anti-epileptic / Sedative / Anti-Parkinson agents	459	15.3
Alcohol	387	12.9
Narcotics and hallucinogens	293	9.7
Cardiovascular agents	99	3.3

Drug category	Positive findings per drug category*	
Systemic and haematological agents	92	3.1
Other chemicals and noxious substances	87	2.9
Hormones	78	2.6
Autonomic nervous system agents	68	2.3
Systemic antibiotics	68	2.3
Gastrointestinal agents	52	1.7
Anaesthetics	37	1.2
Diuretics	34	1.1
Muscle and respiratory agents	19	0.6
Anti-infectives / Anti-parasitics	16	0.5
Topical agents	11	0.4
Other gases and vapours	<5	~
Other and unspecified drugs	588	19.6

*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.
Source: Unpublished HIPE data

Poisons information and clinical toxicology, 2010–2011

A recently published article reviewed poisons information and clinical toxicology in Ireland (Tormey, WP and Moore 2012). The information most commonly accessed on Toxbase by health professionals in Ireland relates to paracetamol, diazepam, analgesics and psychoactive compounds (Table 6.3.1.3).

Table 6.3.1.3 The ten substances most frequently accessed on Toxbase, from all sources in Ireland, 2010–2011

Rank	Drug	Count (% of total)
1	Paracetamol	1431 (5.8)
2	Diazepam	679 (2.7)
3	Zopiclone	592 (2.4)
4	Ibuprofen	552 (2.2)
5	Escitalopram	436 (1.8)
6	Paracetamol/codeine compound	393 (1.6)
7	Salicylates	387 (1.6)
8	Quetiapine	376 (1.5)
9	Venlafaxine	369 (1.5)
10	Alprazolam	359 (1.4)

Source: (Tormey, WP and Moore 2012)

The authors stated that data from the National Drug-Related Deaths Index (NDRDI) is the most accurate available information on toxicological deaths in Ireland. They suggested a more detailed review of the 'Other prescription medication' involved in poisoning deaths as recorded by the NDRDI in order to identify factors to prevent fatal overdoses from these medications in the future. In conclusion, the authors recommended the following:

- provision by the HSE of a web-based, open-access Toxbase or equivalent as a public service;
- co-location of poisons information and laboratory clinical toxicology;
- establishment of a national clinical toxicology institute for Ireland;
- a list of accredited medical advisors in clinical toxicology available for consultation in Ireland;
- multidisciplinary case conferences in complex toxicology scenarios for coronial cases;
- development of a template of standard scenarios on common findings in biochemical toxicology for coronial cases;
- establishment of a national clinical toxicology referral out-patient service in Dublin; and
- tracking changing patterns in the use of drugs of abuse in Ireland – clinically, biochemically and through access to treatment.

Crack-ing the case: a patient with persistent delirium due to body packing with cocaine

A 36-year-old man presented acutely with encephalopathy at an acute hospital in Ireland (Ní Chróinín and Gaine 2012). His initial symptoms included confusion, agitation, aggression and tonic-clonic seizures. He had just returned from West Africa. He did not have a known neurological disorder. He was treated with intravenous anti-epileptic therapy. A few hours later he became extremely disturbed, thrashing in his bed, chewing his own tongue, and shouting nonsensically. He developed a high temperature. He was treated with intravenous benzodiazepines, antibiotics, and anti-epileptic medicines. He was intubated, ventilated, and transferred to the intensive care unit. Difficulties in reducing sedation and taking him off a ventilator prompted repeat urine toxicology screening at day 8, the results of which were still positive for cocaine. Further examination and diagnostic tests led to the discovery of cocaine-containing packages in the gastrointestinal tract. A retrieval colonoscopy was performed to retrieve the cocaine packs. Subsequently, sedation was successfully discontinued and the patient was taken off the ventilator. He was then discharged from the hospital. The author recommended that an index of suspicion should be maintained in patients presenting with drug toxicity following cross-border travel.

Drugs used in intentional overdoses, 2010

The National Suicide Research Foundation (NSRF) prepared a briefing on drugs used in intentional overdoses (Perry*, et al.* 2012). In 2010 the National Registry of Deliberate Self-Harm recorded 11,966 presentations to hospital owing to deliberate self-harm involving 9,630 individuals. Drug overdose was the most common method of self-harm (71%). Women (77%) were more likely to use a drug to cause self-harm than men (65%).

The drugs used in intentional overdoses were a minor tranquilliser, most commonly benzodiazepines (3,568, 42%); more men (43%) than women (40%) used minor tranquillisers. The authors recommended better controls for prescribing, selling and importing benzodiazepines and other minor tranquillisers. Analgesic drugs or pain killers were used to overdose by more women (48%) than men (36%). The common analgesic drugs used were paracetamol, paracetamol compounds, opiates, opiate compounds, aspirin and aspirin-containing compounds. Drugs used to treat depression and mood disorders were used by 22% of self-harm cases, and by 20% of male and 24% of female overdose acts. Street drugs were commonly used by men and the authors recommended that the existing controls be rigorously implemented. Alcohol was involved in 41% of deliberate self-harm cases, 45% of male and 38% of female cases.

Presentations of deliberate self-harm to acute hospital emergency departments, 2011

The 10th annual report from the National Registry of Deliberate Self-Harm was published in July 2012 (National Suicide Research Foundation 2012). The report contained information relating to every recorded presentation of deliberate self-harm to acute hospital emergency departments in 2011, giving complete national coverage of cases treated.

There were 12,216 recorded presentations of deliberate self-harm, involving 9,834 individuals, in 2011. This implies that one in five (2,382, 19.5%) of the presentations were repeat episodes. The rate of presentations decreased from 217/100,000 of the population in 2010 to 215/100,000 in 2011, a 4% decrease.

Concordant with previous reports, 48% of self-harm presentations in 2010 were men and 47% were aged under 30 years. Four hundred and seventy-three (4%) of cases presenting for self-harm were people living in homeless hostels or had no fixed abode, a 53% increase on the number of such presentations in 2010. Presentations peaked in the hours around 10.00 pm and were highest on Sundays and Mondays; 31% of episodes occurred on those two days. There was evidence of alcohol consumption in

39% (4,773) of all presentations and this was more common among men (40%) than women (38%).

Drug overdose was the most common form of deliberate self-harm, occurring in 69% (8,409) of all such episodes reported in 2011. Overdose rates were higher among women (75%) than among men (62%). In 73% of cases, the total number of tablets taken was known; an average of 30 tablets was taken in these cases. The average among men was 32 tablets and among women 29 tablets. Forty-three per cent of all drug overdoses involved a minor tranquilliser (most commonly benzodiazepines); 26%, paracetamol-containing medicines; 22%, anti-depressants or mood stabilisers (most commonly SSRIs); and 10%, a major tranquilliser. The number of deliberate self-harm presentations involving street drugs decreased by 27% (to 479) in 2011, when compared to 2010 (645). Men (10%) were much more likely than women (3%) to self-harm using street drugs.

The next steps, or referral outcomes for the deliberate overdose cases, were 46% discharged home; 33% admitted to an acute general hospital; 8% admitted to psychiatric in-patient care; a small proportion (1%) refused admission to hospital; and 13% discharged themselves before receiving referral advice.

The report provided information on what was being or could be done to reduce the number of self-harm cases. In January 2012, the National Office for Suicide Prevention established a National Working Group on Restricting Access to Means, with priority given to restricting access to minor tranquillisers. The authors recommended that this working group also review the implementation of the paracetamol legislation and prescribing patterns of SSRIs.

The authors reported that alcohol continued to be one of the factors associated with the higher rate of self-harm presentations on Sundays, Mondays and public holidays, around the hours of midnight. These findings underline the need for on-going efforts to:

- intensify national strategies to increase awareness of the risks involved in the use of alcohol, starting at pre-adolescent age;
- intensify national strategies to reduce access to alcohol and drugs;
- enhance health service capacity at specific times and increase awareness of the negative effects of alcohol use, such as increased depressive feelings and reduced self-control; and
- arrange active collaboration between the mental health services and addiction treatment services in the best interest of patients who present with dual diagnosis (psychiatric disorder and alcohol/drug abuse).

The authors reported that there was variation in the next care recommended to deliberate self-harm patients, and in the proportion of patients who left hospital before a recommendation was made, from 8% in the Southern Hospitals Group to 24% in the Dublin North East Hospitals Group. In 2012, a sub-group of the National Mental Health Clinical Programme Steering Group produced *National guidelines for the assessment and management of patients presenting to Irish emergency departments following self-harm*. The authors recommended 'that these guidelines be implemented nationally as a matter of priority'.

Deliberate self-harm in children, 1993–2003

The authors (McNicholas*, et al.* 2011) examined the case notes of children admitted with deliberate self-harm or suicidal ideation for the period 1993–2003. The study identified psychiatric, psychosocial and familial factors associated with deliberate self-harm. During the 11-year period, 231 children presented with deliberate self-harm or suicidal ideation but the medical records of 197 children were available for review.

Of those reviewed, 146 (74.1%) were girls and 51 (25.9%) were boys. The average age was 12.9 years and the age range was 6–17. Twenty-five (12.7%) children were

either in the complete care of a social worker or had a social worker involved with their care at home. Of the 197 children who presented to the national paediatric hospital, 183 engaged in an episode of deliberate self-harm and 14 reported suicide ideation alone. This report concentrated on the children who engaged in deliberate self-harm as they were the cases who used alcohol and other drugs.

Of the 183 who engaged in an episode of deliberate self-harm, 139 (76%) were girls and 124 (67.8%) were 13 years or under. Overdose (81.2%) was the most common method of self-harm and paracetamol was the most common drug used, followed by antidepressants, benzodiazepines, antacids and other painkillers. Sixteen (8.1%) children used a violent method of self-harm such as hanging or jumping from a height. Boys were more likely than girls to use a violent method. The deliberate self-harm episode was immediately preceded and precipitated by a stressful event for 153 (83.6%) children. Examples of stressful events included conflict among family members, and to a lesser extent conflict at school or disagreements with their peers. The vast majority (154, 78.2%) of children committed the self-harm episode at home and almost one in ten committed it in a public place. Over three-quarters (152, 77.2%) of the children were alone during the episode. More than half (102, 55.7%) expressed a wish to die. Fifty-three (29%) children had previously harmed themselves on one or more occasion. On assessment, 98 children reported they were low in mood at the time of the event and 58 were angry. Sixteen children drank alcohol on the day of admission and 12 were intoxicated. Seven children had taken illicit drugs. Eleven per cent (20) had a history of substance misuse including cannabis, inhalants, LSD and ecstasy. Twenty-one children had been sexually abused. Eighty-two children had a family history of mental illness and 12 children had a family member who had committed suicide. Over 90% were referred to child and adolescent mental health services (CAMHS) at the time of discharge from hospital.

Homeless mental health service users: profile and factors associated with suicide and homicide

This study describes the profile of homeless mental health service users attending a special service in Cork (n=54), comparing this group with those attending a generic adult service (n=219) (Dunne, E*, et al.* 2012). The data were collected retrospectively from the patients' case notes. The main variables were demographics, socio-economic details, factors associated with increased risk of suicide and homicide, and diagnosis. Compared to all those attending the generic service, the homeless group were more likely to be men (89% v. 46%), to be unemployed (96% v. 68%), to be unmarried (98% v. 75%) and to be younger (under 65) (94% v. 83%). There was a higher prevalence of schizophrenia in the homeless group than in the whole group attending the generic service (50% v. 34%), and higher prevalences of personality disorder (37% v. 11%), alcohol dependence (61% v. 14 %;) and drug dependence (31% v. 5%). There was a lower prevalence of affective disorders (33% v. 54%; p=0.007) among the homeless service users. There was no difference in the proportion in each group with either depression or bipolar affective disorder alone. The homeless users were more likely to have a history of deliberate self-harm (54% v. 21%) and violence (48% v. 10%).

Of the 24 factors examined, the homeless group had an average of nine factors associated with suicide and similarly, homicide, compared with an average of six factors among the whole group. There were higher levels of active symptoms (57% v. 37%), non-compliance with medication and other treatment (37% v. 10%) and missed appointments (41% v. 17%) among the homeless group, and this group had significantly more input from multidisciplinary team members (74% v. 37%) and were seen more frequently by the psychiatrist.

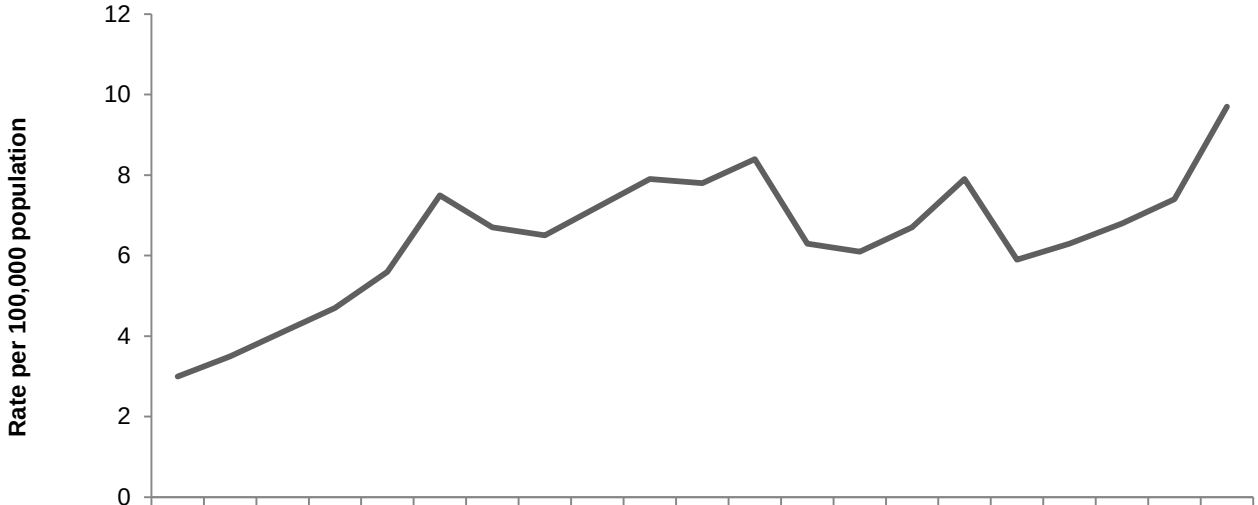
The prevalence of severe mental illness is higher in the homeless population, with particularly high levels of factors associated with suicide and homicide. Poor compliance and complexity of illness lead to a requirement for significant and special input from multidisciplinary mental health teams members.

6.3.2 Other topics of interest e.g. psychiatric and somatic co-morbidity, traffic accidents, pregnancies and children born to drug users

Drug admissions to psychiatric facilities, 2010

Activities of Irish psychiatric units and hospitals 2010, the annual report published by the Mental Health Information Systems Unit of the Health Research Board, shows that the total number of admissions to inpatient care has continued to fall (Daly and Walsh 2011).

In 2010, 966 cases were admitted to psychiatric facilities with a drug disorder, of whom 412 were treated for the first time. Since 2006 there has been a continuous increase in the rate of first admission of cases with a diagnosis of a drug disorder. The report does not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate. Figure 6.3.2.1 presents the rates of first admission between 1990 and 2010 of cases with a diagnosis of drug disorder.



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Drug disorder	3.0	3.5	4.1	4.7	5.6	7.5	6.7	6.5	7.2	7.9	7.8	8.4	6.3	6.1	6.7	7.9	5.9	6.3	6.8	7.4	9.7

Figure 6.3.2.1 Rates of psychiatric first admission of cases with a diagnosis of drug disorder (using the ICD-10 three-character categories) per 100,000 of the population in Ireland, NPIRS 1990–2010

Source: Annual reports from the National Psychiatric In-patient Reporting System (NPIRS), 1990– 2010

Other notable statistics on first admissions for a drug disorder in 2010 included:

- The majority were to psychiatric units in general hospitals (259, 63%), followed by admissions to psychiatric hospitals (102, 25%) and to private hospitals (51, 12%).
- 6% were involuntary admissions.
- The rate was higher for men (14.2 per 100,000) than for women (5.2 per 100,000).

The majority of cases hospitalised for a drug disorder stayed just under one week (54%), while most were discharged within three months.

Youth mental health, 2011

Researchers at University College Dublin and Headstrong completed a national survey examining youth mental health in 2011 (Dooley and Fitzgerald 2012). The researchers estimated the proportion of young people experiencing common mental health problems and explored the known risk and protective factors that are associated with mental health status. The survey population comprised second-level students aged 12–19 years (6,085) and young adults aged 17–25 years (8,221). In total, 14,306 participants completed questionnaires. Fifty-one per cent of the participants randomly selected at second-level schools were female, and 65% of young adults purposively selected through third-level colleges, employers, training centres and unemployment centres were female.

The main findings revealed that the majority of young people (aged 12–25) were functioning well, but that sizeable proportions experienced risk factors.

- One in ten second-level students and between 12% and 16% of young adults reported high levels of anger.
- Five per cent of second-level students and 10% of young adults were very or severely stressed. The main sources of stress for second-level students were school, friends and family, and for young adults, college, money, work and family.
- Eleven per cent of second-level students and 14% of young adults had severe or very severe anxiety.
- Eight per cent of second-level students and 14% of young adults had severe or very severe depression.
- A small proportion second-level students reported avoidance strategies.
- Two-fifths of second-level students experienced bullying at some point in their life and 77% of bullying episodes occurred at school.
- Five per cent of second-level students ranked themselves at the bottom of their class and these students were more likely to experience anxiety and depression.
- One-fifth of young adults had deliberately hurt themselves at some point in their life and seven per cent had attempted suicide.

Cannabis use was less common than alcohol use. Nevertheless, considerable proportions reported using cannabis at some point in their life and its use increased with age (Figure 6.3.2.2). Forty-five per cent of young adults (aged 17–25) used cannabis. Young adult males (52%) were more likely to report cannabis use than their female counterparts (42%). Over three quarters (77%) reported that they took cannabis for the first time when they were aged between 15 and 19.

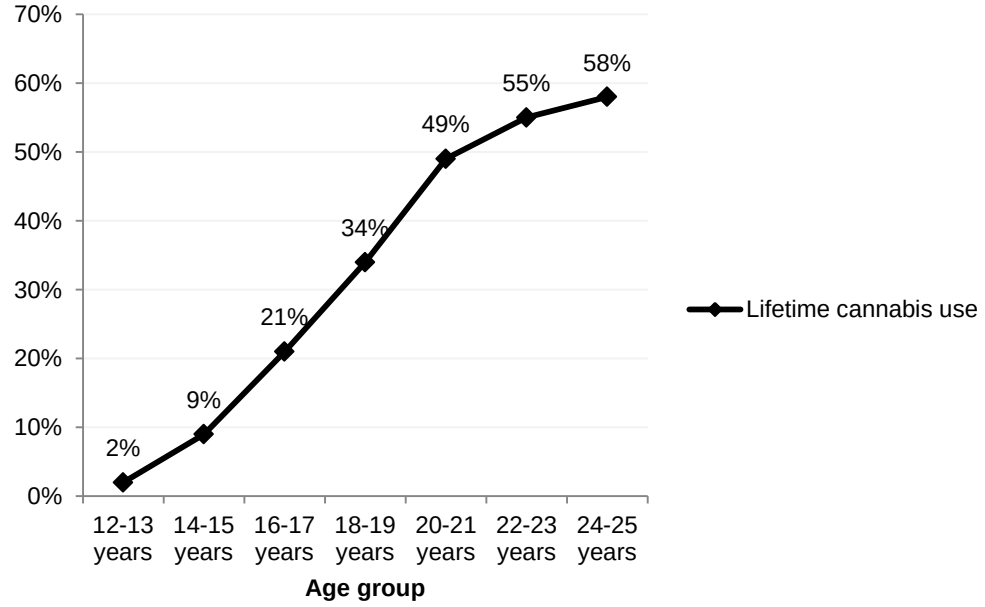


Figure 6.3.2.2 Lifetime prevalence of cannabis use among survey participants by age, 2011
Source: (Dooley and Fitzgerald 2012)

A six-item, yes/no response scale called CRAFFT was used to measures levels of substance misuse; a score of 2 or more indicates a high level of substance misuse. One-quarter of second-level students and half of the young adults scored 2 or more on the CRAFFT scale.

The authors found that self-esteem, optimism, resilience, problem solving and social networks were the protective factors associated with mental health, and that having support from a special adult was beneficial.

Prevalence of drug use and other mental health co-morbidity among admissions to health services

Substance dependence and other mental illnesses co-exist in a proportion of patients attending health services, and substance misuse increases the complexity of managing other mental health conditions and vice versa. Three recent Irish studies have attempted to estimate and describe the phenomenon.

Dixit and Payne (Dixit and Payne 2011) estimated the prevalence of substance misuse in 100 consecutive admissions to a psychiatric unit and additionally the proportion with a primary diagnosis of substance misuse disorder and the proportion with a secondary substance misuse disorder.

The prevalence of drug use substance misuse disorders was 47%.

Twenty-two out of 100 (22%) were admitted with a primary substance misuse disorder and 15 of these patients were considered to be a suicidal risk and the remaining seven were experiencing a social crises.

Twenty-five (25%) patients, who were admitted with a mental health disorder, were also diagnosed with a substance misuse disorder. The mental health disorders included depression/anxiety (12, 48%), psychosis/bipolar disorder (5, 20%) and personality disorder (4, 16%); four cases were classified as 'other mental health disorder'. The co-morbid substance misuse disorders included 16 alcohol-only cases, five single-drug cases and four polydrug cases. More men (68%) than women and more younger people (aged 44 years and under) (88%) than older people (12%) had substance misuse disorder combined with mental illness.

The authors said their study demonstrated the importance of screening for substance misuse in psychiatric inpatient units, and consequently the need for individual case management, development of dual diagnosis services and accuracy in patient data reporting to facilitate future service-planning.

Lyne and colleagues (Lyne*, et al.* 2011) reviewed the records of patients presenting with co-morbid psychiatric diagnoses and drug use at a 12-bed alcohol treatment unit in a psychiatric teaching hospital in Dublin between 1995 and 2006. Patients were included if they were aged 44 years or under, had remained in hospital for more than 28 days, and had a diagnosis of alcohol dependence.

The review of 465 records revealed that 38.9% of patients had used drugs other than alcohol during their life and 34.2% had a documented history of a co-morbid psychiatric diagnosis. The most commonly reported substances were cannabis (26.4%), cocaine (17.1%), and ecstasy (12.5%); just under 10% reported use of benzodiazepines or other sedatives and just under 6% had used heroin. The disease-specific rates for the 465 cases were depressive disorder (25.3%), anxiety disorder (3.9%), bipolar affective disorder (2.8%) and psychotic disorder (2.2%). A small proportion (3.7%) of patients had two or more psychiatric diagnoses alongside their alcohol dependence. Forty-eight (10.3%) patients had a documented history of deliberate self-harm, of whom 29 had a psychiatric diagnosis as well as alcohol dependence.

The median age of the study population was 37 years and the age range was 17–44 years. Just over three-fifths (61.1%) were men, 203 (44.3%) had never married, and 38 (8.3%) were separated or divorced. The proportions of women with a history of depressive disorder, eating disorder or deliberate self-harm were significantly higher than those among men. The proportion of men with a psychotic disorder was marginally higher than that of women. Deliberate self-harm was associated with lifetime drug (excluding alcohol) use. Ecstasy users were more likely to have a diagnosis of depression.

Skinner and colleagues (Skinner*, et al.* 2011) explored the relationship between cannabis use and self-reported dimensions of psychosis in a population of university students presenting for any reason to primary care.

In 2008, 15,000 students were enrolled in undergraduate or postgraduate courses at the National University of Ireland, Galway. Between April and October of that year, 1,049 (7%) students attended the Student Health Unit and they completed self-report questionnaires on:

- demographic profile,
- history of mental illness,
- alcohol and other drug misuse,
- non-clinical dimensions of psychosis (Community Assessment of Psychic Experiences [CAPE]), and
- anxiety and depression (Hospital Anxiety and Depression Scale [HADS]).

The respondents may not be representative of the third-level student population. The average age of respondents was 21.2 years (range 17–54); 82% were women; 94% were Irish; and 96% were single. Sixteen per cent sought professional help for emotional or psychiatric problems, 23% reported a family history of mental illness, and almost 5% reported a family history of psychotic illness.

Respondents reported drinking an average of 9.4 units (range 0–120) of alcohol per week and an average of 5.9 units (range 0–35) per sitting. Forty per cent (423) had smoked cannabis at least once in their lives, of whom 327 reported use between 1 and 30 times, and 86 reported use 30 or more times. The average age at first use of cannabis was almost 17 years (range 10–40). The rates of lifetime use of other drugs were ecstasy (6.9%), cocaine (5.8%), magic mushrooms (5.1%), LSD (2.1%) and heroin (0.1%).

Twenty-one per cent had HADS scores of between 8 and 10 (borderline abnormal level) on the anxiety subscale, and 15% had scores of 11 or above (abnormal level). Just under 3% reported borderline abnormal level on the depressive subscale and 1% reported abnormal level. The average weighted CAPE frequency score for negative symptoms was 1.57 (range 1–4), and for positive symptoms 1.29 (range 1–3). The higher HADS anxiety scores were associated with a personal history of mental illness, a family history of psychiatric disorder and being female. The higher HADS depression scores were associated with a personal history of mental illness.

The CAPE positive psychotic symptom scores were associated with a personal history of mental illness and a family history of psychiatric disorder, and with being younger and male. The CAPE negative psychotic symptom scores were associated with a personal history of mental illness and a family history of psychiatric disorder. The CAPE depressive symptom scores were associated with a personal history of mental illness, a family history of psychiatric disorder and being female.

After controlling for the effects of personal history of mental illness, family history of psychiatric disorder, age and gender, the CAPE positive and negative psychotic symptom scores were associated with high-frequency cannabis use. In addition, the CAPE negative psychotic symptom scores and depressive symptom scores were associated with low-frequency cannabis use.

After further controlling for frequency of cannabis use, it was found that the earlier the age at which a person started cannabis use, the more positive psychotic symptoms they experienced.

These findings support the hypotheses that cannabis use increases the risk of developing psychotic symptoms and that this risk increases further in individuals who use cannabis more heavily and start use at a younger age.

Increased incidence of QT interval prolongation in a population receiving lower doses of methadone maintenance therapy, 2008/09

Roy and colleagues (Roy*, et al.* 2012) investigated the frequency of corrected QT (QTc) interval prolongation in a methadone maintenance therapy population and examined potential associations between this QTc interval and methadone dose as well as concurrent use of opiates, cocaine, and benzodiazepines through a cross-sectional study of 180 patients attending a specialist drug treatment clinic between July 2008 and January 2009; the patients invited to participate were considered to be clinically stable on methadone maintenance.

All patients who agreed to participate in the study had 12-lead electrocardiograms completed, followed by QTc analysis. In addition, their urines were screened for opiates, benzodiazepines, and cocaine. The trough ECG was carried out prior to methadone dose being administered. The normal range for men was QTc 350–450 milliseconds (ms) and for females, 350–470 ms.

The average age of participants was 32.6 (± 7.1) years and the average methadone dose, 80.4 (± 27.5) mg. The mean QTc was 420.9 (± 21.1) ms and the range was 368–495 ms. The proportion of cases testing positive for other opiates was 52%; for cocaine, 27.8%; and for benzodiazepines, 75%. Patients who had a positive toxicology screen for opiates were receiving significantly lower doses of methadone (77.8 ± 23.5 mg versus 85.0 ± 21.4 mg, p=0.04). No significant association was noted between QTc interval prolongation and presence of cocaine metabolites in the urine (p=0.14) or methadone dose (p=0.33). In total, 11.1% (n=20) had QTc intervals > 450 ms. The proportion of women with QTc ≥ 470 ms was 0.5% (n=1) and the proportion of men with QTc ≥ 450 ms was 8.3% (n=15)

Drug-induced QTc interval prolongation is evident in 8.8% of patients receiving relatively low daily doses of methadone therapy when a sex-specific definition is used, and 11.1%, when a single cut-off (> 450 ms) is used. There was no evidence of a dose-response relationship. The presence of cocaine metabolites in urine does not appear to be associated with increased QTc interval.

The authors recommended increasing awareness of cardiac safety guidelines, including relevant clinical and family history and the need for ECGs before and after initial methadone dose to be made part of methadone maintenance therapy protocols.

6.4 Drug-related deaths and mortality of drug users

6.4.1 Drug-induced deaths (overdoses/poisonings)

Deaths owing to poisoning, 2001–2010

In 2010, there were 164 deaths owing to poisoning recorded in Ireland by the NDRDI. This represents a substantial drop compared to 2009, when 216 such deaths were recorded (Table 6.4.1.1; see also Standard Tables 5 and 6). It should be noted that annual data previously reported has been changed as the database has been updated as new information has become available.

Table 6.4.1.1 Poisonings (Selection D) by year, NDRDI, 2001–2010

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Selection D	109	127	108	128	171	189	208	215	216	164

Source: Unpublished data, NDRDI

The number of deaths where cocaine was implicated (either alone or with another drug or substance) declined from 53 in 2009 to 20 in 2010. This reflects decreasing trends in relation to cocaine seen in other areas, with the exception of prevalence data. In 2010 there was a reduction in the number of seizures of cocaine reported (Irish Focal Point (Reitox) 2011) and a reduction in the number of cases treated for cocaine (see Section 5.3.2). However, data from the general population prevalence survey showed an increase in reported lifetime use, from 5.3% in 2006/07 to 6.8% in 2010/11 (National

Advisory Committee on Drugs and Public Health Information and Research Branch 2011). Notwithstanding the increase in lifetime use, there was a small decrease in the prevalence of last-year use, from 1.7% in 2006/07 to 1.5% in 2010/11.
The number of deaths where heroin was implicated (alone or with another drug or substance) also dropped, from 115 in 2009 to 70 in 2010. This is the first time since 2005 there has been a decrease in the number of deaths owing to poisoning where heroin was implicated. In 2010 there was a reduction in the number of heroin seizures reported, but it cannot be ascertained if this was due to a reduction in heroin use, a change in law enforcement activities or another factor as yet unknown (Irish Focal Point (Reitox) 2011).

In early 2011, there were at least six fatal heroin overdoses reported by the Irish media (Holland 2011, February 15); (O'Keefe 2010, December 16); (Irish Focal Point (Reitox) 2011).These deaths had been preceded by a reported heroin drought in December 2010. Comparing the number of deaths where heroin was implicated, by month, for the years 2009 and 2010, shows that the reduction in the number of deaths occurred throughout the year and not just in November and December 2010. The figures do not reflect a sudden event such as a heroin drought late in the year. However, the biggest difference in the number of deaths recorded was for the month of December: 16 deaths in December 2009 compared to three in December 2010. It will be important to analyse the numbers and trends in 2011, to see if there was, as reported in the media, an increase in deaths where heroin was implicated in January–March of 2011.

Regardless of the overall decline in deaths owing to poisonings, opiates continue to be associated with most poisoning deaths recorded in the NDRDI, and indeed was higher than in previous years (93.9%). Similar to 2009, heroin or unspecified opiates *alone* accounted for 23.7% of all poisonings.

In 2010, there were six deaths owing to poisoning where 'head shop' drugs (new psychoactive substances) were implicated (either alone or with another drug or substance), a very slight increase on 2009. This may be partially due to the lack of availability of standards for laboratory testing during this time. However, internationally there are only a small number of reported deaths linked to 'head shop' drugs (Kelleher, Cathy*, et al.* 2011). Data on 'head shop' drugs were collected for the first time in the 2010/11 general population prevalence survey (National Advisory Committee on Drugs and Public Health Information and Research Branch 2011). The prevalence of last-year use of new psychoactive substances (the only data item collected) was 3.5%, second only to cannabis (6.0%) and greater than for cocaine (1.5%) and ecstasy (0.5%), when comparing illegal drugs. The number of cases presenting for treatment for 'head shop' drugs also increased in 2010 (see Section 5.3.2), although the numbers were small.

The mean age of those who died owing to poisonings remained stable compared to previous years at 34.1 years (see Standard Table 6).

Over two thirds (68.3%) of deaths owing to poisonings involved more than one drug, a higher proportion than reported in all previous years. Alcohol, benzodiazepines, antidepressants, and other over-the-counter medications were among the main drugs implicated in polysubstance poisonings.

Drug-related deaths, 2004–2009
The NDRDI has also published national figures on drug-related deaths (Health Research Board 2011). This comprises all deaths owing to poisonings, including both illicit drugs covered by Selection D, and also other drugs such as alcohol and prescription medication not reported in Standard Table 6. This report also includes medical and traumatic causes of death among drug users (see Section 6.4.3).

In the six-year period 2004–2009 a total of 3,358 deaths owing to poisoning and deaths among drug users met the criteria for inclusion in the NDRDI database. Of these deaths, 2,015 were due to poisoning and 1,343 were due to traumatic or medical

causes (non-poisoning) (Table 6.4.1.2). The annual number of deaths in 2009 increased to 628, compared to 617 in 2008. In 2004, the majority (267, 62%) of drug-related deaths recorded in the NDRDI were poisonings, but the percentage of deaths owing to poisoning has decreased over the reporting period, to reach 57% (357) in 2009. The 2009 figure is likely to be revised when new data become available.

Table 6.4.1.2 Number of deaths, by year, NDRDI, 2004 –2009 (N=3,358)

	2004	2005	2006	2007	2008	2009
All deaths	429	501	560	623	617	628
Poisoning (n=2015)	267	300	325	385	381	357
Non-poisoning (n=1343)	162	201	235	238	236	271

Source: (Health Research Board 2011)

Men accounted for the majority of deaths by poisoning in each year, with 68% of the poisoning deaths in 2009 being among men. The percentage of women who died by poisoning remained steady over the six-year period, ranging from 34% in 2004 to 32% in 2009. The majority of those who died were aged between 25 and 44 years. The median age was 38 years. Just over half (51%) of all deaths involved more than one substance.

The number of deaths in which heroin was implicated rose to 108 in 2009, compared to 90 in 2008 (Table 6.4.13). Alcohol was involved in 38% of deaths by poisoning in 2009, more than any other drug. The number of deaths by poisoning where cocaine was implicated dropped to 52 in 2009, compared to 60 in 2008. Cocaine was implicated in 14% of all deaths by poisoning in the six-year period. In 2009 the number of deaths by poisoning where methadone was implicated dropped to 66, compared to 81 in 2008. Benzodiazepines continued to play a major role in polysubstance poisonings.

Table 6.4.1.3 All drugs involved in poisoning deaths, NDRDI 2004–2009 (N=2,015)

	2004	2005	2006	2007	2008	2009	% of total
All deaths *	267	300	325	385	381	357	100
Heroin	29	47	67	79	90	108	20.8
Methadone	40	43	61	54	81	66	17.1
Other opiates†	62	69	55	54	47	50	16.7
Cocaine	19	36	52	66	60	52	14.1
MDMA	13	10	6	19	7	~	2.7
Alcohol	125	116	111	170	152	137	40.2
Benzodiazepines	77	79	116	123	120	132	32.1
Antidepressants	52	53	43	48	81	65	17.0
Other prescription medication§	44	37	39	61	60	59	14.9
Non-opiate analgesic	13	23	12	19	17	16	5.0
Other ‡	9	22	21	25	30	47	7.6

Source: (Health Research Board 2011)
*This is a multi-response table taking account of illicit use of up to six drugs. Therefore numbers and percentages in columns may not add
up to totals shown, as individual cases may use more than one drug or substance.
† Includes morphine, codeine, unspecified opiate-type drug, other opiate analgesic.
§ Includes non-benzodiazepine sedatives, anti-psychotics, cardiac and all other types over-the-counter medication.
‡ includes solvents, insecticides, herbicides, other amphetamines, hallucinogens, cannabis, head shop drugs and other chemicals.
~ Less than five cases

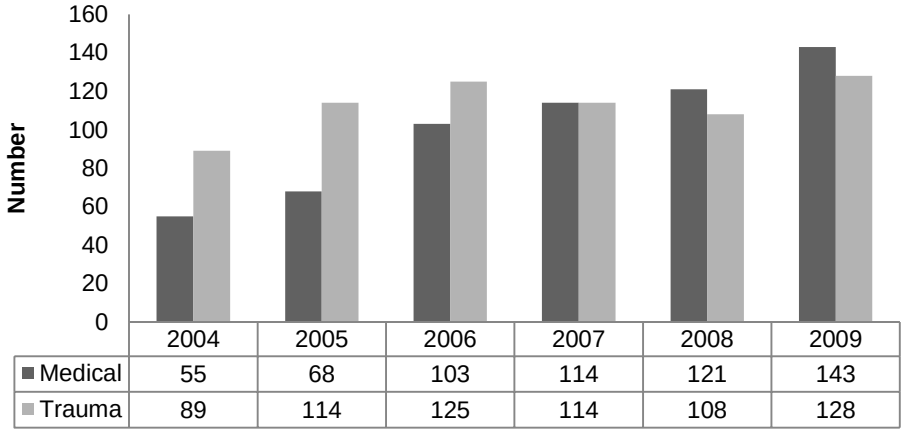
6.4.2 Mortality and causes of deaths among drug users (mortality cohort studies)

Currently there are no mortality cohort studies. However, see section 6.2.1 for the results of a 25-year longitudinal study of a cohort of injecting drug users in inner-city Dublin.

6.4.3 Specific causes of mortality indirectly related to drug use (e.g. HIV/AIDS and HCV related to IDU, suicides, accidents)

Deaths among drug users, 2004–2009

A total of 1,343 non-poisoning deaths were recorded among drug users in the period 2004–2009 (see Table 6.4.1.2) (Health Research Board 2011). These deaths were due to traumatic or medical causes, and do not include deaths among alcohol dependent people who were not drug users. The number of non-poisoning deaths increased by 67% over the reporting period, from 162 deaths in 2004 to 271 in 2009 (Figure 6.4.3.1). Of the 271 non-poisoning deaths in 2009, over half (53%, 143) were due to medical causes and the remainder (47%, 128) were due to trauma. These figures may change when new data become available.



	2004	2005	2006	2007	2008	2009
Medical	55	68	103	114	121	143
Trauma	89	114	125	114	108	128

Figure 6.4.3.1 Non-poisoning deaths among drug users, NDRDI 2004–2009 (N=1,282)
Source: (Health Research Board 2011).

The number of deaths due to trauma increased annually, from 89 in 2004 to 128 in 2009 (Figure 6.4.3.1). The majority (81, 63%) of those who died from traumatic causes in 2009 were aged under 35 years. The median age was 30 years. As in previous years, the majority (99, 73%) of those who died due to trauma in 2009 were male. The most common causes of death due to trauma in 2009 were hanging (65, 51%) and choking (23, 18%).

The annual number of deaths due to medical causes rose steadily over the reporting period, increasing from 55 in 2004 to 143 in 2009. The majority (65%) of those who died from medical causes in 2009 were aged between 30 and 49 years. The median age was 40 years. Males accounted for 71% (102) of those who died due to medical causes in 2009. The most common medical causes of death in 2009 were cardiac events (29, 20%), respiratory infections (19, 13%) and cancer (16, 11%).

Suicide Support and Information System (SSIS)

The first report of the national Suicide Support and Information System (SSIS) was published in July 2012 and presented the results of a pilot implementation of the system in County Cork between September 2008 and March 2011 (Arensman*, et al.* 2012). The research team identified 178 cases of suicide and 12 deaths with open verdicts in County Cork between September 2008 and March 2011.

In relation to the 190 fatalities, data on 189 cases were obtained from the checklists completed on the basis of the coroners' records, and further information was obtained

from psychological autopsy interviews with family members for 70 (37%) cases and from questionnaires completed by medical professionals for 64 (34%) cases.

Suicide cases
The vast majority (178) of those who had died with a verdict of suicide were men (81%). The average age was 38 years and men were significantly younger at the time of death (36 years) than women (45 years). The majority were Irish (92%), single (56%), and living in a house or flat (96%). Just under two-fifths (38%) were unemployed, one-fifth (21%) were living alone and 4% were living in a supervised hostel. In terms of occupation, one-third (33%) had been working in the construction sector.

The majority (71%) of the 178 suicide cases died by hanging, 11% by drowning and 10% (19) by intentional drug overdose. Legal drugs used in the overdose cases included both prescribed (17%) and non-prescribed (83%) medication. Illegal drugs used included cocaine and heroin. Eighteen per cent of the total number of cases had taken medication and/or drugs in combination with other methods, such as hanging and drowning over one-third (36%) had consumed alcohol at the time of suicide. A minority had used other methods, including cutting or stabbing, carbon monoxide poisoning, firearms and self-immolation. Forty-six per cent of cases had left a note, in the form of a letter, e-mail or text message.

Three-fifths (61%) of the suicide cases had a family history of mental disorder and the same proportion had a personal or family history of substance abuse. Over 39% of cases had either a personal experience of significant physical, sexual or emotional abuse or a family history of such abuse. Ten per cent of fatalities had a parent or sibling who had a non-natural death, such as suicide, homicide or accident

At some time before their death, 45% of cases had engaged in at least one act of deliberate self-harm. Of these, 50% had engaged in one act, 21% in two acts and 29% in three or more acts. Just under half (48%) had engaged in deliberate self-harm in the 12 months prior to ending their lives, 24% less than a week before and 12% less than a day before.

Over two-thirds (68%) of the suicide cases were known to have experienced suicidal behaviour (fatal and/or non-fatal) by family members or friends at some point in their lives. Of these, 7% had experienced the event less than 12 months prior to their own death.

A psychiatric assessment was known to have taken place in 31% of the cases. In the majority (61%) of these cases, mood disorder (such as depression or bipolar) was the primary diagnosis, followed by anxiety disorder (13%), schizophrenia (9%) and alcohol dependence (9%).

In the year prior to death, 52% of the cases had abused alcohol and/or other drugs. Of these cases, 44% had abused alcohol only, 34% had abused both alcohol and other drugs and 16% had abused other drugs only.

Two-thirds (65%) of the fatalities were reported to have experienced significant loss in the month prior to death (such as relationships, family members/friends, prestige and finances), 47% experienced a significant disruption to a primary relationship, 34% experienced significant life changes, 24% had legal trouble or difficulties with the Gardaí (24.2%), 23% experienced an event that was perceived as traumatic, and 19% experienced the anniversary of a death or other important loss.

In the year prior to suicide, more than half of the cases had had serious relationship problems for more than a year (53%). Loneliness over a long period of time in the year prior to suicide was reported for 47%. Other commonly reported negative events in the year prior to suicide were serious financial problems (44%), problems with eating

(33%), unemployment (31%), problems bringing up children (28%), mental maltreatment by a partner (28%) and failure in achieving an important goal (20%).

The most commonly reported negative events that occurred earlier in the lives of people who died by suicide were serious relationship problems lasting for more than a year (66%), problems in bringing up children (44%), addiction to alcohol, other drugs or medication (41%), serious financial problems (40%), the experience of loneliness over a long period of time (38%) and a sudden and unexpected emergency (37%).

The majority (81%) of the deceased had been in contact with their GP or a mental health service in the year prior to death. Fourteen per cent had received inpatient psychiatric treatment in that year. Forty-one per cent had been offered outpatient appointments with the mental health services. However, nearly half (48%) had difficulties attending these appointments and in 65% of cases the relatives reported no apparent benefits from attending the recommended outpatient mental health services.

Fifty-seven per cent of cases had used prescription medication for a mental disorder in the year prior to death. However, a high proportion of these (46.4%) did not comply with the instructions on the medication.

Suicide patterns
During the pilot phase, the SSIS identified a cluster of 19 suicides in two small areas in Cork comprising 40,125 inhabitants (males: 19,997, females: 20,128). The cluster involved adolescent and young adult males aged 14–36 years who died by hanging between September 2008 and December 2010. In addition, the system identified another small area in County Cork with an emerging suicide cluster. In this area, six men, aged between 34 and 67 years, took their lives over a 13-month period. The multiple sources of information contributing to the SSIS allowed the researchers to identify a number of direct and indirect relationships among the suicide cluster cases.

A matched comparison between cluster and non-cluster suicide cases in terms of mental health and social risk factors was undertaken. All except three of the young males involved in the larger cluster had used multiple drugs (prescription and street drugs), often combined with alcohol, while this was less common among the non-cluster cases. Compared to the non-cluster cases, the suicide cluster cases were less likely to communicate their suicidal intentions and they were more likely to have lost a friend by suicide.

Open verdict cases
An open verdict was returned in the case of 12 deaths. Two-thirds (67%) were men and the average age was 60 years. One-quarter were single. Only 8% were unemployed, and 42% were retired. With regard to cause of death, 42% died by drowning, 25% died by hanging and 33% had used other methods. A significant minority (46%) had consumed alcohol at the time of death. Seventeen per cent had left a suicide note, e-mail or text message prior to death. Two-fifths (42%) had a history of deliberate self-harm. A relatively high proportion (67%) had a confirmed psychiatric diagnosis. The vast majority (88%) had a mood disorder. One-quarter had a history of alcohol abuse. In the year prior to death, 58% had used psychotropic medication.

The open verdict cases, when compared with the suicide cases, were more likely to be male, older, retired and have a history of depression or alcohol dependence. They were less likely to be single and unemployed. They were also more likely to have died by drowning and less likely to have died by hanging. The number of open verdict cases is small and comparisons need to be interpreted with caution.

Role of cannabis in cardiac deaths
A recently published article examined the role of cannabis in cardiac deaths in Ireland (Tormey, William P 2012, 10 January). Of the 3,193 coronial cases processed between 2009 and 2010 by the Department of Chemical Pathology in Beaumont Hospital,

Dublin, 99 had a positive screening immunoassay for cannabis in the urine. Thirteen of these cases had enough clinical information provided to indicate cause of death involving the cardiac system, and were included in the study.

The deceased had a median age of 47 years (range 17–61 years), and 11 were men. Myocardial infarction was the primary cause of death in 54% (7) of cases. Other causes of death included sudden adult death syndrome, sudden death in epilepsy, and poisoning by alcohol and diazepam. In only one case was cannabis mentioned on the death certificate, and this mention did not indicate that cannabis use was implicated in the cause of death. The author noted that in order to implicate cannabis in the cause of a cardiac-related death, the deceased needs to have smoked cannabis within two hours of the fatality and plasma cannabis values are required to estimate the time of cannabis usage. None of the cases included in this paper had plasma tetrahydrocannabinol (THC) measured.

In conclusion, the author suggested that plasma THC should be measured where urine cannabinoids are positive. He stated: ‘A positive urine cannabinoids immunoassay alone is insufficient evidence in the linkage of acute cardiac death and cannabis.’

7. Responses to Health Correlates and Consequences

7.1 Introduction

This chapter presents new data on preventing drug-related mortality, the management of blood-borne viral infections, and responses to co-morbidity.

7.2 Prevention of drug-related emergencies and reduction of drug-related deaths

National overdose prevention strategy
Currently a national overdose prevention strategy is being developed by a working group comprising the Department of Health, the HSE, the HRB and the NACD (Suzi Lyons, HRB, personal communication, June 2012). The aim of the working group is to identify evidence-based interventions for preventing drug-related deaths and deaths among drug users. The group will advise on the most appropriate of these interventions for the Irish context.

The terms of reference are to:

- consider National Drug-Related Deaths Index reports;
- set targets for the reduction of drug deaths;
- list possible components of an overdose prevention strategy; and
- make recommendations on how different elements of the strategy could be operationalised.

Suicide Support and Information System (SSIS)
The first report of the national Suicide Support and Information System (SSIS) was published in July 2012 and presented the results of a pilot implementation of the system in Co Cork between September 2008 and March 2011 (Arensman*, et al.* 2012).

The specific objectives of the SSIS are to provide better support to bereaved family members; identify and better understand the causes of suicide; identify and improve the response to clusters of suicide and extended suicide; describe the incidence of and explore patterns of suicide in Ireland; and identify individuals who present for medical treatment owing to deliberate self-harm and who subsequently die by suicide.

The SSIS operates a two-step approach:

1. pro-active facilitation of support for family members bereaved by suicide, and
2. obtaining information from the different sources who had been in contact with the deceased in the year prior to death or at the time of death, including coroners' records, family informants and medical professionals.

The research team identified 178 cases of suicide and 12 deaths with open verdicts in County Cork between September 2008 and March 2011. Initial contact with family members of the deceased was made by letter, explaining about the SSIS and offering support, with one or more follow-up phone calls from senior research psychologists on the team in 124 cases.

In relation to these 124 cases, two-fifths (40%) of close family members participated in bereavement support facilitated by the SSIS team. Just under half (48%) had obtained bereavement support prior to contact with the team. A small proportion (8%) welcomed further contact with a member of the team but did not want formal bereavement support. One in twenty (5%) of family members did not wish to receive further contact following the initial invitation letter from the team.

For details of the 190 fatalities, see section 6.4.3.

7.3 Prevention and treatment of drug-related infectious diseases
(update of HCV treatment among IDUs)

Hepatitis C virus treatment
Hepatitis C virus (HCV) is a major cause of liver disease in HIV-infected patients. The HCV treatment outcomes and barriers to HCV referral were examined in a centre with a HIV/HCV co-infection clinic (Kieran*, et al.* 2011). The study identified 441 patients as antibody-positive for HIV and HCV at sometime between 1987 and January 2009. Of the HIV and HCV co-infected clients, 44 patients spontaneously cleared the HCV virus and 13 medical records could not be found. A retrospective chart review was undertaken for 386 patients who had not spontaneously cleared the HCV virus and whose medical record could be located for review.

Of the 386 patients, 107 (28%) had commenced treatment for HCV at the co-infection clinic; 95 (24%) were attending the co-infection clinic but had not commenced HCV treatment at the time of the review; and 184 (48%) were attending the HIV clinic but had never been referred to the co-infection clinic. Of the 107 who commenced HCV treatment, 47 (44%) had cleared the hepatitis C virus; of these, 29 (62%) had injected drugs at some point in their life. There was no difference in the proportions clearing HCV by route of transmission. The main factor influencing viral clearance was genotype. Patients with genotype 1 or 4 (25%) were less likely to clear the HCV virus than patients with genotype 2 or 3 (71%). Of the 95 attending the co-infection clinic but not yet treated, 29 were undergoing pre-treatment screening. Of the 184 patients who were not referred from the HIV clinic to the co-infection clinic, 101 (55%) were still attending the HIV clinic, 69 (37%) had died and 14 (8%) had transferred to another treatment service.

Between 1987 and 2009, 69 cases that had not been treated for HCV and 4 treated cases died, indicating that one-in–five (19%) of the full HIV-HCV infected cohort died.

Multivariate analysis revealed that patients who missed appointments, were younger, were female, were active injecting drug-users, had advanced HIV and were never offered HCV treatment, were less likely to be referred to the HIV-HCV co-infection clinic.

Not surprisingly, patients attending the co-infection clinic were more likely to have been screened for hepatocellular carcinoma than those attending the HIV service.

Two-thirds of patients referred to the clinic (136/202) had engaged with the HCV assessment or treatment programme.

The authors argued that the availability of free treatment and the presence of a multidisciplinary team (doctor, nurse, pharmacist and social worker) are two factors improving attendance and compliance. They further stated that dedicated co-infection clinics lower the threshold for treatment and improve management of liver disease in co-infected patients.

Hepatitis C management
Lowry and colleagues (Lowry*, et al.* 2011) undertook a cross-sectional retrospective review of all referrals made to an urban tertiary-care liver centre for hepatitis C virus (HCV) management between 2000 and 2007. Demographic, clinical and treatment data were extracted from medical charts and the hospital information system. The researchers tracked the progress of each referral and identified the dropout rate at the different stages.
A total of 588 individuals and 742 cases were referred for management of their hepatitis C. Among the 742 referrals, 67 were men and the average age was 33.3 years. Three quarters (74%) of cases were injecting drug users; 83% were Irish; and 57% were referred by their general practitioner. Other sources of referral were hospitals, drug treatment centres, prisons and asylum centres. Of the 742 referrals,

141 (19%) failed to attend their initial appointment, 180 (24%) dropped out from early outpatient management, 29 (4%) failed to attend for liver biopsy and 81 (11%) did not attend subsequent outpatient follow-up. In total, 451 (61%) dropouts occurred. Among those treated, a sustained viral response rate (successful treatment rate) of 74% was observed. The number and proportion of patients who experienced viral clearance varied with genotype: genotype 1, 18/30 (60%); genotype 2, 4/5 (80%); and genotype 3, 40/49 (82%). Those with a history of injecting drug use were more likely than their non-injecting counterparts to drop out immediately after referral, drop out from early outpatient management and drop out over entire span of disease management. Men were more likely ($p<0.05$) to drop out of disease management than women. Eight individuals died during the study period.

The authors reported that an 'exceptionally high rate of dropout exists' among those attending services to monitor and manage hepatitis C in injecting drug users, particularly in the early stages of service delivery. The study findings have led to the development of innovative approaches helping to optimise hepatitis C management in this population, such as texting reminders and using a change model to improve engagement and compliance with behaviour and treatment.

Hepatitis C virus in primary care

This study measured the knowledge of and attitudes towards hepatitis C among 560 nurses working in general practice, public health and addiction, and identified the sources of their knowledge (Frazer*, et al.* 2011). The researchers completed a cross-sectional survey in 2006 with nurses in the three categories of primary care through a postal questionnaire in one region of Ireland. The questionnaire contained five sections: demographic profile, work profile, knowledge, attitudes and education. The questions were validated and pilot tested. The total number of primary care nurses working in the region was 981 and 560 (57%) completed the questionnaire. The response rate varied by nursing specialism: general practice, 57% (126); public health, 55% (385); and addiction services, 83% (49). The attitudes of the nurses towards hepatitis C were not presented in the paper.

Almost all (98%) of the nurses were female, and their average age was 43 years. Nurses in the addiction services were younger than those in general practice or in the public health service. The nurses' qualifications ranged from certificate (25%) to post-graduate degree (4%). Fifty-five per cent were qualified to diploma or higher diploma level and 15% were qualified to at least degree level. Nurses in the addiction and in the public health service had higher qualifications than those in general practice. Nurses working in the public health service had longer service than those in addiction or general practice. Addiction nurses were more likely to work full time.

Among the respondents, 18% had a personal friend or relative who had hepatitis C, and 39% reported having professional contact with people with hepatitis C. As expected, nurses in addiction services had more professional dealings with people with hepatitis C (96%), compared to nurses in public health (30%) or in general practice (44%). According to the authors, 90% of addiction service nurses provided information on the dangers of alcohol, the benefits of hepatitis A and B vaccination, dietary intake and transmission of the virus, while only 30% of nurses in public health provided advice on the dangers of alcohol, and 11% of the same cohort on the benefits of hepatitis vaccination. The advice provided by practice nurses was not reported.

Only 22% of nurses had received formal training on hepatitis C. Not surprisingly, a higher proportion of nurses working in the addiction services (86%) received training on hepatitis C, compared to the proportions working in public health (13%) or general practice (16%). Among nurses working in the addiction services, 96% reported that they were well informed about hepatitis C, while only 20% of practice nurses and 21% of public health nurses reported the same. The respondents were asked to identify 21 statements about hepatitis C as true or false. Although the nurses working in addiction

services had good knowledge about hepatitis C, there were four statements which 25% or more identified as true when they were false:

- Hepatitis C can be spread through close personal contact such as kissing.
- Hepatitis C is commonly spread through sexual transmission.
- Most people who get hepatitis C will die prematurely because of the infection.
- More than 50% of pregnant women with HCV will infect their children.

The level of knowledge among the public health and practice nurses was less than desirable, with 25% of the nurses identifying at least 11 statements as true when they were false. As well as the four listed above, these included:

- People with hepatitis C should be restricted from working in the food industry.
- Hepatitis C is a mutation of the hepatitis B virus.
- There is no pharmaceutical treatment for hepatitis C.
- HIV is easier to catch than hepatitis C.
- Once you have hepatitis C, you cannot get it again because you are immune.
- There is only one genotype of hepatitis C virus.
- Hepatitis C is associated with an increased risk of liver cancer.

Twenty-five per cent of the nurses identified as false the following statement which is in fact true: People can have the hepatitis C virus without being currently infected with the virus.

The authors calculated mean knowledge-level scores for each group of nurses. The mean score for addiction nurses was 22.5, for nurses working in public health 16 and for practice nurses 16.9. The overall mean score was 16.7. Nurses were most likely to have better knowledge about hepatitis C if they were younger, educated to degree level or above, had attended a formal training course, personally knew someone with hepatitis C, had professional contact with patients with hepatitis C, or considered that they themselves were well-informed about hepatitis C.

Nurses working in public health services and general practice require formal training in hepatitis C care and management. Nurses in the addiction services need to update their knowledge in four areas.

7.4 Responses to other health correlates among drug users

Two recent papers presented the results of studies on the health of women, who had been prescribed methadone for the treatment of opiate dependence, and their infants born in the Coombe Women and Infants University Hospital (CWIUH) in Dublin. The first paper reported that the services of a drug liaison midwife (DLM) were required to encourage pregnant women with opiate dependence to attend drug and maternity services regularly, and to liaise between professionals in both services. The second paper reported that the outcomes for mothers prescribed methadone and their new infants were not as good as those for other mothers and infants attending the maternity service.

Carmody and colleagues (Carmody*, et al.* 2011) examined maternal and neonatal outcomes of 436 pregnant women referred to the DLM at the CWIUH between 2002 and 2007, and who were attending a methadone clinic at the time they gave birth. The researchers compared their findings with those of an earlier study (Scully*, et al.* 2004). The authors found that a very high proportion (93%) of the 2002–2007 cohort was taking prescribed methadone, compared to the 1999–2000 cohort (75%). The average dose of methadone at delivery was higher for the later cohort (60mg) than for the earlier cohort (39 mg). The average gestation at delivery was 38 weeks for both cohorts. The average birth weight was higher by 66g in the later cohort. The percentage of babies requiring admission to the special care baby unit (SCBU) had increased from 42% in the earlier cohort to 56% in the later cohort. The proportion of babies requiring treatment for neonatal abstinence syndrome was considerably higher

in the later cohort (45%) than in the earlier cohort (29%), and the babies' average length of stay in the SCBU increased by over 2 days in the later cohort.

The authors noted that their findings were part of a larger study that will examine changes in maternal methadone doses, opioid stability at delivery and whether there is a correlation between maternal methadone dose and neonatal abstinence syndrome (NAS). While acknowledging that information on incidence and outcomes for mothers and babies is useful in planning treatment services, the authors also observed that their study did not ask women their opinions: 'A qualitative research will address some of the issues from their perspective, acknowledge their needs and improve their quality of care' (Carmody*, et al.* 2011) p. 450.

Cleary and colleagues (Cleary*, et al.* 2011) reported on a retrospective cohort study of 61,030 singleton births at the CWIUH between 2000 and 2007, based on antenatal, delivery and postnatal records and the Central Treatment List (of clients prescribed methadone). The aim was to investigate the relationship between methadone maintenance treatment and maternal characteristics and perinatal outcomes. Unlike many previous studies, it was a population-based study rather than a sample-based study, which enabled possibly confounding socio-demographic factors to be controlled for. The study found that 618 women (1%) were on methadone at delivery, and that methadone exposure among the mothers was associated with an increased risk of very preterm birth (<32 weeks of gestation), being small for gestational age (<10th percentile), admission to the neonatal unit, and diagnosis of a major congenital abnormality. There were four cases of Pierre Robin sequence among 618 methadone-exposed babies, compared to eight cases in 60,412 non-exposed infants. Although not statistically significant, the proportion of deaths within the first six weeks of birth was three times higher among the methadone-exposed group (2.4%) than the non-exposed group (0.8%).

The authors also found a dose-response relationship between methadone and neonatal abstinence syndrome. As the mother's methadone dose increased so did the incidence of neonatal abstinence syndrome (see Table 7.4.1). Preterm birth and small gestational age also predicted the presence of neonatal abstinence syndrome.

Table 7.4.1 Methadone dose and its relationship with neonatal abstinence syndrome among methadone-exposed mothers, among all singleton births at CWIUH, 2000–2007 (n=615)

Methadone dose in mg	Neonatal abstinence syndrome		
	Present	Absent	Adjusted odds ratios (95% CI)*
<21	19 (23.8)	61 (76.2)	1
21–50	73 (33.3)	146 (66.7)	0.9–3.5
51–80	117 (47.4)	130 (52.6)	1.6–6.53
81–100	26 (48.1)	28 (51.8)	1.3–7.5
>100	11 (73.3)	4 (26.7)	2.5–48.0

*Adjusted for preterm birth, gestational age, gender, maternal smoking during pregnancy and alcohol use before pregnancy
Source: (Cleary*, et al.* 2011)

After controlling for known adverse socio-demographic factors, methadone exposure was found to be associated with an increased risk of adverse perinatal outcomes. Methadone dose at delivery was one of the important determinants of neonatal abstinence syndrome

8. Social Correlates and Social Reintegration

8.1 Introduction

The links between social exclusion and drug use in Ireland have been well established (Keane 2011). Problem drug users in treatment tend to be young and male, have low levels of education and are unlikely to be employed. Indeed, recent data on those in treatment for problem drug use shows that the proportion of all cases and new cases reporting to be in employment is declining rapidly. For a small proportion, homelessness and insecure accommodation are persistent problems. Research also shows that there are problems with illicit drug use among socially-excluded groups such as the Traveller community, sex workers and homeless young people and adults.

The aim of social reintegration is to empower individuals to plan and pursue alternative activities to those they engaged in when using drugs. It achieves this through providing accommodation, education, and training and employment opportunities for recovering drug users. This chapter presents new data on the social correlates of drug use in Ireland, and describes policy and programmes initiated in the past year to support the social reintegration of recovering drug users. The broad policy approach and funding to support social reintegration are briefly outlined in this section.

The ***National Drugs Strategy (interim) 2009–2016*** **(NDS)** lists as a priority the implementation of the recommendations contained in the report of the Working Group on Drugs Rehabilitation. It proposes that the recommendations be incorporated in a comprehensive integrated national treatment and rehabilitation service, using the four-tier model.

The **Dublin Region Homeless Executive** is responsible for providing support and services to the Dublin Joint Homelessness Consultative Forum and the Statutory Management Group. The Housing (Miscellaneous Provisions) Act 2009 provides a statutory structure to address the needs of people who are experiencing homelessness in Ireland. The Act outlines a statutory obligation to have an action plan in place and the formation of a Homelessness Consultative Forum and a Statutory Management Group.

The **Community Employment (CE) scheme,** funded by FÁS, the national training and employment authority, now located in the Department of Social Protection, continues to oversee 1,000 places ring-fenced for recovering drug users. 'This special programme is part of the continuum of care to facilitate and support participants in their ongoing recovery from alcohol or drug misuse. The programme aims to enable those affected by substance misuse to address their addiction, while giving them an opportunity to upskill. It also supports participants during their work placement with a view to achieving sustainable employment.' (Shortall, Róisín 2011, 8 November)

8.2 Social exclusion and drug use

Social exclusion and drug use remain intertwined and for some marginalised and disadvantaged groups this association remains an intractable problem. Early school-leaving and homelessness among drug users reporting for treatment shows little change over the period 2005–2010 which suggests that measures to tackle these problems are not having the desired effect. Recent research with the Traveller community, homeless groups and sex workers who report use of various types and amounts of drugs is described in Section 8.2.2. While the research varies in quality and depth and we learn more about some groups than others, this work provides a useful lens through which to examine the nexus of drug use and social exclusion. Measures to tackle and remedy the association between social exclusion and drug use are provided in Section 8.3 under the headings of housing, education and training, and employment.

8.2.1 Social exclusion among drug users

The National Drug Treatment Reporting System (NDTRS), which collects data on all people attending drug treatment, is the most reliable database from which to capture information on the socio-demographic profile of drug users in treatment. The database includes information on type of accommodation and education that people report when engaging in drug treatment. Within these categories there is room for people to report if they are homeless or/and have left school early. These are two indicators of social exclusion as they speak of marginalisation (homelessness) and disadvantage (early school-leaving). Tables 8.2.1.1 and 8.2.1.2 provide data on both indicators among drug users attending treatment between 2005 and 2010. Early school leaving among this cohort of drug users has remained fairly steady at around 20%, which may suggest that measures to tackle the association between early school-leaving and drug use are having less than the desired impact. The number of cases reporting to be homeless has not changed significantly which indicates that homelessness remains a problem for a small proportion of drug users in treatment.

Table 8.2.1.1 Social exclusion characteristics of all cases in treatment, 2005–2010

Indicator of social exclusion	2005	2006	2007	2008	2009	2010
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Homeless	217 (4.4)	303 (5.8)	300 (5.2)	**382 (6.0)**	315 (4.8)	297 (3.9)
Early school leaver	986 (20.2)	1059 (20.2)	1149 (20.0)	1324 (20.9)	1315 (20.2)	1413 (18.6)

Source: (Bellerose, *et al.* 2011)

Table 8.2.1.2 Social exclusion characteristics of new cases in treatment, 2005–2010

Indicator of social exclusion	2005	2006	2007	2008	2009	2010
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Homeless	54 (2.7)	104 (4.7)	90 (3.7)	100 (3.8)	101 (3.4)	84 (2.6)
Early school leaver	274 (13.9)	340 (15.3)	369 (15.2)	412 (15.5)	477 (16.3)	448 (14.0)

Source: (Bellerose, *et al.* 2011)

8.2.2 Drug use among socially excluded groups

Travellers

The NDS identifies the need to improve access to drug and alcohol services for members of the Traveller community (Department of Community Rural and Gaeltacht Affairs 2009). Research using semi-structured interviews and focus groups to collect data from members of the Traveller community (n=137) and service providers working with the Traveller community (n=34) reported that Travellers experience problems in accessing drug services (Fountain 2006). These problems include a lack of awareness within the Traveller community about the existence and types of services available, a lack of formal education which prevents Travellers from complying with formal treatment requirements, such as completing forms and adhering to appointments, stigma and embarrassment around revealing their drug use, and a perception that drug services sometimes lack an awareness of the specific needs of members of the Traveller community around approaching services with regard to their alcohol or drug use; for example, their fear that they might be seen accessing services by other members of their community, or that services might breach their confidentiality.

In a recent attempt to explore the experiences of Travellers who do engage with drug and alcohol services, research was undertaken, based on semi-structured interviews with 30 members of the Traveller community who identified as service users (Cafferty

2011). The overall goal of this research was to develop good-practice guidelines, informed by real-life experiences of Travellers. These guidelines can be used by service providers to develop and implement relevant and quality-assured interventions for future generations of Travellers who use drugs and seek help to reduce or cease such use (see Section 3.4.1 for more detail on these guidelines).

Participants in this study comprised 18 females and 12 males. They were recruited using a mixture of techniques. Initially, service providers were recruited to identify members of the Traveller community who were engaging with services and who might wish to participate in the research; following this initial recruitment phase, members of the Traveller community who completed interviews were asked to recruit other members from their community. This second phase, known as the 'chain-referral' approach, was particularly successful in accessing female members of the community who were engaging with services and were willing to disclose and discuss their use of illicit drugs.

Previous research ((Fountain 2006), (Van Hout 2010) and (Walsh 2010)) disputed the use of illicit drugs among female Travellers. However, these studies tended to be over-reliant on the views of service providers and non-drug using members of the Traveller community, with minimal input from drug-using Traveller males. In contrast, Cafferty actively sought the views of drug-using Travellers by visiting services and establishing rapport with female Travellers who often put themselves forward for interview and were happy to recruit other women to be interviewed. The results of this approach highlight the benefits of investing time and resources in actively seeking out the views of 'hidden groups' through a mix of recruitment techniques.

For 29 of the 30 Travellers interviewed, heroin was reported as the main problem drug used and smoking heroin was the main route of administration for almost all of the interviewees. Female interviewees tended to report that they first used alcohol and/or drugs when they were aged between 21 and 25 years; in contrast, male interviewees tended to report first using substances when they were aged between 11 and 16 years. Six of the women interviewed reported that heroin was the first substance they had used, and pressure from their husband or partner was reported as a key influence on initial use of heroin.

A separate study set out to explore the nature of illicit drug use within one Traveller community in the greater Dublin area and to assess the relative merits of mainstream drug services and Traveller-specific drug services in meeting the needs of Travellers with problems associated with illicit drug use (Walsh 2010). Data were collected through semi-structured interviews with seven female and seven male Travellers. Four of the men were using a local drug service; the remaining three men and the seven women were not using drug services and did not report any form of illicit drug use. In addition, seven service providers were interviewed.

There was a perception among interviewees, particularly among service providers, that illicit drug use within the Traveller community was closely associated with the marginal status accorded to members of the community by sections of 'mainstream' society. According to the four male drug-using Travellers interviewed, cocaine was perceived as the drug most used in their community, followed by cannabis, ecstasy and prescription tablets. They said that these drugs were primarily used as part of the social and recreational night-out scene. Smoking cannabis was perceived to be part of normal activity in the community. There was a perception among these men that heroin use was confined to a small number within their community, but they expressed concern about the likely impact of heroin use if it became more prevalent.

All but one of the 21 interviewees was of the view that illicit drug use within the local Traveller community was confined to men. The one dissenting male agreed that illicit drug use was predominantly a male activity; however, he mentioned being aware of plenty of Traveller women who used illicit drugs. The Traveller women interviewed

were of the view that it would be highly unusual for women to get involved in illicit drug use. It was noted above that, while several other research studies into drug use in the Traveller community have also reported that illicit drug use is not perceived to be a common activity among Traveller women, the study by Cafferty (Cafferty 2011), described above, challenges this perception.

Within the Traveller community studied by Walsh, interviewees had mixed views about how illicit drugs were being supplied. Some Travellers believed that other Travellers were dealing drugs in the community; other interviewees felt that drugs were being purchased from the settled community. The four male drug-using Travellers recalled their experiences of being introduced to illicit drug use (often ecstasy or cocaine) through contacts with members of the settled community. The negative image of Traveller men using illicit drugs and the potential impact of this image on young children was cited as a key concern by the Traveller women; fears were also expressed that an escalation in illicit drug use could contribute to an increase in conflict and criminal activity within the Traveller community.

Service providers not working directly with drug-using Travellers were in favour of Traveller-specific drug services, whereas two service providers working directly with drug-using Travellers favoured the option of mainstream drug services as they could offer more privacy and confidentiality, a view endorsed by all the Travellers interviewed. Three of the four male drug-using Travellers were using a mainstream drug service on the recommendation of other Travellers.

Retaining traditional religious values and practices, a close-knit family life and the important role of women in preserving the family were mentioned as distinctive cultural aspects of the Traveller community. There was a perception that families that adhered to religious practices and had fewer interactions with the settled community also protected themselves against the use of illicit drugs. There was a degree of consensus that the influence of Traveller women, both as mothers and as wives, can deter the men from using illicit drugs, for example, the fear of the wife leaving the husband. It was acknowledged by some that despite the advantages of familial closeness, drawbacks included a lack of personal privacy and individuality. Because of the methodological limitations in this study which does not include sufficient data from drug-using Traveller men and women, it can be argued that it is more of a snapshot of untested assumptions than an exploratory analysis of the nature of illicit drug use within this community.

Homeless groups

A ‘point in time’ survey of health and homelessness was undertaken between 26 July and 1 August 2010 at all eight services provided to homeless people by the Simon Communities in Ireland (Simon Communities of Ireland 2010). Data were collected through a survey questionnaire administered in face-to-face interviews, and by reviewing the records of individuals using the projects and services during the one-week period. The 788 people who completed the survey questionnaire were selected through convenience sampling, in other words, participants were selected because they were readily available for interview. Sampling of this nature can provide useful insights into the health needs of a proportion of homeless people but the data generated from such a sample cannot be generalised to the health needs of the wider homeless population. Data were collected from three types of service users: those who were currently homeless, those who had been homeless and needed support to maintain their current home, and those who were at risk of becoming homeless. Just over three quarters of the sample were male, 51% received a disability allowance and 65% were registered as homeless with the local authority.

Of the 471 currently homeless people, 20% were homeless for six months or less, 45% for between seven months and five years, and 35% for more than five years. Of the 146 people who were formerly homeless and were being supported by Simon Tenancy Sustainment Services, 58% reported having been homeless for more than three years.

Reasons for first becoming homeless
When responses on primary and secondary reasons for becoming homeless in the first instance were analysed together, the main reasons given were personal alcohol use (19%), family conflict (14%), personal drug use (12%), relationship breakdown (9%) and personal mental health problems (7%).

Physical health conditions
Fifty-six per cent (442) of the respondents had at least one diagnosed physical health condition. The most common diagnosed conditions were as follows:

- 123 cases of cardiovascular disease, including angina, hypertension and stroke, and
- 115 cases of infectious disease, including (most commonly) hepatitis C, and also hepatitis B, HIV, sexually transmitted infection, tuberculosis and urinary tract infection.

Diagnosed mental health conditions
Fifty-two per cent (411) of the respondents had at least one diagnosed mental health condition: 29% reported having depression, 9% schizophrenia, 7% panic attacks, 5% social anxiety disorder, 4% mild cognitive impairment and 3% bi-polar disorder. Fifteen per cent of respondents reported self-harming episodes at the time of the survey, 23% reported suicide ideation and 8% had attempted to commit suicide in the six months prior to the survey.

Alcohol and drug use
Of the 769 people who answered the question about alcohol and drug use, 66% reported consuming alcohol. Fifty-five per cent of respondents had physical complications as a result of alcohol use. Drug use other than alcohol was reported by 38% of respondents. Heroin was the most common other drug, used by 20% (n=159), followed by cannabis, 15% (n=116). Thirty-one per cent of respondents who used drugs were using two drugs at the same time and 25% were using three drugs. Fifteen per cent (115) of all respondents were intravenous (IV) drug users.

Homelessness among women in Dublin, Cork and Galway was the subject of a recently published in-depth qualitative study (Mayock, Paula and Sheridan 2012). Data were collected from 60 women aged 18–62 years, using life-history interviews and a questionnaire to record socio-demographic data. Data were also collected by observation at four homeless services in Dublin City, by involving a small number of the women in a photography project. Focus groups were also held with providers of services to homeless women. The 60 women who participated in the research were either homeless at the time of data collection or had experienced homelessness in the preceding six months.

When interviewed, 40 of the women were living in either emergency or transitional accommodation for the homeless; of the remaining 20, four lived in domestic violence refuges, four in long-term supported accommodation, three with a family member or friend on a temporary basis, one in a dilapidated house, one was sleeping on the street, and seven had recently entered private rented accommodation following a period of homelessness. A large number of the women had spent periods of time in 'hidden' homeless situations, i.e. staying with friends or a family member for short time periods. To paraphrase the authors, these living arrangements concealed these women from homeless services and statistical counts of homelessness, thereby rendering them the 'hidden homeless'. Twenty-seven of the women had slept rough at some time, 16 for a period exceeding one month.

Twenty-one of the 43 women of Irish or UK origin had no formal educational qualifications, while 13 had progressed to Junior Certificate level prior to leaving school early. The Junior Certificate is an educational qualification awarded to students who successfully complete the required three years of second-level education; students normally undertake the examination at the age of 14 or 15. The women of Irish or UK

origin in this study reported strained relationships with teachers and difficult home situations which impacted adversely on their schooling. In contrast, 16 of the 17 immigrant women interviewed had completed the equivalent of Leaving Certificate level or higher; the Leaving Certificate examination is normally undertaken by students in Ireland when they are aged 16 to 19. Nine of the immigrant women had achieved a third-level qualification. All but one of the 60 women were dependent on welfare payments.

Twenty-seven women were married, but all were either separated or estranged when interviewed; 21 reported being in a current relationship and 13 of these partners were also homeless. Forty-one women were mothers, with a total of 105 children between them, and three were expecting their first child when interviewed. Of the 105 children born to the women, 77 were aged less than 18 years and 49 were aged less than 12 years.

A majority of the women had grown up in low-income households in disadvantaged areas and a number had spent time when they were children in homeless hostels with a parent, usually their mother. These episodes of family homelessness were often related to parental drug and alcohol misuse and/or domestic violence. Eighteen women had experienced homelessness as children, i.e. before the age of 18, and of these, four had become homeless directly after leaving a care setting. Fourteen women first experienced homelessness when they were aged between 18 and 25. Women who became homeless earlier in life tended to report longer histories of homelessness and more complex needs than those who became homeless later in life; these complex needs were related, in many cases, to traumatic childhoods, drug and alcohol misuse and mental health issues. Twelve of the women had spent periods of their childhood in state care, and all of these reported housing instability in adulthood, an experience often related to difficulties adjusting to life outside the care system. Four women reported sexual abuse in a state care setting.

Forty-three of the women reported having experienced some form of abuse or violence as children; 30 had experienced domestic violence, either as victims or as witnesses, with the violence most often perpetrated by their fathers. A small number reported domestic violence by a mother or a brother. Parental alcohol and drug abuse was often a factor in the domestic violence experienced by these women. Twenty-eight of the women reported sexual abuse during childhood.

Thirty-seven of the women reported a current (32) or past (5) substance abuse problem. Ten named alcohol as their current primary substance of misuse and a further two named alcohol combined with cocaine. The remaining 22 women used heroin, often combined with cocaine, crack cocaine and benzodiazepines. According to the authors,

> Substance misuse posed significant challenges for a large number of the women and had negative consequences for their health and well-being. For the majority, drug and alcohol use preceded first homeless experiences and some women attributed the loss of housing to problems arising from alcohol or drug use. However, substance misuse was rarely the sole presenting issue or problem at the time women first entered homelessness. Furthermore, problems related to drug or alcohol consumption were invariably exacerbated by the homeless experience itself. (p.12)

Half the women interviewed reported multiple episodes of homelessness. The authors identified some of the ‘triggers’ that led to some women returning to homelessness, including the transition from institutional settings such as places of detention, psychiatric hospitals or state care facilities. For example, some were unable to secure housing following time in prison and often returned to emergency accommodation where they became further entrenched in drug use and repeat offending. Other women reported problems in sustaining their housing tenancies because of disputes with

landlords, domestic violence, drug and alcohol use and a general inability to cope with the financial and emotional demands of independent living.

The experience of homeless women is a field of inquiry that has often been overlooked in the past. The experiences documented in this research paint a vivid picture of the role of childhood poverty and deprivation, childhood trauma and abuse and family breakdown and addiction had on their entry into homelessness and on their many unsuccessful attempts to exit homelessness. The legacy of these fractured childhoods is inextricably linked in adulthood with their alcohol and drug misuse and mental health issues. Finally, it is hoped that the gender perspective conveyed in this research can, in the words of the authors, '…critically inform and influence policy and help to ensure that services work appropriately and effectively to meet the needs of homeless women' (p.16).

Two voluntary agencies working with disadvantaged people in Cork undertook a snapshot study of service users between 4 and 11 July 2011 in an attempt to document the health and related needs of people using their services (Good Shepherd Services and Cork Simon Community 2011). The researchers collected data from 115 women who used the services during the week of the study and were homeless or at risk of becoming homeless. Eighty-four of the women were supported in different housing tenures, including high support (9), low-to-medium support (11), local authority (20), private rental (31) and other (13); 31 women were living in emergency accommodation, 11 of them for six months or longer. Family conflict, domestic violence, relationship breakdown and personal alcohol and drug use were among the most common factors contributing to the women's first experiencing homelessness.

A diagnosed physical health condition was reported by 66 of the women, the most common being asthma, anemia and high blood pressure; 32 women reported two or more conditions and 18 reported three or more conditions. Women reporting multiple conditions tended to live in emergency accommodation and high-support housing. A diagnosed mental health condition was reported by 46 women, the most common being depression, bipolar disorder and anxiety. Forty-one women reported a combination of physical and mental health conditions; women in emergency accommodation and high-support housing tended to report combined diagnoses. Women with diagnosed mental health conditions, problem alcohol or drug use and living in emergency accommodation were more likely to have self-harmed, had suicidal thoughts or reported a suicide attempt.

Forty-six women reported using alcohol, with 24 of this group indicating problem use. Women in emergency accommodation and high-support housing tended to report problems with alcohol use, including falling down and head injuries, memory loss and gastric problems. Drug use was reported by 23 women. Drug use was higher among women in emergency accommodation and high-support housing than among women in local authority and private rented housing; no use of drugs was reported by women in low-to-medium support housing. Heroin, cannabis, head shop substances and unprescribed benzodiazepines were the drugs most commonly used; 10 women reported injecting heroin. All 11 of the women living in emergency accommodation for six months or longer reported using drugs.

Although this was a relatively small snap-shot study of homeless women in Cork, important insights emerge that signal the apparent association between long-term homelessness and living in emergency accommodation and poorer health and related outcomes. According to the authors: 'The health and related issues appear to be starker for women in emergency accommodation, with much higher rates of drug use, intravenous drug use, problem alcohol use, self-harming, suicide ideation and attempted suicide. These issues appear to be even starker for women who experienced long-term homelessness, with higher rates of heroin use and intravenous drug use [reported]' (p. 23).

A report was published recently by the Ombudsman for Children's Office (OCO), detailing the experiences of homeless children in Ireland (Ombudsman for Children's Office 2012). The report is based on face-to-face interviews with 15 young people aged 16–19 who were currently using, or had recent past experience of using, emergency hostel accommodation services in Dublin and Cork.

Homeless children needing access to emergency accommodation in the Dublin area are required to present at a Garda station and request the services of the out-of-hours social worker. They then have to wait in the Garda station until the social worker arrives to link them in with available accommodation. The children interviewed by staff from the OCO were critical of this practice. They recalled feeling embarrassed, ashamed and anxious while waiting in the Garda station for the social worker to arrive and many questioned the appropriateness of this route to emergency accommodation. The OCO concurred with these concerns and reported that 'children should not be expected to wait for hours in a Garda station for social work services' (p. 38).

Of the 15 children interviewed, five had spent between one and three months in emergency accommodation and seven had used the service for more than six months. Six children had been in one placement and six had been in up to three placements. Children who had moved between placements criticised this practice and the instability it brought to their already fragmented lives, while some of the children who were able to reside in one stable placement over several months noted some benefits from their experience. The experience of multiple placements is often exacerbated by the requirement to present to the emergency services as homeless on a daily basis, a practice criticised by the OCO: '…the practice of requiring children to present on a day-to-day basis should cease' (p. 39).

Eight of the 15 children interviewed were in full-time post-primary education when they first used emergency care services and only three continued in education without interruption while using the emergency services. Some of the children praised the support they received from staff in Youthreach, a service for early school-leavers. However, most of the children voiced their concern at the considerable amount of time that they and other homeless children spent hanging around the streets during the day. They reported using alcohol and drugs and engaging in petty criminal acts while hanging out with 'acquaintances'; they also talked about the intimidation, exploitation and violence that they were regularly exposed to as part of their immersion in street culture.

Similar experiences were reported in an earlier study, which interviewed 40 young homeless people in the Dublin metropolitan area as part of a longitudinal cohort study of youth homelessness (Mayock, Paula and Vekic 2006). The vast majority of these children had also used or were using the out-of-hours service in the city centre and were moving between city-centre hostels where they were exposed to alcohol and drug use, criminal activity, intimidation and bullying. When this exposure lasted over an extended period, young people became heavily involved in using drugs; half of the cohort reported having used heroin, with almost all reporting their heroin use as problematic to the point of dependency. The majority of those who used heroin had first experimented with it *after* they became homeless. According to the authors, this long-term exposure to the street scene led to a process of 'acculturation', where the young people 'learned the street competencies they needed to survive by becoming embedded in social networks of homeless youths' (p. 23).

The OCO was highly critical of the model and location of emergency accommodation services for homeless children (Ombudsman for Children's Office 2012). The report stated:

> Short-term, hostel-style accommodation is not a suitable model for children under eighteen and should never be used to accommodate children under sixteen or children who are particularly vulnerable. The practice of

> accommodating children in Dublin city centre should cease because it exposes children to unacceptable risks and increases the likelihood of their involvement in harmful and criminal behaviours. …Ideally, emergency care accommodation should be located in or close to children's local communities. (p.39)

Similar points were made in a report published six years ago (Pillinger 2006). One of the first detailed strategies to prevent homelessness recommended that support measures needed to be put in place at local level, particularly in the Dublin suburbs, to prevent young homeless people congregating in the city centre and becoming involved in drug use and criminal behaviours. The advantages of a decentralised approach to homelessness in Dublin would mean that young people could be accommodated closer to their homes, continue contact with their families and remain in school.

Sex workers

The report of a study of drug users who were engaging in or had engaged in sex work in Dublin was published in the reporting year (Whitaker*, et al.* 2011). The study was based on 35 interviews with drug users: 31 women and 4 men. The sample was purposively selected and access was primarily secured through service providers; the display of posters advertising the research in drug treatment centres led to some interviewees contacting the research team independently.

Self-reported drug use during the 90 days prior to each interview revealed that 24 interviewees used methadone purchased on the street, 22 used heroin, 16 used non-prescribed benzodiazepines, 12 used cannabis, 10 used cocaine and five used crack cocaine. All the interviewees reported a history of injecting drugs and over half had injected in the previous 90 days. Four of the women were in prison at the time of interview and four had recently been released from prison and were living in transitional accommodation; around a quarter of the interviewees were living in emergency hostels. The health status of the interviewees was poor, with 26 reporting to be HCV positive and seven reporting to be HIV positive.

All the interviewees reported using drugs prior to engaging in sex work; for most, entry into sex work was facilitated by friends or family networks and their sex work was mainly undertaken on the street. Most of the interviewees had grown up in socially and economically deprived areas of Dublin where illegal drugs were available. Some had also experienced family dysfunction, physical and sexual abuse, early school leaving, being placed in care and episodes of homelessness during their youth.

An analysis of the data from the interviews revealed that many felt an acute sense of stigma arising from their use of drugs and employed various strategies to cope with these feelings. For example, many of the interviewees sought to conceal the scars of injecting and pass as non-injecting drug users; injecting heroin was perceived to be the most stigmatised form of drug use. Interviewees also reported injecting in less visible parts of the body such as the neck, the groin or feet; for some, visible scars were the worst legacy of their drug use as it incurred stigma when seen by others. The stigma surrounding their use of drugs, particularly injecting heroin, co-existed with their sense of shame about engagement in sex work and having contracted HIV and/or HCV.

8.3 Social reintegration

Social reintegration of drug users is an aspiration of national drug policy. Action 32 of the NDS calls for the implementation of the recommendations of the report of the working group on drugs rehabilitation (Working Group on drugs rehabilitation 2007). The recommendations contain a number of actions to improve housing, education and training and employment opportunities for people recovering from drug use. It is proposed to undertake action on some of these measures within the context of the new national drugs rehabilitation framework (NDRF) (Doyle and Ivanovic 2010). This framework is currently being piloted in three sites. The current Programme for

Government includes a number of proposals to progress some of the recommendations of the working group on drugs rehabilitation (Fine Gael and the Labour Party 2011). These include:

- expanding rehabilitation services at local level in line with need and subject to available resources,
- assisting drug users in rehabilitation through participation in suitable local community employment schemes, and
- developing compulsory as well as voluntary rehabilitation programmes.

8.3.1 Housing

Recent research in Ireland among homeless groups highlights the continuing association between drug use and homelessness (see Section 8.2). Previous research had also highlighted the links between these two seemingly intractable issues (Lawless and Corr 2005); (Keane 2007). The current Programme for Government contains a commitment by the coalition parties to tackle the issue of homelessness through pursuing an evidence-based approach. Specifically, the coalition government is committed to:

> …ending long-term homelessness and the need to sleep rough. To address the issue of existing homelessness we will review and update the existing Homeless Strategy, including a specific focus on youth homelessness, and take into account the current demands on existing housing and health services with a view to assessing how to best provide additional services…we will alleviate the problem of long-term homelessness by introducing a "housing first" approach to accommodating homeless people. In this way we will be able to offer homeless people suitable, long-term housing in the first instance and radically reduce the use of hostel accommodation and the associated costs for the Exchequer.… ((Fine Gael and the Labour Party 2011), p. 45)

The Dublin Region Housing First Demonstration Project has been established to provide tenancies in scattered-site, self-contained housing units in the Dublin area. The target group are people who have been sleeping rough long-term. The project invites participants to identify their own goals and to be involved in choosing a suitable housing unit; the Housing First team work with participants to achieve their goals. Tenancies are supported through an intensive specialist case management team who visit the tenants on an arranged basis

A three-year longitudinal evaluation of the project is being undertaken by Dr Ronni Greenwood of the University of Limerick, and Pathways New York. This evaluation will produce an initial report reviewing the first 12 months of the project. It is envisaged that this report and the overarching evaluation will make recommendations regarding the potential application of this model in the Dublin region and nationally. Participants will continue to be supported, even if they cannot sustain the tenancy (personal communication, Elaine Butler, Homeless Agency, 2011).

Research consistently shows that young people experiencing homelessness continue to report problems with using drugs (Mayock, Paula and Vekic 2006); (Mayock, P*, et al.* 2008); (Ombudsman for Children's Office 2012). The Youth Homelessness Strategy (Department of Health and Children 2001) was published in 2001, and there has been no formal review of the strategy. Recently the Department of Children and Youth Affairs (DCYA) commissioned the Centre for Effective Studies (CES) to undertake a high-level review of the implementation of the strategy. The review will include in-depth interviews with key stakeholders involved in the implementation of the strategy, an on-line survey targeting practitioners, service managers, policy makers and researchers, and focus groups with young homeless people. The review will also seek the views of all three groups on how a youth homelessness strategy can be effectively implemented in the future. The final review is due to be completed in the second half of 2012.

Sundial House
Perhaps the only service dedicated to providing long-term sustainable accommodation to people who have experienced long-term homelessness in Ireland is Sundial House, operated by DePaul Trust Ireland. The remit for Sundial is to provide long-term supported housing to 30 individuals who have experienced extended periods of street homelessness and have entrenched alcohol misuse. The service offers dedicated support for individuals with multiple and complex bio-psychosocial issues as a result of long-term homelessness; the service is based on a low-threshold and harm reduction philosophy. Service users have their own rooms and 24-hour access to the building, with their own front-gate key.

According to the most recent report of service provision, 44 service users have been accommodated since September 2008, and 17 of the group accommodated during the initial opening period (Sept/Oct 2008) have sustained their accommodation (Depaul Ireland 2010). In addition to providing long-term accommodation to this group of people, the service also works with them to reduce the risky and chaotic nature of their entrenched alcohol consumption. The report documents that some progress has been achieved towards this objective, with some service users reported to have changed from drinking large quantities of spirits to consuming lager or cider, which are deemed less risky. Service users are also reported to have slowed their consumption and reduced their intake of alcohol; these changes are reported to have contributed to improvements in health, increased appetite, and reductions in adverse behavioural issues.

8.3.2 Education, training

The client forum of Dublin North East Regional Drugs Task Force commissioned an exploratory study of the experience of individuals in receipt of methadone maintenance, who had also engaged with the Special Community Employment scheme (Van Hout and Bingham 2011). The Special Community Employment scheme operates mainly through community drug rehabilitation projects. The aim of the scheme is to prepare participants to enter the labour market by providing personal development and vocational training. The researcher collected data through in-depth interviews with 15 men and 11 women.

The meaning of recovery and rehabilitation differed among interviewees. For some it meant being on methadone and not using the main problem drug, i.e. heroin, while for others it meant the cessation of all substance use. The improvement in quality of life and the pursuit of mainstream norms such as employment and a settled family life were also cited as meaningful components of recovery.

The majority of interviewees reported that their engagement with the Special Community Employment scheme was a positive experience. Accounts varied as to the nature of these experiences and included improvements in personal development, addiction management strategies and the development of positive daily structures. For some interviewees, the value of the scheme lay in the interactions they had with other participants who were ‘clean’ and with staff who provided a listening ear and support. The effectiveness of the scheme in developing vocational and employment skills was less pronounced; however, some interviewees reported that they had developed literacy and computer skills. Several expressed the aspiration of progressing to third-level education from the scheme.

The variety of experiences narrated in this report is testament to the diverse needs of this cohort of people, needs which, according to the people themselves, are not being met by the provision of other addiction recovery supports and services. Interviewees referred to the lack of connectivity between services, having to wait long periods to access a counsellor and not having adequate information on what services were available to promote and support progression and social reintegration. Several interviewees noted a lack of tangible outcomes for those who attended the employment schemes. For example, there was a feeling that employers would be prejudiced against

potential applicants owing to their engagement with such schemes, gaps in their curriculum vitae and a lack of formal education and training qualifications. Several noted the lack of aftercare and support for those that exit the schemes.

This report, although exploratory in nature, and confined to the context-specific location of the Dublin North East Regional Drugs Task Force area, provides an important insight into participants' experiences in the Special Community Employment scheme. It would appear that for these individuals, participation in the scheme helped their personal development but was less effective in developing educational skills and improving employability, the purpose for which the scheme established. Several participants expressed the aspiration of progressing to third-level education from the scheme but could not envisage how this aspiration could be fulfilled. According to the authors of the report, '…Special Community Employment schemes [provided] little real life employment preparation, assistance in seeking and securing employment or vocational skills development.' (p. 44)

The role of adult education in addiction recovery

A research report on the role and benefits of adult education in drug rehabilitation and recovery from addiction was published (Keane 2011). The report was based on an analysis of data from in-depth interviews with 20 individuals in recovery from substance addiction. All of the people interviewed had progressed through the Health Service Executive (HSE) Soilse drug rehabilitation programme.

For most interviewees in this study, their family upbringing and school experience was set within a social context of poverty and disadvantage; most were early school-leavers and some had poor literacy and numeracy skills and modest formal educational achievements. Nearly all the people interviewed had experienced repeated episodes of family conflict in the home, often against a background of alcohol abuse among their parents. Their narratives suggested that they drifted into addiction from various experimental episodes with drugs. Official treatment programmes, such as methadone, detoxification and residential rehabilitation, played a modest part in their recovery. They were caught in the dilemma of 'multiple recoveries'; they were not just recovering from addiction but also from a lifetime of exclusion, emotional turmoil and a 'fractured identity'.

The data were analysed using the recovery capital framework, which looks at social, physical, human and cultural outcomes. Recovery capital is a concept used to illustrate the different resource dimensions that can assist with recovery from substance addiction. It has been defined as the sum of resources – including social, physical, human and cultural capital – that is necessary to initiate and sustain recovery from substance misuse (Cloud and Granfield 2009). The present study with former participants in the Soilse programme was the first attempt to apply the construct of recovery capital to addiction recovery in Ireland.

This study of 20 people in self-reported recovery from substance addiction demonstrates the contribution that adult education can make to developing recovery capital. Education can play a role in all four dimensions. It can improve:

- social capital by opening up opportunities to develop new networks of friends outside the confines of formal treatment and self-help groups;
- physical capital by improving career options and job opportunities which can improve living standards;
- cultural capital by exposing people to new values, beliefs and attitudes and instilling a revised work ethic grounded in the demands of educational pursuits; and
- human capital by empowering people to look after their health, become a more effective parent, reappraise ingrained negative belief systems, develop achievable goals and improve day-to-day functioning and personal efficacy.

8.3.3 Employment

The proportion of all drug treatment cases in employment declined from 22% in 2005 to 9% in 2010 (Bellerose*, et al.* 2011). According to the author of the report, '…This [drop]

is most likely a reflection of the current economic climate, and highlights the continued importance of social and occupational reintegration interventions as part of the drug treatment process' (p. 2).

Table 8.3.3.1: Number and percentage of all cases in treatment in employment, 2005–2010

	2005		2006		2007		2008		2009		2010	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
All cases	1025	(21.8)	1071	(21.0)	1059	(18.9)	921	(15.0)	689	(10.9)	670	(9.1)

Source: (Bellerose*, et al.* 2011)

There was an even greater drop in the proportion of new cases reporting for treatment, i.e. have never been treated for problem drug use, who were in employment, from 29.7% in 2005 to 11.7% in 2010. New cases are individuals that have never been treated for problem drug use.

Table 8.3.3.2: Number and percentage of new cases in treatment in employment, 2005–2010

	2005		2006		2007		2008		2009		2010	
	n	**(%)**	**n**	**(%)**	**n**	**(%)**	**n**	**(%)**	**n**	**(%)**	**n**	**(%)**
New cases	542	(29.7)	590	(28.0)	592	(25.6)	524	(20.8)	386	(13.9)	357	(11.7)

Source: (Bellerose*, et al.* 2011)

9. Drug-related crime, prevention of drug-related crime and prison

9.1 Introduction

This chapter presents the most recent statistical data on drug-related crime in Ireland. It also describes policies and programmes initiated in the past year to prevent drug-related crime both in the community and in prisons as well as research studies on drug-related crime, prevention and prison. In this section the data sources and types of drug-related crimes in Ireland are described, and the approaches to preventing drug-related crime, both in the community and in prisons, are also briefly outlined.

Since 2006 reporting crime statistics has been the responsibility of the Central Statistics Office (CSO). The CSO data are derived from the Garda Síochána computerised PULSE system (Police Using Leading Systems Effectively).

The vast majority of drug offences reported come under one of three sections in the Misuse of Drugs Act (MDA) 1977: section 3 – possession of any controlled drug without due authorisation (simple possession); section 15 – possession of a controlled drug for the purpose of unlawful sale or supply (possession for sale or supply); and section 21 – obstructing the lawful exercise of a power conferred by the Act (obstruction). Other MDA offences regularly recorded relate to the importation of drugs (section 5), cultivation of cannabis plants (section 17) and the use of forged prescriptions (section 18).

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

In reading the tables in this chapter, please note that *'relevant proceedings'* refer to the legal proceedings, such as prosecution, taken in relation to an offence as it was originally recorded in the PULSE system. *'Proceedings'* is a list of charges and proceedings which do not necessarily relate to an offence as originally recorded in the PULSE system.

Over and above the 'inherent' drug crimes, that is crimes under the Misuse of Drugs Acts or the Road Traffic Acts, 'non-inherent' drug crimes are also recorded in Ireland, for example acquisitive crime to pay for drugs, crimes of intimidation and violence inflicted by drug gangs, money laundering, smuggling or other finance-related crimes, or public nuisance. However, they are not reported in this chapter as it is not possible to separate those associated with the operation of the illicit drug market from those not associated with illicit drugs.

Crime prevention in Ireland proceeds on several fronts. Tackling community disadvantage is one important approach. Disadvantage in communities is recognised as a risk factor in contributing to, among other things, the spread of drug-related crime. A wide range of national initiatives exist to tackle disadvantage and its consequences, including community and local development programmes, the RAPID and CLAR programmes, and targeted urban regeneration projects. These initiatives all contain components relating specifically to illicit drugs. Specifically in relation to the drug problem, in 1998 local drugs task forces (LDTFs) were established in areas identified

as having the highest concentrations of drug misuse; without exception, these areas were all also experiencing high levels of disadvantage. The purpose of the LDTFs is to co-ordinate local action plans in relation to curbing local supply as well as treatment, rehabilitation, education and prevention. A central feature of the LDTFs is that as well as co-ordinating the provision of services locally, they also allow local communities and voluntary organisations to participate in the planning, design and delivery of services. Diversion is another important means of seeking to prevent crime including drug-related crime – both before, and after, a crime has been committed. Garda Youth Diversion Projects are local community activities which work with children. These projects aim to help children move away from behaving in a way that might get them or their friends into trouble with the law. In 2005 the Irish Youth Justice Service (IYJS) was established to develop a co-ordinated partnership approach among agencies working in the youth justice system, to improve service delivery in the system through diversion, restorative justice, rehabilitation and detention as a last resort. Garda (Irish police force) statistics show that the types of offence committed by children under the age of 18 years are primarily theft, alcohol-related offences, criminal damage, assault, traffic offences, drugs possession, public order offences and burglary. The Garda Juvenile Diversion Programme is used to deal with children under 18 years of age who have committed offences, including alcohol-related and drug possession offences. This programme exists across the country and is included as part of the Children Act 2001. First established on a pilot basis in 2001 the Drug Treatment Court is a specialised District Court which offers long-term court-monitored treatment, including career and education support, to offenders with drug addictions as an alternative to a prison sentence. The idea is that by dealing with the addiction, the need to offend is no longer present.

Finally, individuals and communities are encouraged to participate in helping to prevent and/or detect crime. For example, the Customs Drugs Watch Programme, first launched in 1994, encourages those living in coastal communities, maritime personnel and people living near airfields to report unusual occurrences to Customs. Under the Garda Síochána Act 2005, Joint Policing Committees (JPCs) have been established in local authority areas to bring together public representatives, representatives of local authorities, the Garda Síochána and representatives of the voluntary and community sectors to assess levels of crime and anti-social behaviour, including that related to alcohol use and illicit drug use, and to make recommendations as to how to prevent and address such problems. The JPCs are empowered to establish local policing fora (LPF), to deal specifically with drugs and associated issues such as estate management and anti-social behaviour. In September 2008 a Dial-to-Stop Dealing campaign was launched and operates nationwide; individuals and communities affected by drug dealing are urged to pass information by dialling a confidential number.

The presence of drugs in prisons led the Irish Prison Service (IPS) to develop a policy based on three underlying principles (Irish Prison Service 2006):

- the presence of drugs in prison will not be tolerated;
- prisoners will be encouraged and supported to develop a responsible attitude to drugs, both while in prison and following release, through a range of measures including education and counselling; and
- prisoners who are addicted to drugs or have other medical problems caused by the misuse of drugs will be offered every reasonable care and assistance.

In the accompanying strategy the IPS lists two aims in relation to illicit drugs in prisons: (1) to eliminate the supply of drugs into prisons, and (2) to provide prisoners with a range of opportunities which encourage them to adopt a drug-free lifestyle, before and after release, thereby reducing demand for drugs.

The Probation Service works in partnership with communities, local services and voluntary organisations to reduce offending and to make communities safer. It funds and supports organisations and projects providing drug treatment to offenders, as well

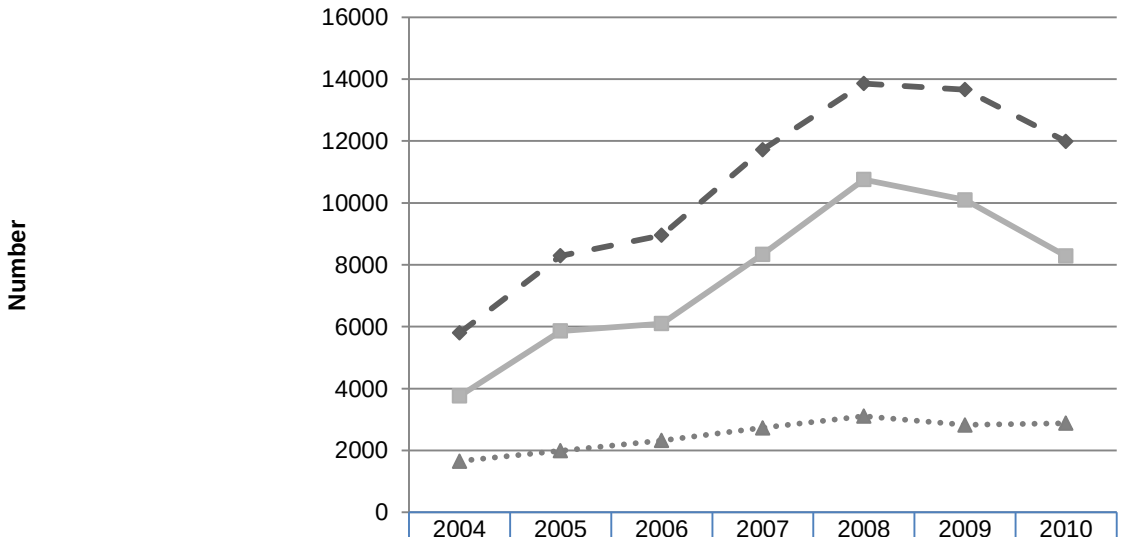
as other important services such as employment placement, accommodation, education and training, restorative justice initiatives. Probation Service staff in the community and in prisons may refer clients to these community-based projects, to enhance their re-integration and resettlement as positive, contributing members of their communities.

9.2 Drug-related crime

The link between drugs and crime in Ireland exists simply by virtue of prevailing legislation which defines as criminal offences the importation, manufacture, trade in and possession, other than by prescription, of most psychoactive substances. Along with such official statistical indicators, research and analysis has also been conducted in Ireland on the connection between illicit drugs and other types of crime such as theft from the person, burglary, larceny and prostitution (Connolly, J. 2006c). Data on drug law offences is presented in section 9.3 and information on other drug-related crime is presented in section 9.4.

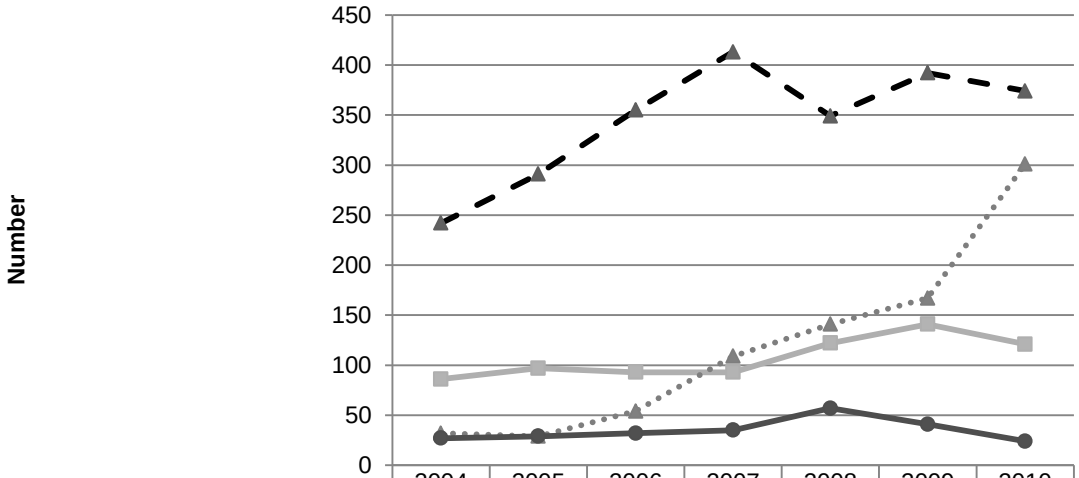
9.3 Drug law offenses

Figures 9.3.1 and 9.3.2 show trends in proceedings for drug offences from 2004 to 2010 (see Standard Table 11). As can be seen from Figure 9.3.1, criminal proceedings for the possession of drugs for personal use (simple possession) decreased in 2009 for the first time since 2004. This decrease continued throughout 2010. Possession offences accounted for 69.1 % of total drug offences (n = 11,984) in 2010. Proceedings for drug supply increased slightly in 2010, from 2,824 in 2009 to 2,881 in 2010.



	2004	2005	2006	2007	2008	2009	2010
Total drug offences	5800	8292	8952	11722	13860	13661	11984
Drug possession for personal use	3760	5858	6096	8341	10753	10096	8283
Drug possession for supply	1653	1988	2322	2731	3107	2824	2881

Figure 9.3.1 Trends in relevant legal proceedings for total drug offences, drug possession for personal use and for supply, 2004–2010
Source: (Central Statistics Office 2012) Accessed 31 July 2012



	2004	2005	2006	2007	2008	2009	2010
Obstruction	242	291	355	413	349	392	374
Forged/altered prescriptions	86	97	93	93	122	141	121
Cultivation or manufacture	32	29	54	109	141	167	301
Importation/manufacture	27	29	32	35	57	41	24

Figure 9.3.2 Trends in relevant legal proceedings for selected drug offences, 2004–2010
Source: (Central Statistics Office 2012) Accessed 31 July 2012

The offence of obstructing the lawful exercise of a power conferred by the Misuse of Drugs Act, 1977 (s21) continues to be the largest category of offence prosecuted, although there was a slight decline in such offences in 2010 following an increase in 2009. Obstruction offences often involve an alleged offender resisting a drug search or an arrest or attempting to dispose of drugs to evade detection. A similar trend can be observed in relation to the offence of being in possession of forged/altered prescriptions.

Of particular significance has been the large increase in the offence of cultivating/manufacturing controlled drugs. Proceedings for the cultivation or manufacture of drugs have continued to increase since 2005. In 2005 there were 29 proceedings for such offences. By 2009, the number of proceedings for drug cultivation/manufacture had risen to 167 offences. In 2010 the number of prosecutions for such offences almost doubled on the previous year, to 301 offences. It is unclear whether this increase reflects a genuine growth in the commission of such offences or whether it reflects a sustained concentration of law enforcement on detecting such offences. For example, in 2010, the Garda Síochána conducted Operation Nitrogen, a nationwide investigation with district and divisional drug units into cannabis cultivation sites. This specific focus may have had an impact on the data presented here (An Garda Síochána 2012).

Courts Service Annual Report 2011

The Courts Service Annual Report for 2011 provides statistics on the outcomes of prosecutions for drug offences between January and December 2011 (Courts Service 2012). Table 9.3.1.1 shows the outcomes of trials for 17,715 drug offence cases prosecuted in the District Court, the lowest court in the system where most drug offences are dealt with. The most common outcome was for cases to be struck out (20.5%, n=3,641). There were 3,224 offences that resulted in fines (18.2%). Almost 9% (1,544) of cases resulted in a prison sentence.

Table 9.3.1Sentences for drug offences in the District Court, 2011

Sentences	Imprisonment	Fines	Community service/ probation	Struck out	Dismiss	Taken into consideration*	Other	Peace bond	Total

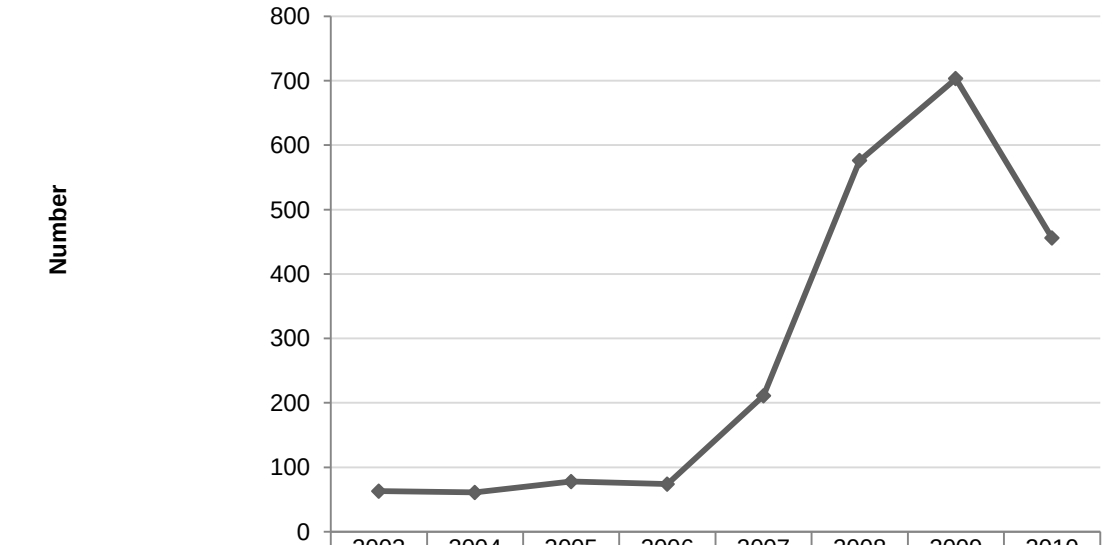
Sentences	Imprisonment	Fines	Community service/ probation	Struck out	Dismiss	Taken into consideration*	Other	Peace bond	Total
Number of offences	1544	3244	2415	3641	332	2859	3430	270	17715

* Taken into consideration: The Criminal Justice Act, 1951, s8, provides that where a person, on being convicted of an offence, admits him- or herself guilty of any other offence and asks to have it taken into consideration in awarding punishment, the Court may take it into consideration accordingly. If the Court takes an offence into consideration, a note of that fact is made and filed with the record of the sentence, and the accused cannot be prosecuted for that offence, unless her/ his conviction is reversed on appeal.
Source: (Courts Service 2012)

The Courts Service reports that 2,333 drug offences were tried in the Circuit Court, which has a higher jurisdiction than the District Court and can thus impose a more severe sentence (Courts Service 2012) (p.43). Of these prosecutions, 829 led to guilty pleas. Of the 53 cases which went to trial, 14 resulted in convictions, 26 in acquittals and 13 in a *nolle prosequi*, where the prosecution enters a stay on criminal proceedings. The data provided do not specify the precise sentence imposed in relation to the 14 convictions. However, of those who pleaded guilty, 88 were imprisoned for up to two years, 238 between 2 and 5 years, 79 from 5 to 10 years and 6 people were imprisoned for more than 10 years. 335 cases resulted in a suspended sentence.

Drug driving offences

Figure 9.3.3 shows the trend in prosecutions for driving under the influence of drugs (DUID) from 2003 to 2010. After 2006, the number of prosecutions for DUID increased rapidly year on year, reaching 703 by the end of 2009 (compared to 74 in 2006), an increase of more than 900%. It is unclear why this increase occurred. It could be due to either an increase in the incidence of DUID or the more likely possibility that there was an increase in targeted police activity in this area. In 2010 the number of such offences decreased significantly, to 456 offences.



	2003	2004	2005	2006	2007	2008	2009	2010
Number of prosecutions	63	61	78	74	211	576	703	456

Figure 9.3.3 Trend in relevant legal proceedings for driving/in charge of a vehicle while under the influence of drugs, 2003–2010
Source: (Central Statistics Office 2012)

9.4 Other drug-related crime

A recently published study sought to measure the relationship between crime committal rates and ongoing benzodiazepine and cocaine use by clients in opiate drug treatment programmes (Comiskey, Catherine*, et al.* 2012). The study involved a national,

prospective, longitudinal, multi-site drug treatment outcome study. A total of, 404 participants were recruited from inpatient and outpatient settings and 97% were located at three years. The study found that of those who had not committed an acquisitive crime at intake, those who used cocaine regularly at one year were 6.5 times more likely, and those that used benzodiazepines regularly were eight times more likely, to commit an acquisitive crime at one year. Of those who had committed an acquisitive crime at intake, those who used heroin regularly at one year were nine times more likely to commit acquisitive crime than those who did not use heroin regularly at one year. The study concluded that treatment must place greater emphasis on reducing substitute drug use if opiate treatment is to effectively sustain crime reduction.

In June 2012, following a year of research and consultation, a Strategic Response Group (SRG), a partnership set up to address public substance misuse and perceived anti-social behaviour in Dublin city centre in the long term, published its report (Strategic Response Group 2012). The issue of substance misuse and related anti-social behaviour in Dublin city centre has for a long time been a source of media focus and public concern. Following the establishment in 2010 of the Dublin City Local Business Policing Forum, this issue became a recurring item of discussion. A number of agencies and organisations were invited to make presentations on the topic, and in January 2011, in his capacity as chairman of the Dublin City Local Business Policing Forum, former Lord Mayor of Dublin, Councillor Gerry Breen, called a meeting of representatives of some of Dublin City's key stakeholders. Arising from this, the Strategic Response Group (SRG) was formed with the objective of developing ways to build sustainable street-level drug services and address related public nuisance. The SRG was independently chaired and its membership included representatives of the four main drug treatment centres in Dublin city centre (Ana Liffey Drug Project, the City Clinic, Drug Treatment Centre Board, and Merchants Quay Ireland); An Garda Síochána; Dublin City Business Improvement District; Dublin City Council; Dublin Simon Community; the North Inner City Local Drugs Task Force; the South Inner City Local Drugs Task Force and the Union for Improved Services, Communication and Education (UISCE).

The SRG commissioned a study to provide an evidence base to assist it in developing its response and recommendations (Van Hout and Bingham 2012a). A summary of the unpublished research is presented below (see also Section 12.3).

The research used a rapid assessment research (RAR) method to gather evidence of perceived anti-social behaviour associated with the provision of drug treatment in Dublin's city centre, as a basis on which to build a strategic response incorporating short/medium/long term goals and actions. The RAR method combined various research methods and data sources in order to cross-check and compare the information from several different sources, including the following:

- a critical review of the literature;
- PULSE data for the research area, analysed by the Garda Síochána;
- a mapping exercise, including an environmental visual assessment (using digital photographs) of the geographical distribution of drug and alcohol related public nuisance, in order to identify 'hotspots' for public nuisance, anti-social drug- and alcohol-using congregations, drug-related littering, alcohol retail outlets and the placement of drug treatment, housing, policing and community services in the area;
- interviews and focus groups with business and transport stakeholders (n=19), community, voluntary and statutory stakeholders (n=19), and service users (n=23); and
- random street intercept surveys with passers-by (n=25) and with drug users (n=26).

The research was exploratory and limited by the small sample size. However, despite the small number of participants, the validity and accuracy of the findings were optimised by the triangulation of the data sources.

A continuum of 'acceptable' versus 'not acceptable' forms of public behaviours was identified. A range of definitions of anti-social behaviour were recorded in the interview narratives, with anti-social behaviour deemed to be (typically) illegal, causing interference, visual and physical intimidation, and contributing to perceptions of lack of safety. It was seen as impacting negatively on businesses, services, customers, tourists and individuals accessing the area whether on foot, in private transport or on public transport. Particular anti-social activities mentioned included visible drinking and drug use, intoxication, aggressive and loud behaviour, youth and child drinking and drug dealing on the streets, phone snatching, graffiti, night-time alcohol abuse, harassment, street assaults, begging/'tapping' on the street and at Luas ticket machines, car break-ins, pick pocketing and other petty crimes. PULSE data reflected drug crime detections corresponding closely with business hours, peaking between 10am and 5pm.

The research area was divided into a number of quadrants for the purpose of data analysis. A clear distinction between specific quadrants is presented in terms of crime profile, with criminal activity corresponding with the predominant commercial activity in the area, be it retail or night-time entertainment. Quadrant 6 is significantly different to all other areas of the study, owing to the inclusion of Temple Bar, which has its own specific crime profile. Property crime is associated with the retail areas and public order offences are associated with the night-time entertainment areas.

Negative media portrayal of anti-social behaviour in the research area was also highlighted by the researchers. The urban design and poor lighting of certain streets was mentioned in the interviews and focus groups as contributing to feelings of fear and perceptions of lack of safety. Tourists and visitors to the research area, spoken to during 'walkabouts' in the area, had not observed any forms of anti-social behaviour, and reported feeling safe and happy with the Garda presence in the area. However, those working in the area had all observed anti-social behaviour, had felt intimidated, and reported feeling unsafe in the area both during the day and at night.

9.5 Prevention of drug-related crime

Drug-related crime and anti-social behaviour in Dublin
The SRG (described in Section 9.4 above), in seeking to address perceptions of drug-related crime and anti-social behaviour, acknowledged that for historical reasons there was a clustering of drug treatment and homelessness services in or adjacent to the inner city. While these services play a major role in the provision of effective treatment for problematic drug users, the report recommended that there should be greater, and prompt, access to provision of treatment options nationally and that people should be treated and accommodated in the most appropriate setting for their circumstances and provided with support services as close to their home as possible.

The report took a holistic approach to addressing the issues in the city centre. Recommendations were given under the headings of treatment, rehabilitation, homelessness, policing responses, planning and urban design, legislation and regulation and implementation, and are made for the short, medium and long term (see Section 12.3 for further information).

Social exclusion and crime
A position paper by the Irish Penal Reform Trust (IPRT) highlighted the causative connection between social exclusion, deprivation and crime (Irish Penal Reform Trust 2012). The paper argued that marginalised communities are more heavily policed and that people from such communities receive more severe punishment than those from more affluent communities. It also argued that on-going cuts to community-based services will exacerbate crime rates. Speaking at the launch of the paper, Liam Herrick, executive director of the IPRT, stated:

> Austerity measures which see cuts to health, education and other key services impact disproportionately on marginalized communities… increasing levels of social exclusion which will have a negative impact on crime (Irish Penal Reform Trust 2012, 2 February).

Other speakers at the launch, organised jointly by the IPRT and Community Platform (www.communityplatform.ie), included John Lonergan, former governor of Mountjoy Prison and a patron of the IPRT, Kathleen Lynch, professor of equality studies at University College Dublin, Tony Geoghegan, chief executive of Merchants Quay Ireland, Orla O'Connor, head of policy at the National Women's Council of Ireland, and Brid O'Brien of the Irish National Organisation of the Unemployed.

The paper explored the social profile of prisoners and the 'specific ways in which the criminal law is unduly focused on marginalised groups' ({Irish Penal Reform Trust, 2012`, 2 February #2028p.9). The IPRT called for the cessation of the practice of imprisonment for non-payment of fines, citing research which found that 'fine defaulters had an 85% likelihood of returning to prison after release' (p.9). The paper was also critical of the Criminal Justice (Public Order) Act 2011, which prohibits some forms of begging, describing it as 'a regressive legislative measure, which unduly penalises the most vulnerable members of society' (p.11). The paper highlighted the links between substance misuse and crime and was critical of the recent budgetary cuts for projects in drugs task force areas (p.17). With regard to the reintegration of offenders upon release from prison, the paper called for adequate resources to be applied to Integrated Sentence Management so that prisoners are adequately prepared for their release, 'receiving assistance with accommodation, mental health and/or addiction supports' (p.18).

The IPRT also highlighted how offenders from different socio-economic backgrounds are treated disproportionately by the Irish criminal justice system. According to Herrick, 'That we continue to imprison thousands of people every year for not paying fines, while those involved in "white collar" crime remain largely unpunished, further underscores Ireland's disproportionate punishment of some sections of society.' {Irish Penal Reform Trust, 2012`, 2 February #2028}

The paper forms part of the IPRT's Shifting Focus campaign (www.iprt.ie/shifting-focus), which uses evidence and research to support its call for a movement away from traditional criminal justice responses to issues of social exclusion and associated crime and to demonstrate to policy makers that such a shift, '– with emphasis on prevention and early intervention – makes social and economic sense'. (Irish Penal Reform Trust 2012, 2 February)

Dial-to-stop drug dealing

In response to a parliamentary question, the Minister of State at the Department of Health with special responsibility for the National Drugs Strategy, Roisín Shortall TD, stated with regard to the dial-to-stop drug dealing campaign (see (Irish Focal Point (Reitox) 2010), Section 9.4.2, for an overview of this campaign):

> Following a review of the Dial to Stop Drug Dealing Campaign, it has been decided to put in place a more cost efficient approach to promoting the campaign in partnership with CRIMESTOPPERS from 2012 onwards. The Department is currently in discussions with CRIMESTOPPERS regarding the arrangements for the promotion of the initiative this year in Drugs Task Force areas and other areas where there is a high concentration of drug activity. In the meantime, Drugs Task Forces have been advised that any one wishing to pass on information on drug dealing should call the CRIMESTOPPERS freephone confidential number 1800 25 00 25 (Shortall, Róisín 2012, 24 January).

The Irish Crimestoppers Trust was set up in 1998 by the Dublin Chamber of Commerce and the Garda Síochána to provide a confidential means for citizens to report crime.The current sponsors of Irish Crimestoppers Trust include the Department of Justice, Equality and Defence, Dublin Chamber of Commerce, Iarnrod Éireann (National Rail), An Post, Ulster Bank, Ladbrokes and Penneys. For further information see www.crimestoppers.ie

Lord Mayor's commission on anti-social behaviour
A commission on anti-social behaviour, established by the former Lord Mayor of Dublin, Councillor Andrew Montague, issued its final report in June 2012 (Lord Mayor's Commission on Antisocial Behaviour 2012). Representatives on the commission included elected councillors, representatives of Dublin City Council, the Garda Síochána, the Irish Prison Service, the Probation Service, the Health Service Executive, the Irish Youth Justice Service within the Department of Justice, Equality and Defence, a representative of the Northside partnership, Ballymun Local Drugs Task Force, the Ana Liffey Drug Project, Dublin City Business Improvement District, and an academic from the Department of Social Work and Policy in Trinity College Dublin. The Commission met nine times between October 2011 and May 2012 and also organised a conference, attended by over 300 people, on the theme of preventing and responding to anti-social behaviour. The report and recommendations of the commission were presented across a range of themes, including early intervention and prevention, education, discrimination and prejudice, management of offenders and alternatives to prison, alcohol and other drugs, city centre issues and urban design.

Specific relevant recommendations in relation to drugs included the following:

Prevention and education
- Deliver a national awareness campaign on the dangers of using alcohol, cannabis and other drugs during pregnancy and ensure that clear drug and alcohol policies are developed and implemented in each school.

Drug-related crime and intimidation
- Assist the rollout of locally based systems of support which address issues related to family intimidation and drug debt in areas with concentrated drug problems and which build on the north-east inner city pilot project.
- Expedite plans to identify key Garda personnel at district and divisional level who would be designated officers for families and individuals requiring support as a result of intimidation.
- Establish local and national intelligence systems to gather information on drug debt and liaise directly with the Criminal Assets Bureau.
- Develop system of notification between Gardaí and HSE Children's Services for the early identification of children who become involved in criminal (often drug dealing related) activity.
- Identify effective systems of family intervention and supports in this regard.
- Empower the Gardaí to prosecute in cases where offenders are found to be trading prescription drugs.

9.6 Interventions in the criminal justice system

Alternatives to prison
The report of the Lord Mayor's commission on anti-social behaviour, described in Section 9.5, also called for a greater use of alternatives to prison (Lord Mayor's Commission on Antisocial Behaviour 2012). Included among its recommendations were the following:
- promote a greater focus on early interventions with young offenders to prevent offending and greater support during and after detention as well as on community-based sanctions (e.g. probation and community service as the 'default' rather than custodial sentences);

- research the effectiveness of restorative justice and other alternatives to prison and present findings to our judges and criminal justice system; and
- increase the capacity of the criminal justice system to respond to offenders with mental health and or addiction issues by increasing access to secure treatment centres and community-based supports.

In late July 2011, the Courts Service and the HSE agreed to extend the catchment area of the Drug Treatment Court (DTC) to all areas of Dublin County, north of the River Liffey, and also to make it accessible to those receiving treatment in the Castle Street drug treatment centre, which provides services to people in Dublin 2, 4, 6 and 8 (Irish Focal Point (Reitox) 2011)) (Section 9.4.1). The extension of the catchment area was to be piloted for a period of six months, after which the capacity of the court to manage a further extension was to be considered (Tom Ward, chief clerk of the Dublin Metropolitan District Court, personal communication, June 2011). A review of the operation of the DTC is currently being conducted by the Drug Court Advisory Committee, which is due to submit its report to the Department of Justice, Equality and Defence in late 2012 (Tom Ward, chief clerk of the Dublin Metropolitan District Court, personal communication, June 2012).This report will inform future government policy in relation to the court.

9.6.1 Other interventions in the criminal justice system

For most recent information, see National Report 2011 (Irish Focal Point (Reitox) 2011) (Section 9.4.2).

9.7 Drug use and problem drug use in prisons

In a report published in 2012, the Jesuit Centre for Faith and Justice (JCFJ) called on the government to radically reform its approach to imprisonment. The report provided a detailed analysis of existing research on a range of topics, including the links between imprisonment and socio-economic deprivation – owing to poor education, unemployment, homelessness, and the incidence of mental illness and substance misuse among prisoners (Jesuit Centre for Faith and Justice 2012). Citing an earlier study (Hannon*, et al.* 2000), the report stated that '51% of male prisoners and 69% of female prisoners reported that they had been under the influence of drugs when they committed the offence for which they had been imprisoned' (p.22). The report also highlighted tensions and the potential for 'extreme violence' within prisons as a consequence of drug debts and 'territorial disputes within and between groups involved in the sale and distribution of drugs' (p.22).

Launching the report, John Lonergan, who was governor of Mountjoy Prison for 22 years, said that the issue of drugs in prison represented a huge policy failure: 'Drugs have an enormously damaging impact on life within prisons and can undermine even the most positive programmes and enlightened regimes.' (Jesuit Centre for Faith and Justice 2012, 14 March) Acknowledging that prison authorities had a duty to try and keep drugs out of prison, Lonergan said 'the reality that the costly and intrusive measures needed to control the entry of drugs will be ultimately of very limited effect if the demand for drugs persists.' He added that it was essential that there be an equal emphasis on providing drug treatment and that such treatment 'needs to be accompanied by the opportunities for meaningful activity – education, training and work – and decent physical conditions, otherwise it is extremely difficult for prisoners to remain drug free'.

The report argued that, with more than a doubling of the prison population over the past decade, overcrowding is now one of the most serious issues in the Irish prison system, that it leads to a 'pressure cooker' atmosphere within prisons, and 'impacts profoundly on the whole experience of imprisonment', leading as it does to the enforced sharing of cells by 'drug-user and non-drug-user, smoker and non-smoker'

(Jesuit Centre for Faith and Justice 2012) (pp.26–27).The JCFJ called for a closing of the gap between what it sees as the reality of Irish prisons and the espoused principles of Irish prison policy, as implied in the ratification of international human rights conventions and as expressed in official policy statements. Citing international prison conventions and research evidence in support, the report called for the prompt introduction of a 'comprehensive drug and alcohol detoxification and treatment' service (p. 121).

The Inspector of Prisons, Judge Michael Reilly, published a report on Limerick Prison in November 2011(Inspector of Prisons 2011). The report noted that 'most prisoners have addiction problems' (p. 27). In relation to the availability of drugs in the prison, the report stated:

> … all yards are covered by nets, a dedicated search procedure (with appropriate protocols) operates for all persons entering the prison, a dedicated drug dog is on duty, mandatory drug testing of prisoners is the norm and random targeted searches are carried out. The Operational Support Group (OSG) is the dedicated unit responsible for such initiatives. These measures have had the combined effect of reducing the amount of drugs and contraband entering the prison. (p. 26)

The Inspector's report was, however, highly critical of overcrowding and the presence of 'gangs' in the prison. It also reiterated the need to establish a drug-free unit in the prison, stating that 'there are a number of prisoners, not only in Limerick prison but in all prisons in the Irish prison system, who wish to either remain drug free or try to become drug free' and that Limerick, 'in common with all closed prisons, should have a drug free support unit' (p. 38). In a follow-up report (Reilly, Judge Michael 2012b), published in March 2012, the Inspector commented further in relation to a drug-free unit: 'Because of the present overcrowding in Limerick Prison it has not been possible to identify a section of the prison that could be dedicated as a drug free support unit.' (p. 8)

A prison visiting committee is appointed for each prison under the Prisons (Visiting Committees) Act 1925 and Prisons (Visiting Committees) Order 1925. These committees report to the Minister for Justice, Equality and Defence on an annual basis. In relation to drug issues, the Wheatfield prison visiting committee in its 2011 annual report stated that: 'One of the most difficult problems for prisoners was in relation to family visits. Since the introduction of dogs to curb the introduction of drugs into the prison many visitors have failed to pass the dog test and therefore are only allowed screen visits. Many prisoners are unhappy with screen visits but we have to advise them that it is in the best interest of all prisoners that drugs are kept out of the prison.' (Wheatfield Prison Visiting Committee 2012) (p. 4).

The Mountjoy prison visiting committee in its annual report for 2011 also referred to the drug problems in the prison, including the issue of people becoming addicted in the prison:

> We are particularly concerned at the increased level of tablet availability, and the difficulty in detecting these. Also the problem of interaction between drug users and non-drug users must be addressed in 2012. The incidences of prisoners becoming addicted in Mountjoy must be dealt with in a decisive manner. A drug free environment has got to be seriously worked on. The Visiting Committee is of the view that increased measures must be put in place to eliminate the passing of tablets etc. which cannot be detected by dogs. The introduction of nets over the yards has strengthened the controls on drug supplies, but desperation leads to some amazing inventions, as has been witnessed in Mountjoy over the years. So there is no room for complacency or relaxation in pursuing new ways of dealing with the issue of supply. A programme of dealing with addiction should be set up, so as to allow for far

> greater availability of treatment for drug users encouraged or wishing to come off drugs. It is astounding that prisoners locked up for 23 hours per day can still avail of a constant supply of drugs/tablets. (Mountjoy Prison Visiting Committee 2012) (p.18)

With regard to the provision of treatment in the prison, the committee called for a review of the drug treatment programme in the medical unit:

> The Medical Unit provides a primary pro-active care service, with a focus on preventive medicine. The facility provides for integrated programme for prisoners committed to becoming drug-free with a view to preparing for eventual release from prison. Prisoners wanting to participate in this programme are subject to specific qualifying considerations. We believe the programme should be widened to include all prisoners wishing to participate, who qualify. This whole area needs revision, as maybe it is time to look at the possibility of including all prisoners affected by drug addiction, in drug programmes. (p. 17)

The Cloverhill Prison Visiting Committee also referred to the need to establish a drug-free unit in the prison:

> In our 2008 report we first suggested and strongly recommended exploring the possibility of establishing a Drug Free unit within this prison and again we strongly suggest exploring the possibly of doing a feasibility study. We are disappointed to note that there have been no developments in this area but accept that this may be difficult on a Practical level in a predominately remand setting. (Cloverhill Prison Visiting Committee 2012) (p. 22)

9.8 Responses to drug-related health issues in prisons (and other custodial settings)

In his annual report for 2011(Reilly, Judge Michael 2012a), the Inspector of Prisons, Judge Michael Reilly, stated that drugs in prison and drug-free areas were among the issues that he intended to address in a report to be published following the publication of the Irish Prison Service (IPS) Three-Year Strategic Plan 2012–2015 (Irish Prison Service 2012), which is described below.

9.8.1 Drug treatment

The IPS Three-Year Strategic Plan 2012–2015 commits the prisons to ensuring ‘an increase in the number of prisoners receiving prison based treatment and programmes designed to aid rehabilitation and reintegration’ (Irish Prison Service 2012) (p. 30).The IPS also plans to review the IPS’s clinical drug policy so as to bring policy into line with changes in community practice. The introduction of drug-free units in all closed prisons and the provision of ‘equivalence healthcare to all prisoners in custody’ are two actions within the plan.

9.8.2 Prevention and reduction of drug-related harm

For most recent information see National Report 2011 (Irish Focal Point (Reitox) 2011) Section 11.

9.8.3 Prevention, treatment and care of infectious diseases

For most recent information see National Report 2011 (Irish Focal Point (Reitox) 2011) Section 11.

9.8.4 Prevention of overdose-risk upon prison release

The IPS Strategic Plan 2012–2015 states that it will ensure the ‘seamless transition of prisoners, established on drug treatment, from our care into community drug treatment settings’ (Irish Prison Service 2012) (p. 32).

9.9 Reintegration of drug users after release from prison

The IPS Strategic Plan 2012–2015 states that the IPS 'will strengthen family supports to facilitate on-going contact with prisoners while in custody and their reintegration post release, with appropriate supports and programmes' (Irish Prison Service 2012) (p. 32).

10. Drug Markets

10.1 Introduction

The first comprehensive study of illicit drug markets in Ireland is due to be published by the National Advisory Committee on Drugs (NACD) and the Health Research Board (HRB) in late 2012. A detailed summary of the relevant findings from this study was presented in Ireland's National Report for 2011 (Irish Focal Point (Reitox) 2011) (Section 10). Data from several other information sources, which give indications of the nature and size of the market, are presented in this chapter.

Prevalence surveys may ask respondents about their access to illicit drugs and about the availability of various drugs. For example, the all-Ireland general population drug prevalence survey, described in detail in Section 2.1 of this report, asks respondents how they obtained individual substances (who from and under what circumstances), where did they obtain them (in what type of location) and how easy were they to obtain. The European School Survey Project on Alcohol and Other Drugs (ESPAD), also described in detail in Section 2.1 above, contains a question, the answer to which indicates the perceived availability of some illicit substances – 'How difficult do you think it would be for you to get each of the following (cannabis, amphetamine, ecstasy)?'.The above studies are not reported in every National Report.

Data on drug seizures by Customs Drug Law Enforcement (CDLE) and the Garda Síochána provide insights into the origins of drugs being brought into Ireland, and the nature of the market in terms of supply and availability. However, these data must be treated with caution as the number of drug seizures in any given period can be affected by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of traffickers to law enforcement activities.

Drug offence data published by the Central Statistics Office (CSO) can assist in understanding aspects of the operation of the illicit drug market in Ireland. With regard to the so-called middle market level, which involves the importation and internal distribution of drugs, data on drug supply offence prosecutions by Garda division are a possible indicator of national drug distribution patterns. While these data primarily reflect law enforcement activities and the relative ease of detection of different drugs, they may also provide an indicator of national drug distribution trends. These data can be compared with other sources such as drug treatment data, for example, to show trends in market developments throughout the State. Such data can also indicate trafficking patterns by showing whether there is a concentration of prosecutions along specific routes.

For policing purposes Ireland is divided into six regions, each of which is commanded by an Assistant Commissioner. The six regions are:

- Dublin Metropolitan Region
- Northern Region
- Western Region
- Eastern Region
- Southern Region
- South Eastern Region

Each region is divided into divisions commanded by a Chief Superintendent, and each division is then divided into districts commanded by a Superintendent, who is assisted by a number of Inspectors. The districts are divided into sub-districts, each normally the responsibility of a Sergeant.

Map 10.1.1 Irish Garda regions and divisions

The Forensic Science Laboratory (FSL) provides impartial scientific evidence following examination of crime scenes, including seizures of drugs. However, not all drugs seized by the law enforcement agencies (the Garda Síochána or Customs Drug Law Enforcement) are necessarily analysed and reported on by the FSL. For example, if no individual is identified in relation to the drug seizure, and no prosecution takes place, the drugs may not be sent for analysis and may be destroyed. Moreover, drug purity data are not collated in a systematic way at different market levels in Ireland. The primary function of the FSL in this area relates to supporting the criminal justice system, and not to research. Only a very small proportion of drugs seized are tested to ascertain the percentage purity.

10.2 Availability and supply

10.2.1 Perceived availability of drugs, exposure, access to drugs e.g. in general population, specific groups/places/settings, problem drug users

Recent research on the Dublin city centre drug market is described in Section 12.3.

A report by the North Dublin Inner City Local Drugs Task Force (NICDTF) provides a summary of the results of the first online survey on drugs misuse, trends and behaviours, undertaken by the NICDTF in April 2012 (North Inner City Drugs Task Force 2012). Invitations to participate were sent to 87 individuals in organisations linked to the three NICDTF sub-groups – Treatment and Rehabilitation, Prevention and Education, and Supply Control. The invitation was issued on 2 April 2012 and the survey closed on 16 April 2012. Nineteen separate organisations based in the NICDTF area completed and returned the survey. Thirteen of these organisations worked primarily with adults, five mainly with youth (aged 12 to 23) and their families, and one with children (under 12 years) and their families. The survey was designed to be quick and easy to complete, using mainly multiple-choice and rating scale questions, and with minimal text input required.

Key findings included the following:

- While use of heroin/opiates was highlighted, other illegal and legal substances including high-strength cannabis (weed), crack/cocaine, tablets and alcohol were causing huge concern with individuals/groups seeking support from projects supported by the NICDTF.
- A distinction needs to be made between hash and high-strength cannabis through awareness-raising.
- There is a need to distinguish between the type of 'street tablets' being used: 'Benzo' is a common term that is applied widely as a 'catch all' phrase. However, though there is also a considerable amount of Zopiclone/Zimovane (brands of hypnotic) in local use.
- Projects described polydrug use as a major issue of concern.

10.2.2 Drugs origin: national production versus imported

A study by the EMCDDA about cannabis production and markets in Europe has pointed to Ireland as an important access route for cannabis resin from Morocco, the main production country, into the United Kingdom and the European continent (European Monitoring Centre for Drugs and Drug Addiction 2012)

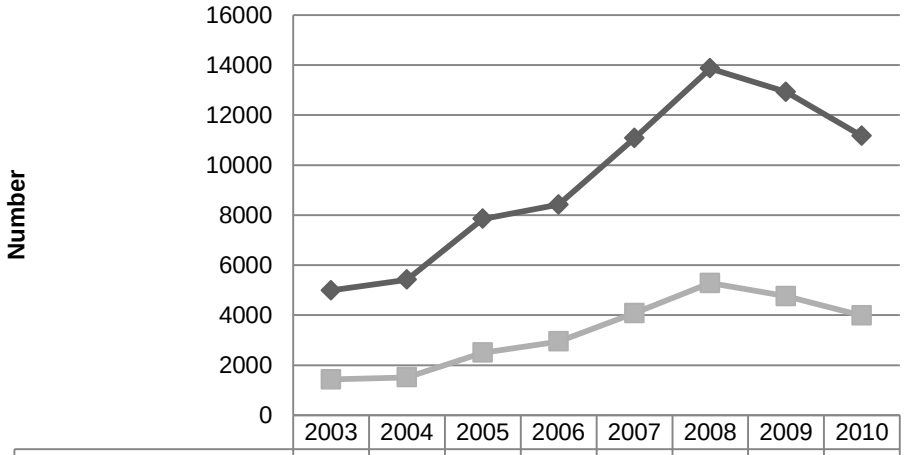
This study brings together available evidence to provide a comprehensive analysis of cannabis production and markets across the EU. It combines information from EMCDDA routine reporting — data on patterns of prevalence and use, seizures, police reports, drug-law offences, cannabis potency and retail market prices — with literature on cannabis markets to create an in-depth analysis of the issue in a European context.

With reference to Ireland, the report states:

> The largest average seizures of cannabis resin tend to be found in countries that are relatively close to producing areas, or are major entry points to Europe. For resin originating in Morocco, the Iberian Peninsula has historically been used as a point of entry into Europe; Italy lies just across the Mediterranean Sea; and Ireland is an entry point for resin destined for the Irish or United Kingdom markets. …Seizure sizes, on average over a kilogram, point to Portugal and Ireland as other entry points for Moroccan resin into Europe. In these two countries, resin imports appear to supply both the national and other markets, with the two territories being used as transit areas.'(p. 208)

10.2.3 Trafficking patterns, national and international flows, routes, modi operandi; and organisation of domestic drug markets

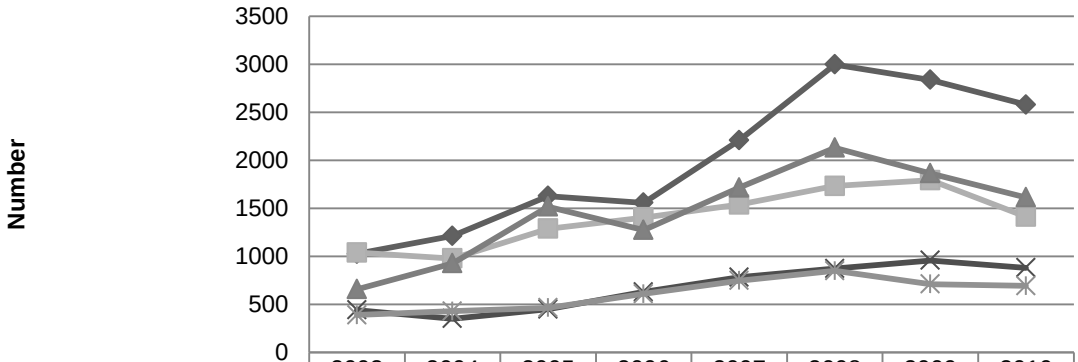
From 2004 to 2008 there was an upward trend in relevant legal proceedings for possession (including for personal use and supply), and then the trend declined in 2009 and 2010 (Figures 10.2.3.1 and 10.2.3.2). The majority of such proceedings were in the Dublin metropolitan region (DMR). The number of such offences in the DMR increased steadily from 1,433 in 2003 to 5,279 in 2008. The number then decreased to 3,986 in 2010, just below the level reported for 2007.



	2003	2004	2005	2006	2007	2008	2009	2010
Ireland (total)	4986	5413	7846	8418	11072	13860	12920	11164
Dublin Metropolitan Region	1433	1515	2500	2944	4081	5279	4759	3986

Figure 10.2.3.1 Trends in relevant legal proceedings for possession of drugs for personal use and for sale or supply, nationally and in the Dublin Metropolitan Region (DMR), 2003–2010.
Source: Central Statistics Office 2012, unpublished data

Figure 10.2.3.2 shows that the proportion of the total number of supply offences outside the DMR has increased in most regions since 2003. In 2009 and 2010 relevant legal proceedings for drug possession (for personal use and supply) decreased in all regions, with the exception of the Northern region where there was a slight increase in 2009 on the previous year, followed by a decrease in 2010.



	2003	2004	2005	2006	2007	2008	2009	2010
Southern region	1026	1213	1628	1558	2208	2997	2836	2578
South eastern region	1039	977	1287	1404	1539	1733	1792	1413
Eastern region	657	928	1517	1274	1715	2130	1864	1614
Northern region	442	351	449	629	782	872	958	881
Western region	389	429	465	609	747	849	711	692

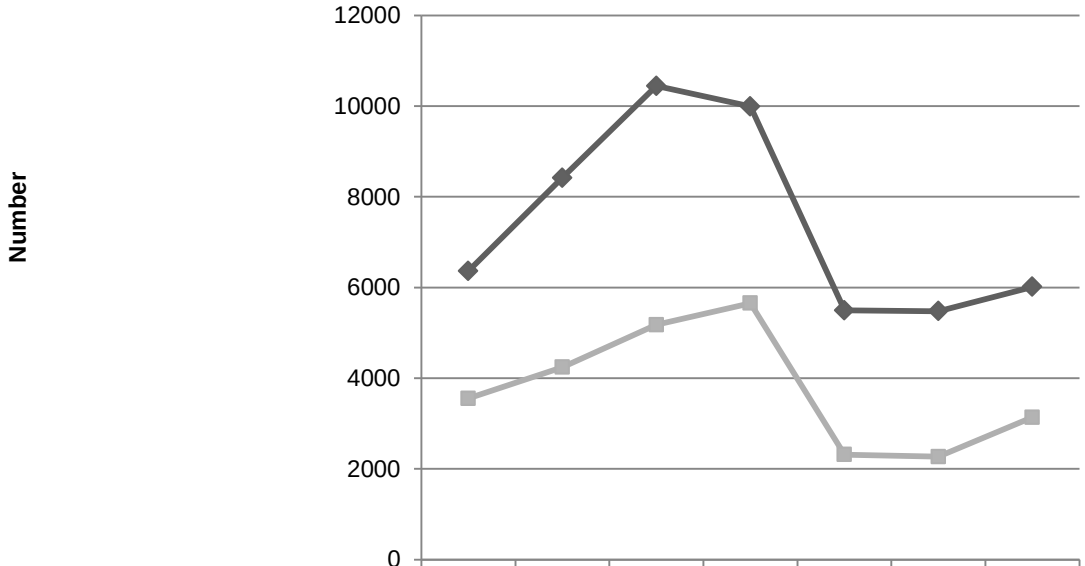
Figure 10.2.3.2 Trends in relevant legal proceedings for possession of drugs for personal use and for sale or supply, by region, excluding the DMR, 2003–2010
Source: Central Statistics Office 2012, unpublished data

10.3 Seizures

10.3.1 Quantities and numbers of seizures of all illicit drugs

Cannabis
The number of drug seizures in any given period can be affected by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of traffickers to law enforcement activities. However, drug seizures are considered indirect indicators of the supply and availability of drugs. (See Standard Table 13.)

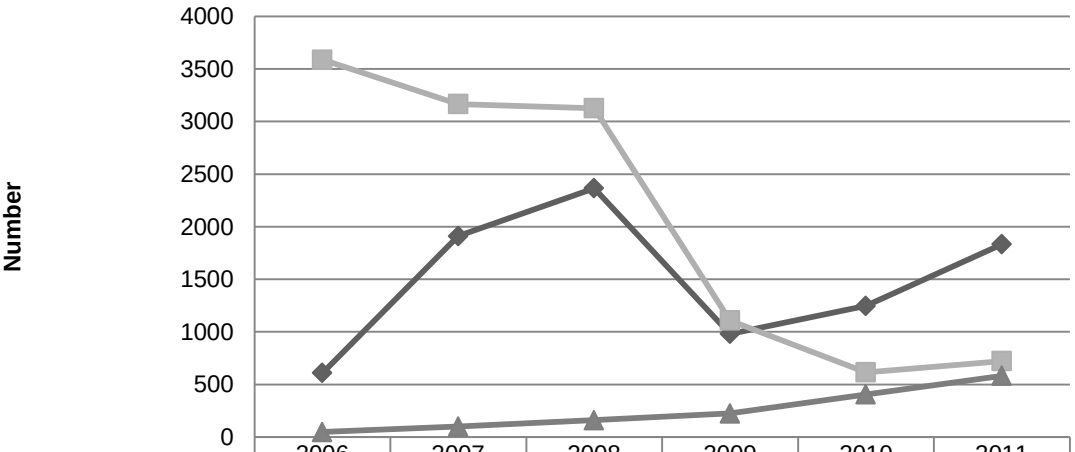
Cannabis seizures account for the largest proportion of all drugs seized. Figure 10.3.1.1 shows trends in cannabis-related seizures and total seizures between 2005 and 2011. The total number of drug seizures increased from 6,362 seizures in 2005 to a peak of 10,444 seizures in 2007. Between 2007 and 2010, the number almost halved, to 5,477. This decrease can be explained primarily by the significant decrease in cannabis-type substances seized. Although, as explained in section 10.1 above, not all drugs seized by law enforcement are necessarily analysed and reported by the FSL, it is difficult to know if the reduction in cannabis-related seizures reflects a decline in cannabis use or a reduction in law enforcement activity.



	2005	2006	2007	2008	2009	2010	2011
All seizures	6362	8417	10444	9991	5494	5477	6014
Cannabis-type substances	3555	4243	5176	5652	2314	2268	3137

Figure 10.3.1.1 Trends in the total number of drug seizures and cannabis seizures, 2005–2011
Sources: Central Statistics Office 2008, 2009, 2010, 2011, 2012, unpublished data

The decrease in cannabis seizures may also be partly explained by a change in the nature of cannabis use, with people moving from resin to more potent forms of cannabis. For example, Figure 10.3.1.2 shows that although seizures of cannabis resin decreased between 2009 and 2011, seizures of cannabis plants have increased steadily since 2006, and herbal cannabis seizures almost doubled between 2009 and 2011, from 981 in 2009 to 1,833 in 2011 (see Section 9.3 in relation to the increase in cultivation offences).



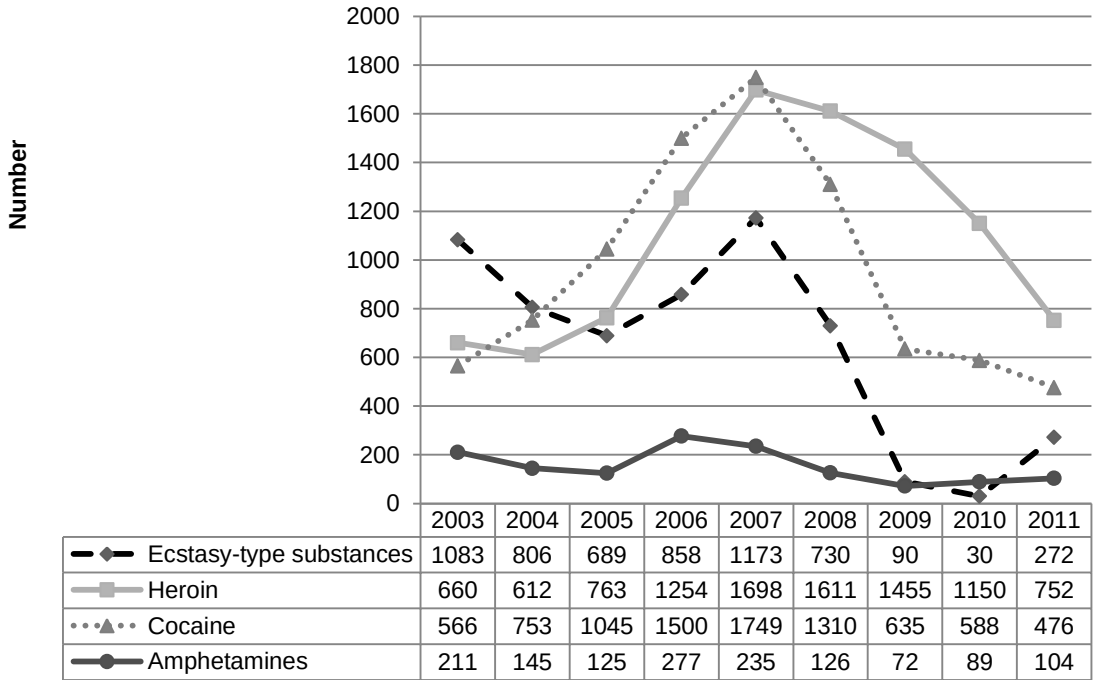
	2006	2007	2008	2009	2010	2011
Cannabis	609	1910	2366	981	1247	1833
Cannabis resin	3587	3166	3126	1109	616	722
Cannabis plants	47	100	160	224	405	582

Figure 10.3.1.2 Trends in the total number of drug seizures by cannabis type, 2006–2011

Sources: Central Statistics Office 2008, 2009, 2010, 2011, 2012, unpublished data

Other controlled drugs

The reduction in the total number of reported seizures since 2007 shown in Figure 10.3.1.1 may also be explained by a reduction in the number of seizures of other drugs since 2007. Figure 10.3.1.3 shows trends in seizures for a selection of drugs, excluding cannabis, between 2003 and 2011. There has been a significant decline in seizures of cocaine and heroin since 2007. Ecstasy-type substances also decreased significantly between 2007 and 2010. However, in 2011, seizures of ecstasy-type substances increased by more than 900% over the previous year.



	2003	2004	2005	2006	2007	2008	2009	2010	2011
Ecstasy-type substances	1083	806	689	858	1173	730	90	30	272
Heroin	660	612	763	1254	1698	1611	1455	1150	752
Cocaine	566	753	1045	1500	1749	1310	635	588	476
Amphetamines	211	145	125	277	235	126	72	89	104

Figure 10.3.1.3 Trends in the number of seizures of selected drugs, excluding cannabis, 2003–2011
Source: Central Statistics Office 2012, unpublished data

In a reply to a parliamentary question, the Minister for Finance, Michael Noonan TD, provided data on trends in the illegal drugs seized by Customs Drug Law Enforcement (CDLE) (Noonan 2012, 6 June). These data are presented in Table 10.3.1.1.

Table 10.3.1.1 Illegal drugs seized by Customs Drug Law Enforcement, 2011

Type of Drug	Quantity (Kg)	Value (€)
Herbal cannabis	449.5	5,394,013
Cannabis resin	935.4	5,612,347
Ecstasy	50,722 tablets	254,382
Heroin	1.7	255,900
Cocaine	138.5	9,697,242
Khat	177.1	354,200
LSD	0.04	600

Source: (Noonan 2012, 6 June)

Table 10.3.1.2 shows the particulars of all drugs seized in 2011 that were reported on by the FSL. As noted in Section 10.1 above, not all drugs seized by law enforcement agencies (the Garda Síochána and Customs Drug Law Enforcement) are necessarily analysed and reported by the FSL.

Table 10.3.1.2 Particulars of drugs seized in 2011 and analysed by the Forensic Science Laboratory

Drug	Quantity	No of Cases
Alprazolam	32,246 tablets	121
Amphetamine	23,077.421 grams	104
BK-MBDB	80.278 grams	1
Buprenorphine	40 tablets	3
BZP	17,625 tablets, 9,942.104 grams, 5 capsules	114

Drug	Quantity	No of Cases
Cannabis	1,865,607.334 grams	1833
Cannabis resin	1,814,348.979 grams	722
Cannabis plants*	6,606 plants	582
Clonazepam	1,731 tablets	16
Cocaine	179,752.345 grams	476
Diamorphine (Heroin)	32,408.528 grams	752
Diazepam	210,250 tablets, 206.078 gram	479
Dihydrocodeine	109 tablets	10
Ephedrine	27,291 tablets	26
Ecstasy MDMA	97,882 tablets, 33 capsules	272
Flephedrone	884.667 grams	3
Flunitrazepam (Rohypnol)	9 tablets	3
Fluoxetine**	10 capsules	2
Flurazepam	3,193 capsules, 27 tablets	46
Ketamine	90.222 grams	18
Lignocaine**	17,534.968 grams	37
Lorazapam	3 tablets	2
LSD	1,946 squares, 97,882 tablets	19
Methandienone**	1,584 tablets	18
Methadone	4,401.500 mls 94 tablets	36
Methylamphetamine	3708.975 grams	41
Oxymetholone**	834 tablets	13
Sildenifil**	1,299 tablets	17
Stanozolol**	70 tablets	3
Temazepam	41 tablets	5
Triazolam	226 tablets	13
TFMPP	18,224 tablets	58
Zolpidem	358 tablets	14
Zopiclone**	36,591 tablets	155

Source: (Central Statistics Office, unpublished data, 2012) The list above is a record of main categories of drugs delivered to the FSL and reported on for 2011. There may be some large cannabis/cannabis resin cases without a suspect, in relation to which no analysis was conducted and no weight was determined.
*****The number of cannabis plants does not reflect the total number detected as only a sample of the plants is sent for analysis for practical reasons.
******These drugs are not controlled under the Misuse of Drugs Acts, 1977 & 1984.

Prescription drugs

The street sale of prescription drugs has been highlighted in a recent report ((Lord Mayor's Commission on Antisocial Behaviour 2012)). In reply to a parliamentary question on the issue, the Minister for Justice, Equality and Defence, Alan Shatter TD, provided data on the type, quantity and value of prescription drugs seized by the Garda Síochána during the arrest of persons engaged in the illegal sale of prescription drugs for the first four months of 2012 (Shatter 2012, 6 June). This is presented in Table 10.3.1.3.

Table 10.3.1.3 Type, quantity and value of prescription drugs seized by the Garda Síochána, January – April 2012*

Drug	Volume in Grams	Tablets/Capsules	Value
Alprazolam	-	1,388	€2,776
Bromazepam	-	1	€1
Clonazepam	-	627	€627
Diazepam	263	95,831	€101,091
Flunitrazepam	-	1,667	€3,334
Fluoxetine	-	1	€1
Flurazepam	-	134	€268
Lormetazepam	-	10	€20
Morphine	-	40	€40
Oxycodone	-	1	€1
Phenacetin	2,737	0	€2,737
Temazepam	-	4	€4
Triazolam	-	143	€143
Amylobarbitone	-	35	€35
Tramadol	-	10	€10

Drug	Volume in Grams	Tablets/Capsules	Value
Sildenafil	-	59	€59
Zolpidem	-	151	€302
Zopiclone	-	3,124	€6,248

Source: (Shatter 2012, 6 June)
*This table was prepared from information provided by the FSL and is based on prescription drugs analysed at the FSL valid up to 15 May 2012.

Section 17 of the Irish Medicines Board (Miscellaneous Provisions) Act 2006 appointed officers of Customs as enforcement officers for the purpose of the Irish Medicines Board Act 1995. Revenue's Customs service works closely with the Irish Medicines Board in enforcing the law relating to medicinal products, drug precursors, medical devices and other healthcare products. In response to a parliamentary question, the Minister for Finance, Michael Noonan TD, provided data on trends in the seizures by Customs of prescription drugs (Noonan 2012, 6 June). These data are presented in Table 10.3.1.4. The principal types of prescription drugs seized from 2005 to the middle of 2012 have been sedatives such as benzodiazepines, sleeping tablets, erectile dysfunction medicines, steroids and slimming tablets.

Table 10.3.1.4 Prescription drugs seized by Customs Drug Law Enforcement, 2005–June 2012

Year	Number of Tablets	Estimated value €
2005	14,902	147,924
2006	1,160	16,205
2007	207,178	1,534,615
2008	556,956	1,665,191
2009	935,181	2,384,530
2010	1,652,124	2,752,219
2011	1,285,340	2,211,079
June 2012	360.527	686,383

Source: (Noonan 2012, 6 June)

10.3.2 Quantities and numbers of seizures of precursor chemicals used in the manufacture of illicit drugs

See National Report 2010 for most recent information (Irish Focal Point (Reitox) 2010)

10.3.3 Number of illicit laboratories and other production sites dismantled; and precise type of illicit drugs manufactured there

No new information but see section 9.3 with regard to the seizure of laboratory's for cannabis cultivation.

10.4 Price/purity

See National report 2011 for most recent information (Irish Focal Point (Reitox) 2011)

10.4.1 Price of illicit drugs at retail level

See National report submitted to EMCDDA October 2011 data remains unpublished.

10.4.2 Purity/potency of illicit drugs

See National report submitted to EMCDDA October 2011 data remains unpublished.

10.4.3 Composition of illicit drugs and drug tablets

This data has never been reported in Ireland.

Part B: Selected Issues

Summary of selected issues

11. Residential treatment for drug users in Europe

Residential treatment services for drug users have been provided in Ireland since the 1960s, partly by the public sector and partly by the voluntary and community sectors. Provision declined in the 1980s and 1990s owing to competing demands from other drug treatment modalities. However, in the last decade the need for a range of responses and alternative drug-free approaches has seen residential treatment services come to the fore again, especially within the context of the 4-tier treatment model and integrated care packages, which have been adopted as official policy since 2009.

There is very limited information on the types and characteristics of residential drug treatment services in Ireland. In 2007 it was estimated that there were 634.5 beds for residential treatment (both drugs and alcohol) and a need for a further 252.2 beds. Subsequent national drug treatment data indicate an increase in the number of cases entering residential treatment but whether this reflects a true increase, or is due to some other intervening variable, is not clear. Detoxification and rehabilitation are intrinsically linked in Ireland as many centres require a person to be drug-free before entry, so it is difficult to distinguish residential detoxification from residential treatment.

The economic climate is adversely affecting the provision of all drug treatment services, including residential services; for example, the only residential mother and baby service in the state closed in September 2012 owing to lack of funding. New initiatives such as community detoxification have proved a successful alternative for those who require detoxification but for whom a stay in an inpatient facility is not the best option.

12. Drug Policies of large European cities

In this selected issue we have sought to address the specific questions raised by the EMCDDA. Dublin, Ireland's capital city does not have its own specific drug policy. Drug policy in the city is considered within the context of the NDS. Much of the information and data gathered by agencies such as the Health Research Board (HRB) or the National Advisory Committee on Drugs (NACD) that is regularly reported by the National Focal Point is not specific to Dublin. However, where possible, we have highlighted recent studies that focus on drug-related problems in the city. Along with these research studies and reports, other sources used include government websites, policy documents and parliamentary debates. We have also consulted with the Drug Policy Unit in the Department of Health.

11. Residential treatment for drug users in Europe

11.1 History and policy frameworks

11.1.1 History of residential treatment

In 1969 the Department of Health set up Ireland's first drug treatment services. They comprised an out-patient clinic for drug problem drug users, based in a general medical hospital in Dublin's city centre (Jervis Street Hospital), where emergency medical care and laboratory testing facilities were available, and an in-patient unit for treatment and rehabilitation, for both illicit drugs users and people who were alcohol dependent, located in a psychiatric hospital in Dublin (St Brendan's Hospital), where residential psychiatric nursing and other ancillary facilities were available. This system followed that being introduced in Britain around the same time, which emphasised the value of centralised and specialist services, with a minimal role for primary health care or localised service provision. The rationale behind setting up the residential unit in the psychiatric hospital was explained as follows: 'We feel that in-patient facilities are best suited in a psychiatric hospital where they will have available to them the background system and expertise of residential psychiatric nursing and other ancillary facilities' (p. 121) (Butler 2002).

It should be noted that problem drug use had been treated in Irish psychiatric hospitals before 1969. The report *Activities of Irish psychiatric hospital and units 1965 to 1969* (O'Hare and Walsh 1970) showed that in 1965, 84 people were treated for drug addiction, compared to 1,638 for alcoholism. Just over half were first admissions**.**

Within a year of opening the in-patient unit in St Brendan's, the relevant health authorities decided that it should only be used for the treatment of those who were alcohol dependent, leaving only Jervis Street to provide treatment for illicit drug use. The decision to stop treating problem drug users in the in-patient unit was the result of the difficulties experienced by the staff in providing a joint response to alcohol and drugs problems: problem drug users and those who were alcohol dependent 'appeared to feel a great mutual antipathy towards one another and the resulting conflict militated against the creation of a therapeutic milieu' (p. 123) (Butler 2002). Butler suggests that these difficulties could have been overcome but that, at a more fundamental level, the exclusion of problem drug users from the in-patient unit revealed 'the tendency of mainstream health service systems and professionals to distance themselves from illicit drug users' (p. 124).

A small, closed residential unit for drug users was set up at the Central Mental Hospital in Dundrum about the same time, again within the psychiatric system. It was based within the forensic psychiatric system and offered a therapeutic programme, based on behaviourist 'token economy' principles, to a small number of problem drug users transferred from Mountjoy prison. However, the unit was closed by 1977.

Around the same period, the voluntary sector was beginning to respond to the issue, as described by an editorial in the *Irish Medical Journal* of 1971:

> The treatment of the established drug taker is extremely frustrating and therapeutically unrewarding. The task is usually given to our psychiatric colleagues. … Subsequent management varies but psycho-therapy has not been demonstrably successful and psychiatrists are not willing to claim more than a very small percentage of cures…One of the most heartening features of health care in Ireland over the last twenty years has been the great revival of the voluntary effort in dealing with the handicapped members of society. (p. 125) (Butler 2002)

In 1966 Sister Consilio established the Cuan Mhuire (Harbour of Mary) centre (initially in the dairy of the religious convent of the Sisters of Mercy) to help those with problem

drug and alcohol use. In 1972 Sr Consilio was able to fund a new purpose-built centre and so continue to provide residential treatment, including detoxification.[16] There are now five Cuan Mhuire residential centres on the island of Ireland.

In 1973 the Coolmine Therapeutic Community was set up, and was the first, and for almost a decade, the only voluntary body concerned with the treatment of problem drug users in Dublin. The programme was instigated by one individual, Lord Paddy Rossmore, who had seen his friends develop addiction problems. The programme was based on a self-help approach and for the first nine years, Coolmine could only accommodate nine people at a time. It has expanded since that time and still continues to provide residential care to this day (Coolmine Therapeutic Community 2012). In 1978 the Rutland Centre set up and continues to provide a range of private residential care for various addiction problems.

Following those early initiatives, other voluntary organisations set up (and expanded) a variety of residential services based on different therapeutic models of care. In response to the growing demand for treatment for young adolescents, the first residential centre for adolescents was set up in 1998: a subsidiary of Aiséirí Cahir and a registered non-profit making organisation, the Aislinn Centre, located on a 12-acre site in Ballyragget, County Kilkenny, is a twelve-bed drug-free residential centre for male and female adolescents aged 15–21 years.

11.1.2 Strategy and policy frameworks for residential treatment

The first official Irish report devoted solely to the issue of problem drug use, published in 1971, included among its recommendations with regard to treatment, a recommendation for a special controlled therapeutic 'closed' unit where appropriately trained staff would provide detoxification, industrial therapy and other basic facilities for education and general rehabilitation (Working Party on Drug Abuse 1971). The report also suggested that 'closed' units should contain a small ward for disruptive patients whose behaviour could be 'shaped'. The report recommended the integration of services for the rehabilitation of the problem drug user, including social services and probation, housing and vocational training. However, Butler (Butler 2002) points out that the recommendations in the report in relation to treatment and rehabilitation were 'effectively pre-empted' as the Department of Health had already set up a treatment system in 1969 (see Section 11.1.1).

In 1979 the Eastern Health Board (EHB) Community Care Programme took on responsibility for drug treatment from the EHB's Special Hospital (Mental Hospital). Rather than signalling a shift in policy away from centralised psychiatric services towards localised prevention and treatment initiatives, this change was made mainly for administrative convenience (p. 148) (Butler 2002). The EHB did set up a task force on drug abuse in 1982 but the report of this task force did not contain anything specific on residential treatment (Byers 1983).

In 1991 the *Government strategy to prevent drug misuse* (National Co-ordinating Committee on Drug Use 1991) recommended a shift away from centralised drug treatment systems, acknowledging the need for different treatment approaches, but it did not discuss residential treatment:

> Of its nature, the treatment, care and management of the drug misuser does not lend itself to any 'one-solution approach'. The Government accept that the provision of services aimed at the achievement of a drug-free society only or harm reduction programmes solely are inappropriate. There is a need to make available to the drug misuser, a range of possible approaches and the means of access to the service(s) most appropriate to his/her immediate needs and capabilities. A fundamental consideration in this respect is to ensure that

[16] http://www.cuanmhuire.ie/index.php

> services available are attractive and accessible in order to encourage misusers to avail of them and to motivate them to continue with treatment (p.16) (National Co-ordinating Committee on Drug Use 1991).

The report did acknowledge the importance of the voluntary sector in this area and urged them to work towards ensuring cohesive and cost-effective programmes in their regions.

In 1996 the first report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (the first Rabbitte report) recommended a broad environmental and multi-sectoral strategy for the prevention of drug problems (Ministerial Task Force on Measures to Reduce the Demand for Drugs 1996). The task force made two recommendations in this report with regard to residential treatment: more residential treatment centres should be established and there should be more emphasis on rehabilitation, therapeutic centres and psychiatric services (pp 62–63).

The second Rabbitte report contained a short chapter entitled 'The role of therapeutic communities' (pp *65–67)* (Ministerial Task Force on Measures to Reduce the Demand for Drugs 1997). This chapter did not review or evaluate this model of care but presented the findings of the (small number of) submissions to the ministerial task force on the subject of therapeutic communities. These asserted that the State's response to the issue of problem drug users concentrated too heavily on methadone maintenance. While some of the submissions argued that abstinence was the only model of treatment capable of long-term success, others suggested that people had different needs at various stages of their addiction and a whole range of responses should be available to meet these needs. Additionally, some of the submissions stated that the State should improve the funding of the voluntary sector for this treatment and that admission to such a service should not be based on ability to pay. The second Rabbitte report concluded that the therapeutic community should be part of an overall range of treatment and rehabilitation services available for people with problem drug use.

In 2001 the *National Drugs Strategy 2001–2008* (NDS 2001–08) was published (Department of Tourism Sport and Recreation 2001). Public submissions to the Review Group tasked with drafting the NDS 2001–08 had highlighted the lack of residential treatment places, along with the need to increase funding for existing services. The Review Group concluded that 'detoxification programmes followed by drug-free residential programmes have been used with varying degrees of success in the treatment of opiate and other forms of addiction. However, to date they have been somewhat overshadowed by the demand-led requirement to eliminate waiting lists for methadone treatment' (para. 6.4.8) (Department of Tourism Sport and Recreation 2001). The strategy stated that the expansion of both types of services (detoxification and residential) went hand in hand, as many residential centres required clients to be drug-free on admission, and so were dependent on the availability of detoxification beds. Therefore there was a clear need to increase the availability of both these services.

The NDS 2001–08 included two actions relating to residential care:

> *Action 57*: To oversee the development of comprehensive residential treatment models incorporating detoxification, intervention, pre-treatment counselling, motivational work, therapeutic treatment and high quality rehabilitation for misusers who wish to become drug-free. Resources should continue to be targeted at the most efficient and effective of these services.
> *Action 58*: To report to the NACD [National Advisory Committee on Drugs] on the efficacy of different forms of treatment and detoxification facilities and residential drug-free regimes on an on-going basis.

In 2005, following a mid-term review of the NDS 2001–08, rehabilitation was adopted as a fifth 'pillar' (Department of Community Rural and Gaeltacht Affairs 2005). On foot

of this, the HSE set up an expert working group on residential treatment and rehabilitation (substance abuse) in order to gain a detailed overview of the current situation and to make recommendations on requirements for residential treatment in the future. The expert group (Corrigan and O'Gorman 2007) mapped existing inpatient detoxification and residential services (see Table 11.2.1.3 below), but did not examine the different models/types of residential treatment.

The expert group endorsed the use of the four-tier model of care as the framework for drug and alcohol services in Ireland (Recommendation 3.1).[17] Subsidiary recommendations included (pp 4–5):

- All four tiers of this model need to be fully resourced for the model to be fully effective because one tier cannot be developed or function in isolation from the others.
- While not all problem alcohol or drug users will require Tier 4 (inpatient/residential) services, client outcomes are generally recognised as being superior for inpatient versus outpatient provision for those whose care plan calls for Tier 4 services.
- The Four-Tier Model of Care implies that clients should be offered the least intensive intervention appropriate to their need when they present for treatment initially. Where this does not succeed, more intensive interventions should be offered.
- Attention is drawn to the fact that detoxification itself is not an effective treatment and that it must be followed up by post-detoxification psychosocial interventions as part of a client-centred rehabilitation programme.
- The group emphasises that the transition from detoxification from alcohol or any other drug into rehabilitation should be seamless so as to avoid waiting lists and delays which can result in client relapse. It is recognised that in the case of relapse to opiate use, there is a major risk of fatal overdoses occurring at this time.

With regard to existing service provision, the expert group recommended that, *inter alia* (p. 5):

- Clients with comorbidity issues who are in residential drug and alcohol services should be provided with adequate support by the mental health services, and that clear pathways into residential mental health services for those requiring them should be agreed, as outlined in the NACD-commissioned report on mental health and addiction services and the management of dual diagnosis in Ireland.
- Community-based or outpatient detoxification services, including the role of Level 2 GPs in their provision, should be reviewed.

With regard to the assessment of need for inpatient detoxification, stabilisation and residential rehabilitation (pp 6–8), the expert group made the following points:

[17] Four tiers of service delivery are used to denote different levels of service provision. These are:
Tier 1: Generic services which would include drug - related information and advice, screening and referral and would be aimed at those who might consider, or who are at the early stages of, experimentation with drugs or alcohol. Service providers might include An Garda Síochána, General Practitioners or community and family.
Tier 2: Services with specialist expertise in either mental health or addiction, such as juvenile liaison officers, local drugs task forces, home – school liaison, Youthreach, General Practitioners specialising in addiction and drug treatment centres. The types of service delivered at this level would include drug-related prevention, brief intervention, counselling and harm reduction and would be suitable for those
encountering problems as a result of drug or alcohol use. Tier 2 interventions are delivered through outreach, primary care, pharmacies, emergency departments, liver units, antenatal clinics or in social care, education or criminal settings (An Garda Síochána, the Probation Service, the Courts Service, Irish Prison Service).
Tier 3: Services with specialist expertise in both mental health and addiction. These services would have the capacity to deliver comprehensive treatments through a multi - disciplinary team. Such a team would provide medical treatment for addiction, psychiatric treatment, outreach, psychological assessment and interventions, and family therapy. Tier 3 interventions are mainly delivered in
specialised structured community addiction services but can also be sited in primary care settings such as level 1 and 2 GPs, pharmacies, prisons and probation services.
Tier 4: Services with specialist expertise in both mental health and addiction and the capacity to deliver a brief, but very intensive, intervention through an inpatient or day hospital. These types of service would be suitable for those encountering severe problems as a result of drugs or alcohol.

- The group's strong preference is that such beds [for detoxification, stabilisation and residential rehabilitation] should be provided in fully-staffed, dedicated units but recognise that problems of patient and family access may militate against this in some parts of the country.
- The staffing of IPUs (inpatient units) as well as of residential rehabilitation services must be in line with recognised best practice to ensure full occupancy, maximum client safety and the highest standards of care.
- The group recommends that the treatment of problem drug and alcohol users who are homeless should be prioritised, since homelessness is one of the key criteria indicating client suitability for inpatient admission.
- The increased provision of inpatient unit beds the group has recommended will allow for the stabilisation and respite needs of drug users including pregnant women, cocaine and/or polydrug users. Such beds must be physically separated from detoxification beds.
- The needs of recovering drug users with young children present particular challenges when it comes to inpatient/residential treatment. The group welcome the investigation of innovative approaches such as providing the necessary supports so that family members can act as short-term foster parents.

The National Drugs Strategy 2009–2016 (NDS 2009–16) also addresses the issue of residential services (Department of Community Rural and Gaeltacht Affairs 2009). The need for more residential beds is acknowledged and the report states, 'While there has been a significant expansion of treatment services in clinical and community settings since 2001, detoxification and residential services have not progressed to the same extent' (p. 46) (Department of Community Rural and Gaeltacht Affairs 2009). The NDS 2009–16 promotes the four-tier model and therefore any changes or expansion of residential services should be considered within that context. Both residential and appropriate aftercare are seen as integral to providing alternative drug-free approaches to treatment for problem drug users, especially opiate users. The need for after-care/follow-on supports in the community is stressed to maximise recovery.

The NDS 2009–16 also endorses the findings and recommendations of *The report of the HSE working group on residential treatment & rehabilitation (substance abuse)* and specifically in relation to the identified number of additional beds required and the need for adequate detoxification facilities (Corrigan and O'Gorman 2007). One of the key performance indicators was 25% increase in residential rehabilitation places by 2012, based on 2008 figures.

Most recently, *the National Drugs Rehabilitation Framework Document* also endorses the four-tier model (Doyle and Ivanovic 2010). The document aims to provide 'A framework through which service providers will ensure that individuals affected by drug misuse are offered a range of integrated options tailored to meet their needs and create for them an individual rehabilitation pathway' (p. 7) (Doyle and Ivanovic 2010). Within this framework, specialised care, such as detoxification, is provided in specialised wards or units, which may include general psychiatric wards. The framework envisages seamless care where a person needs to be referred on to residential rehabilitation. The framework states that 'The effective provision of facilities and services requires not only the availability of both existing and additional resources, but also the development of appropriate strategies for the planning, management, financing, implementation and co-ordination of these facilities and services. This will ensure best fit and value for money' (p.13) (Doyle and Ivanovic 2010). The framework was rolled out in a number of pilot sites all over the country and an evaluation is under way (Department of Health 2012b).

11.2 Availability and characteristics

11.2.1 National (overall) availability

National data on inpatient drug treatment

The only source of national data on residential treatment is the National Drug Treatment Recording System (NDTRS). There was an increase in the total number of drug treatment services available in Ireland and participating in the NDTRS between 2005 and 2010 (Table 11.2.1.1) (Bellerose*, et al.* 2011). In 2010, data were provided by 376 treatment services, an increase of 107 since 2005. The majority of services were in outpatient settings, while a tenth of services (n=37) were inpatient services. While the number of inpatient services participating in the NDTRS has increased from 21 in 2005 to 37 in 2010, it should be noted that not all inpatient treatment centres operating in Ireland participate in the NDTRS. Additionally, these figures include inpatient services which provide detoxification only and/or treat only problem alcohol use.

Table 11.2.1.1 Number of treatment services, by type of service provider, NDTRS 2005–2010

	2005	2006	2007	2008	2009	2010
All services	269	238	288	316	349	376
Outpatient	146	146	173	209	212	215
Inpatient	21	23	27	32	34	37
Low threshold	3	3	5	9	27	51
General practitioner	99	66	83	66	76	73

Source: (Bellerose*, et al.* 2011)

The majority (68%) of cases received treatment in outpatient settings. The number of cases entering treatment in outpatient services increased by 45%, from 3,828 cases in 2005 to 5,565 cases in 2010 (Table11.2.1.2). The number of cases entering residential treatment increased by 51%, from 817 cases in 2005 to 1,232 cases in 2010.

Table 11.2.1.2 Cases treated for problem drug use, by type of service provider, NDTRS 2005–2010

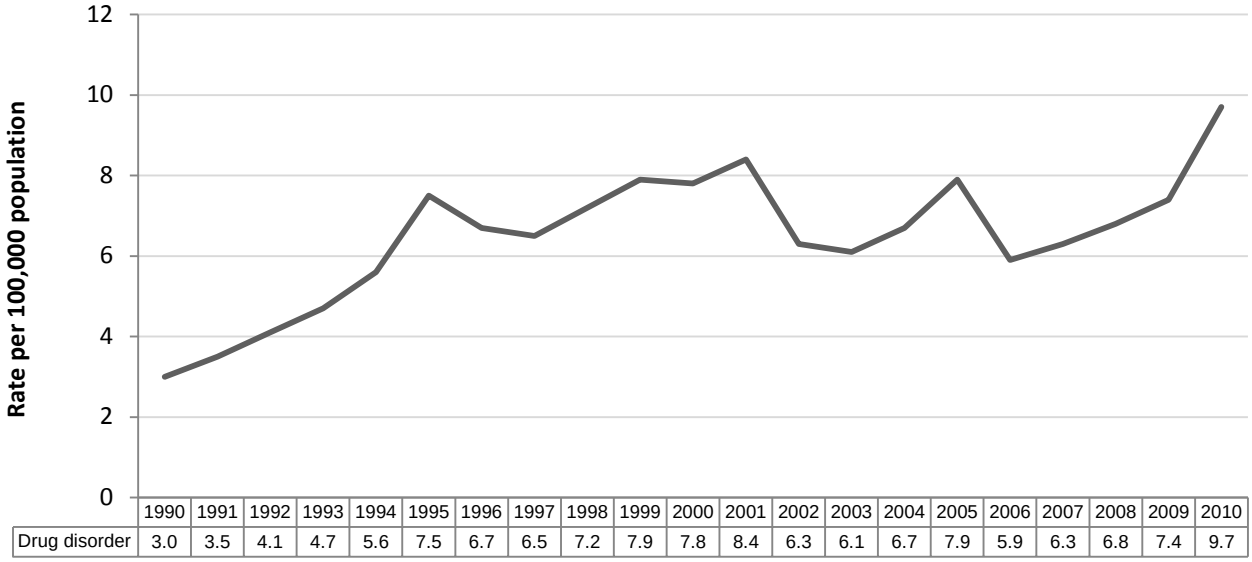
	2005	2006	2007	2008	2009	2010
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
	5176	5475	5977	6576	6667	7878
Outpatient	3828 (74.0)	4094 (74.8)	4532 (75.8)	5061 (77.0)	5005 (75.1)	5565 (70.6)
Inpatient	817 (15.8)	987 (18.0)	1065 (17.8)	1156 (17.6)	1064 (16.0)	1232 (15.6)
Low threshold*	191 (3.7)	146 (2.7)	91 (1.5)	137 (2.1)	341 (5.1)	793 (10.1)
General practitioner	340 (6.6)	248 (4.5)	289 (4.8)	222 (3.4)	257 (3.9)	288 (3.7)

Source: (Bellerose*, et al.* 2011)
* Low-threshold services provide low-dose methadone or drop-in facilities only.

By comparison, in 2010 the NDTRS reported that 34% (n=3,227) of all cases treated for problem alcohol use were treated in inpatient/residential services (Carew*, et al.* 2011). This means that the majority of cases (72%) treated in residential care in 2010 in Ireland reported alcohol as their main problem substance.

Data on hospital in-patient drug treatment

In 2010, 966 cases were admitted to psychiatric facilities with a drug disorder as their primary diagnosis, of whom 412 were treated for the first time (Daly and Walsh 2011). Since 2006 there has been a continuous increase in the rate of first admission of cases with a diagnosis of a drug disorder. The report does not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate. Additionally, only primary diagnosis is collected so there is no information on treatment provided, e.g. detoxification. Figure 11.2.1.1 presents the rates of first admission between 1990 and 2010 of cases with a diagnosis of drug disorder.



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Drug disorder	3.0	3.5	4.1	4.7	5.6	7.5	6.7	6.5	7.2	7.9	7.8	8.4	6.3	6.1	6.7	7.9	5.9	6.3	6.8	7.4	9.7

Figure 11.2.1.1 Rates of psychiatric first admission of cases with a diagnosis of drug disorder (using the ICD-10 three-character categories) per 100,000 of the population in Ireland, NPIRS 1990–2010
Source: (Daly and Walsh 2011)

Other notable statistics on first admissions for a drug disorder in 2010 include:

- The majority were to psychiatric units in general hospitals (259, 63%), followed by admissions to psychiatric hospitals (102, 25%) and to private hospitals (51, 12%).
- 6% were involuntary admissions.
- The rate was higher for men (14.2 per 100,000) than for women (5.2 per 100,000).

The majority of cases hospitalised for a drug disorder stayed just under one week (54%), while most were discharged within three months. Less than one per cent remained in hospital for more than three months.

Requirements for inpatient detoxification and residential treatment
In 2007, the *Report of the HSE working group on residential treatment & rehabilitation (substance abuse)* (Corrigan and O'Gorman 2007) calculated the requirements for inpatient detoxification and residential treatment for both problem drug and alcohol use in Ireland (Table 11.2.1.3, also see section 11.1.2 above). The authors concluded there was a deficit of 356.5 beds (252.5 for rehabilitation). The calculations were based on a population of just over four million. The model/type of residential treatment was not examined in this report. In the report, detoxification and rehabilitation are intrinsically linked as many centres require a person to be drug-free before they enter, therefore usually necessitating detoxification immediately prior to starting. The report also highlighted the need for residential services for under-18s.

Table 11.2.1.3 Current and recommended estimate of need for inpatient detoxification and residential treatment, 2007

Bed Type	Current Provision	Estimated Need	Deficit
Stabilisation Services	5.5	127 (IPU)	104 (64 for alcohol detoxification; 40 for drugs other than alcohol)
Community-based Residential Detoxification	15		
Medical Detoxification	17.5		
Residential Rehabilitation	634.5	887 (205+382+300)	252.5[29]
Step-down, Halfway house	155	296	141
General and Psychiatric Hospitals	79[30]	N/A	N/A

Source: (Corrigan and O'Gorman 2007)
IPU – Inpatient unit
[29] Includes the provision for under 18 year olds
[30] The Working Group note the evidence for treating people with drug and alcohol problems in these settings is not the best practice.

The report looked at substance abuse, including alcohol, illicit and licit drugs, and therefore it is difficult to separate out the requirements for illicit drug users. Of the 887 residential beds required, 205 were for problem drug users transferring from inpatient detoxification, 382 for problem alcohol users transferring from detoxification, and 300 for problem drug or alcohol users coming from inpatient services.

The report also estimated that there were 13 beds used for detoxification in general hospital settings and the equivalent of 66 beds in psychiatric hospitals.

A review of Tier 4 HSE funded services has been undertaken (Department of Health 2012b) recently. It aims to build on a number of previous reports in this area, including both detoxification and residential services (Corrigan and O'Gorman 2007) (Doyle and Ivanovic 2010, Working Group on drugs rehabilitation 2007). The objectives of the review are to:

- calculate the level of demand by local health office (LHO) area for Tier 3 and Tier 4 interventions;
- identify gaps and overlaps;
- make recommendations for better integration of HSE services and Tier 4 Voluntary/Community services (to include better integration of HSE services and Voluntary/Community services and will identify the best practice models for integration);
- assess existing funding models for HSE funding to the residential rehabilitation sector and recommend standardised models; and
- discuss with the residential services the potential for one service level agreement per agency.

The review is reported to be finished but has not yet been published (Department of Health 2012b).

Characteristics of those attending residential treatment

Keltoi, a residential therapeutic rehabilitation programme for problem opiate users, evaluated their service, using a cross-sectional survey of a sample of clients who had been discharged between one and three years prior to interview (Sweeney*, et al.*

2007). The treatment model used had been based on international findings that rehabilitation with a focus on developing new living skills produced more favourable outcomes.

Of the 485 clients referred to Keltoi between 2002 and 2004, 149 (31%) were treated. Ninety-five per cent of clients admitted to the treatment programme had severe opiate dependence problems, and a small proportion had severe cocaine dependence. To be admitted to the programme, clients had to be drug-free for two to six weeks, depending on the individual case and the assessment of the team. Ninety-two participants (62%) agreed to be interviewed, with two dying prior to the interview date. Eighty questionnaires were completed. The final sample comprised 52 (74%) men, 18 (26%) women and 10 individuals whose gender was not recorded.

The study reported that a large proportion of those who started treatment completed it (83%, 58/70). Half (29/58) of those who completed treatment were drug-free in the month prior to the interview. The abstinence rate for men (50%) was higher than for women (39%). The proportion who committed at least one crime during the 30 days prior to interview was lower among those who had not used drugs in that time than among those who had, 15% compared to 30%. Five of the 29 who had used at least one drug in the last month had injected it.

The study was limited as there was no baseline data and drug-free status was self-reported. In addition, it is possible that other treatment interventions may have taken place between discharge from Keltoi and the study interview and these may account for some of the positive findings. Nevertheless, these findings indicated that the Keltoi approach to treatment for drug users could lead to favourable outcomes.

A follow-up study (White*, et al.* 2011) aimed to evaluate how effective the Keltoi programme had been in helping participants to remain drug free. Clients who had attended the programme between September 2002 and July 2004 were followed up. During the evaluation period, 149 clients had entered Keltoi, 94 had participated in the original evaluation, and 80 of these participated in the follow-up interview, which was based on the Maudsley addiction profile (MAP). The interviews started in May 2004 and finished in July 2009. The average time between discharge and follow-up interview was 1.9 years (range 1.2 to 3.0 years). Two participants in the original evaluation had died before the follow-up interview took place, giving a mortality rate of 2.1% for the 94 participants. There was no control group.

Half (51.3%) of the interviewees self-reported as fully abstinent (defined as abstinence from all substances including alcohol and prescription substitution drugs) in the 30 days before the interview. Most (88.1%) were still in contact with some type of drug treatment service. Those who were abstinent reported higher levels of well-being than those who reported that they were not abstinent. In the 30 days before the interview:

- five (6.3%) interviewees reported injecting;
- a lower proportion of those who were abstinent (3.8%) reported suicidal thoughts compared to the proportion among those who were not abstinent (18.8%);
- over two thirds (77.5%) of those interviewed reported no criminal activities; and
- half (50.0%) reported having undertaken paid employment.

Self-reported abstinence was recognised to be a limitation by the authors, but the level of self-reporting was felt to be reasonably reliable among this population as there were no negative consequences for the interviewees. Because of the methodology used it was not appropriate to undertake statistical analysis of the data looking for factors which might be associated with abstinence. The authors stated that, for the same reason, they were ‘wary of direct comparisons with the majority of current international literature’ in this area. This lack of comparability is an issue in many studies.

The authors found large gaps in outcome-based evaluations for treatment programmes in Ireland and recommended the introduction of a health outcomes monitoring system. They also concluded that the evidence from their studies and others done in this area showed that many of those who enter residential treatment do not have successful outcomes. They concluded it was important to find out what works and what does not work for different people.

The **ROSIE study**[18] reported on the outcomes of abstinence-based (Cox*, et al.* 2007). At baseline, the study recruited 404 opiate users aged 18 years or over entering treatment or, in the case of a sub-sample of 26 (6%), attending needle-exchange services. The participants were engaged in one of three different forms of treatment: methadone maintenance/reduction (53%, n=215), structured detoxification (20%, n=81) and abstinence-based treatment (20%, n=82). The abstinence cohort comprised 82 individuals, the majority recruited from inpatient settings (85%, n=70), with the remainder being treated in outpatient settings (15%, n=12).

The abstinence modality was defined as 'any structured programme which required individuals to be drug-free (including free from any pharmacological intervention) in order to participate in, and remain on, the programme'. Participants were required to attend a structured programme of daily activities and were given intensive psychological support.

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

The treatment completion rate was high, with 66% of participants successfully completing their abstinence programme (n=37). Just over one-quarter of the cohort (27%, n=15) dropped out of treatment; 2% (n=1) transferred to another treatment type before completing the programme; and the remaining 5% (n=3) were still engaged in their treatment programme at one year.

In addition to those still engaged in their abstinence treatment programme one year after treatment intake, 64% (n=36) reported that they were in some form of drug treatment. Less than one-quarter of the cohort (23%, n=13) were on a methadone programme, 23% (n=13) were attending one-to-one counselling and 37% (n=21) were attending group work (Narcotics Anonymous [NA] meetings, aftercare programmes and structured day programmes).

The number of participants who reported using heroin, non-prescribed methadone, non-prescribed benzodiazepines, cocaine, cannabis or alcohol in the 90 days prior to interview decreased between treatment intake and the one-year follow-up. The most substantial reduction was in cocaine use, both in terms of the proportion of participants using the drug (46% at treatment intake compared with 14% at one year), the frequency of use (an average of 10 out of 90 days at treatment intake compared with an average of 2 out of 90 days at one year) and the quantities consumed (an average of 1 gram per day at treatment intake compared with an average of 0.3 grams per day at one year).

[18] The ROSIE (Research Outcome Study in Ireland) study was Ireland's first national, prospective, longitudinal drug treatment outcome study. It aimed to 'evaluate the effectiveness of treatment and other intervention strategies for opiate use'. In 2003/04, 404 opiate users who entered treatment were recruited, of whom 72% completed follow-up questionnaires one year and three years later. The reports on the ROSIE study are available at www.nacd.ie.

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

There was a non-significant reduction in the number of participants who reported injecting drug use. There were no changes in participants' injecting-related risk behaviours. The proportion of participants who reported an overdose within the previous 90 days remained at 4% (n=2) over the two time periods.

There was an increase in participants' contact with general practitioners and with employment/ education agencies. The authors stated that the findings demonstrated that participation in an abstinence-based treatment programme was followed by positive outcomes in relation to drug use, involvement in crime, and physical and mental health symptoms. The outcomes for ROSIE participants in abstinence-based treatment compare favourably with the outcomes reported in other international outcome studies.

Information at the 3–year follow–up showed that 69% of those who entered abstinence-based treatment completed the treatment (Comiskey, Catherine *, et al.* 2009). The authors noted that completing treatment can be a good indicator of successful treatment and felt that the high treatment completion rate for this modality in the ROSIE (which was very similar to detoxification) was a very positive outcome.

Coolmine is currently undertaking a longitudinal study of their clients with follow-up at 18 months, two years and three years. The results are not yet available (Coolmine Therapeutic Community 2012).

11.2.2 Types and characteristics of residential care units

Information on all residential centres recorded on the NDTRS contact database is compiled to give an overview of the types and characteristics of residential treatment units in Ireland. It should be noted that the NDTRS contacts database is designed to record contact data only and was never intended to be used for analysis purposes. Therefore this section does not give a complete overview of all residential treatment units in the country although every effort is made by the NDTRS team to keep the database up to date. Additionally, not all those included on the database comply with the NDTRS. Services were contacted to attempt to confirm/complete information but not all services responded so Table 11.2.2.1 is incomplete. Services that treated clients for alcohol only or only provided detoxification were excluded, if that information was known. Information on hospital–based care has been taken from the most recent publication of the National Psychiatric In-patient Reporting System (NPIRS) (Daly and Walsh 2011).

Table 11.2.2.1 Overview of different types of residential treatment settings

	No. units	No. cases treated 2010	No. of beds/places	Minimum duration (no. units) 2010				Range
				< 3mts	3 < 6 mts	6 < 12 mts	>12 mts	
Hospital based	67*	966*	66†	Not available	Not available	Not available	Not available	<1 week to 1 year* §
Residential treatment‡	28	871	Not available	8	5	0	0	28 days to 'no set period'
Therapeutic community‡	13	223	Not available	3	3	2	0	6 weeks to 6 months

* Source (Daly and Walsh 2011) 2010 data
† Source (Corrigan and O'Gorman 2007) 2007 data
‡ Source NDTRS unpublished data
§ Median length of stay 6 days; 54% stayed less than 1 week; 1 person stayed between 1 to 5 years

11.2.2.1 Common approaches

Of the 41 non-hospital services where information was supplied, 15 stated that their philosophy was the 12 Step/Minnesota Model and 13 services stated that they were therapeutic communities.

11.2.2.2 Typical mix/integration of services

This section only deals with (where the information is available) the 41 non-hospital based services known to the NDTRS. All but four treated both problem drug and alcohol use. A number (not specified) also treated other problems, for example gambling. Many would have HSE–funded beds. Entry criteria were based mainly around gender as some services took only one gender. There were two services which only accepted adolescents. There were other criteria depending on the service: clients to be drug free on admission (16); clients stable on methadone (4); clients stable on other prescription drugs (3); specified catchment area (2); funding (2); appropriate referral (2); registered homeless (1). Most services only had two or three criteria for entry.

Typical interventions provided by all services included: individual counselling, group counselling, social and occupational reintegration, complementary therapy, education awareness, family therapy and aftercare.

11.2.2.3 Integration of OST in residential care

The Central Treatment List reports on opiate substitution treatment (OST) in Ireland. Their figures on continuous care (i.e. the number of clients in OST on 1 January every year) show that very small numbers, ranging either just over or just under 10 clients per year between 2005 and 2010, received OST in residential services (unpublished data, Central Treatment List, February 2012).

11.2.2.4 Typical levels of collaboration and networking

Many services refer clients on, to aftercare, back to other types of drug treatment or to other social services as appropriate. There are no national published studies or data available that show typical levels of collaboration or formal (or informal) networks.

Analysis of NDTRS data shows that in 2010 the highest proportion of cases (37%) self-referred *to* a residential treatment service (either therapeutic community or 12-step) (Table 11.2.2.4.1).

Table 11.2.2.4.1 Source of referral to residential treatment services, NDTRS 2010 (1,094*)

Source of referral	%
Self	36.8
Other drug treatment centre	17.3
Court/probation/police	11.4
Family	10.9
Social services	8
General practitioner	3.4
Prison	2.8
Friends	2.7
Outreach worker	2.5
Hospital/medical agency	2.4
Other/not known	1.9

* Excludes those treated for alcohol as a main problem substances and detoxification-only services

The NDTRS collects information on where a case is transferred to, if applicable, once they have left the residential treatment service. However, the NDTRS only collects information on services relevant to the NDTRS, so does not collect information if cases were transferred to a centre, for example that provides only social care such as housing. In 2010, information was available on 145 cases who were transferred: most were transferred to either another residential service or an outpatient drug treatment programme.

A good example of complex levels of collaboration and networking between all the difference services comes from the list of partnerships included in the most recent

strategy document of the Coolmine Therapeutic Community (Table 11.2.2.4.2) (Coolmine Therapeutic Community 2012).

Table 11.2.2.4.2 Coolmine Therapeutic Community Partnerships, 2012

Contact and Assessment	Primary Treatment	Integration	Aftercare
Anna Liffey Drug Project	Visiting Medical Officer	Focus Ireland	Arbour House Cork
Hartstown/ Huntstown Community Drugs Team	Barnardos	Peter McVerry Trust	Merchants Quay Ireland
Irish Prison Service	ASKES	YMCA	FÁS
Probation Services		Homeless Agencies	
Arbour House Cork		Threshold	
HSE Addiction Services and Maternity		Fingal County Council	
Homeless Agencies		Various county & city councils	

Source: (Coolmine Therapeutic Community 2012)

11.3 Quality management

11.3.1 Availability of guidelines and service standards for residential care

There are no national guidelines available for residential care (Irish Focal Point (Reitox) 2011) and no local guidelines were provided.

The *Report of the HSE working group on residential treatment & rehabilitation (substance abuse)* (Corrigan and O'Gorman 2007) identified issues and recommendations in relation to quality assurance for inpatient and residential services, as follows:

6.1: The working group fully endorses the concept that the quality of the residential facilities, the organisation, the delivery and evaluation of services, and also of the staff involved in the delivery of the service must be of the highest possible standard. It is vital, therefore, that all three components be subject to regular auditing using recognised benchmarks and targets.

6.2: The group therefore recommends that a national quality assurance scheme for all four tiers of the alcohol and drugs services be established following the necessary consultation, negotiation and training.

6.3: We recommend that the Quality in Alcohol and Drugs Services (QuADs) suite of organisational standards and the companion Drug and Alcohol National Occupational Standards (DANOS), as developed for the UK by Alcohol Concern and Drugscope and by the Management Standards Consultancy for Skills in Health respectively, should be adapted for use by drug and alcohol services in Ireland.

6.4: The group also recommends that there must be standards for the quality of the residential facilities themselves and believes that the HSE should enter into discussions with the Health Information and Quality Authority (HIQA) about the inclusion of residential services for drug and alcohol users within the range of services to be regulated by HIQA's social services inspectorate. This would help avoid duplication of effort when quality audits are undertaken.

6.5: The group also recommends that the HSE put in place an Internal Quality Audit function within the drugs and alcohol services in order to assist both HSE-funded and HSE-provided services to prepare for and respond to external audits of the facilities, organisation and staff.
6.6: There was particular concern expressed by the group about the need for relevant stakeholders to ensure that all detoxification procedures meet the highest standards of clinical governance, care and patient safety.
6.7: The group highlights the need for ongoing staff training and support to assist in role development. Managers and those who lead rehabilitation teams should ensure that staff are clear about their role definition and purpose, and that they possess or are actively working towards he required qualification(s).

The NDS 2009–16 endorsed these recommendations and concluded that they should be progressed (Department of Community Rural and Gaeltacht Affairs 2005).

QuADs, the quality standards framework created in the UK, has been endorsed by the HSE Addiction Services in Ireland.[19] Eight residential services are currently involved in QuADs (Personal Communication, Caroline Gardner, Progression Routes, 1 October 2012). Of those services known to the NDTRS, a further 10 residential treatment centres run by voluntary agencies reported that they were accredited with another UK-based company.

In 2010 Cuan Mhuire won the international CHKS Quality Improvement award which recognises significant improvements in patient care and patient experience as well as staff welfare, safety and morale (Galvin 2010).

11.4 Discussion and outlook

Starting in the 1960s, the factors influencing the recognition and development of residential treatment services in Ireland included both the example set in the UK, which the Irish health services followed, and also the interest of voluntary groups, which established residential treatment centres. In the 1980s, Jervis Street/Trinity Court drug treatment centre (outpatient) combined well with Coolmine (residential) in providing a range of treatment services for those with drug problems.

In the 1980s and 1990s, support for residential treatment declined as competing demands attracted attention, including:

- local communities demanding to be involved in policy development and policy implementation, especially around issues such as the 'heroin epidemic' in the early 1980s;
- the emergence of health-related risks of intravenous drug use from the late 1980s onwards leading to priority being given to harm reduction measures such as methadone maintenance through primary healthcare workers; and
- the need for prison-based services, services for under-18s, harm reduction services, and services across the country.

In the 21st century the recognition of the need for range of responses and alternative drug-free approaches for those with problem substance use brought the role of residential treatment to the fore again. This included specialised inpatient services for those with specific medical problems such as liver disease or dual diagnoses, detoxification and drug-free residential treatment. The 2007 report of the HSE working group on residential treatment and rehabilitation (substance abuse) endorsed the 4-tier treatment model. The adoption of this 4-tier treatment model and integrated care packages in the NDS 2009–16 as the framework for the provision of all health,

[19] http://www.progressionroutes.ie/index.php?page=quads-support-project

including addiction, services means that the role of residential treatment is now officially acknowledged.

In Ireland, detoxification and rehabilitation are intrinsically linked as many centres require a person to be drug-free before entering, therefore usually necessitating a detoxification immediately prior to starting in a residential centre. It is very difficult to separate residential detoxification and residential treatment in this context or in the available documentation.

There is very limited information on the types and characteristics of residential services and unfortunately the results of the most recent review of Tier 4 are not available at this time (Department of Health 2012b). Therefore there is no update on residential treatment services since the 2007 report of the HSE expert working group on residential treatment and rehabilitation. That report estimated that there was a deficit of 252.2 beds for residential treatment (including both drugs and alcohol) (Corrigan and O'Gorman 2007). From the NDTRS data it is clear that the number of cases entering inpatient treatment has increased (see Table 11.2.1.2). This increase may be due to several reasons – an increase in the number of residential centres participating in the NDTRS, an increase in the number of residential places available or a true increase in the number of people being treated in residential care. In 2010 in Ireland, the majority of cases in residential treatment, as recorded in the NDTRS, had alcohol as a main problem substance. The number of people receiving treatment for drug disorders in psychiatric hospitals has also increased over the past years, but the length of stay in those facilities is usually less than 1 week.

11.4.1 Outlook

The economic climate is affecting all drug treatment services, including residential services. For example, in September 2012 the only residential mother and baby service run by the Coolmine Therapeutic Community faced {Lally, 2012 #410}

The recommendations of the HSE expert working group on residential treatment and rehabilitation specifically mentioned the challenges faced by problem drug users when accessing residential care (Corrigan and O'Gorman 2007).

New initiatives such as community detoxification programmes have proved a successful alternative for those who require detoxification and where a stay in an inpatient facility is not always the best option (Lyons, Dr Suzi 2008a) (Irish Focal Point (Reitox) 2011). However as endorsed by the2009–16 NDS, there will always be a need for Tier 4 residential treatment which provides the individual with another choice of treatment which may be most appropriate and beneficial option for them at that time.

12. Drug Policies of large European cities

In this selected issue we have sought to address the specific questions raised by the EMCDDA. Dublin, Ireland's capital city does not have its own specific drug policy. Drug policy in the city is considered within the context of the NDS. Much of the information and data gathered by agencies such as the Health Research Board (HRB) or the National Advisory Committee on Drugs (NACD) that is regularly reported by the National Focal Point is not specific to Dublin. However, where possible, we have highlighted recent studies that focus on drug-related problems in the city. Along with these research studies and reports, other sources used include government websites, policy documents and parliamentary debates. We have also consulted with the Drug Policy Unit in the Department of Health.

12.1 Large cities (defined as capital city + all cities above 300'000 habitants)

12.1.1 Functions and responsibilities of large cities in drug policy

The Department of the Environment, Community and Local Government (DECLG) oversees the operation of the local authority system in Ireland and implements national policy.[20] There are 29 county councils, 5 city councils, 5 borough councils and 75 town councils. The Department oversees the operation of the local government system and implements policy in relation to local government structures, functions, human resources and financing. Local government in Ireland consists of a number of local and regional authorities.

Local government is different from other public sector agencies in that it is democratically elected. Apart from Dáil Éireann (Irish Parliament) and the Presidency, it is the only other institution whose members are directly elected by the people. Local government has therefore both a representational and an operational role, with responsibility for a range of services.

The elected council is the policy-making arm of the local authority, and acts by what are termed 'reserved functions'. Reserved functions are defined by law and specified across a whole range of enactments. These comprise mainly decisions on important matters of policy and finance (e.g. adoption of annual budget, development plan, bye-laws). The day-to-day management of the local authority, including staffing matters, is vested in a full-time chief executive, known as the county or city manager. The manager and/or staff to whom functions are delegated discharge what are termed 'executive functions' – in effect, these involve the day-to-day running of the authority within the policy parameters as determined by the council. Any function of a local authority that is not specified in law as a reserved function is deemed to be an executive function. The legal character of a local authority thus comprises two elements, the elected council of the authority and the manager, with responsibility for performing local authority functions shared between them. However, legally all functions, whether performed by the elected council or by the county/city manager, are exercised on behalf of the local authority. In the Dublin region there are four local authority areas with responsibility for the provision of a range of local services.

What areas of drug policy and service provision are cities responsible for and active in?

The NDS sets out the overall policy in relation to drugs (Department of Community Rural and Gaeltacht Affairs 2009). Large cities do not have specific drug policies, strategies or action plans. The NDS sets out a number of specific actions for the

[20] The information in this section is derived from the Department's website at http://www.environ.ie/en/LocalGovernment/LocalGovernmentAdministration/

DECLG. These are discussed below. The report of the working group on drugs rehabilitation also identified a role for local authorities, in conjunction with other relevant agencies, in relation to access to education and housing for those recovering from drug misuse (Working Group on drugs rehabilitation 2007). Local government's involvement in addressing the drugs issue derives from legislation; the assignment of responsibilities under the NDS to local authorities is on foot of these prior statutory roles and responsibilities.

The NDS assigns a key role to local and regional drugs task forces (LDTFs and RDTFs) in addressing the drugs problem. The original terms of reference of the LDTFs required them to assess the extent and nature of the drug problem in their areas and to develop and monitor the implementation of action plans to respond to the problem as identified (Ministerial Task Force on Measures to Reduce the Demand for Drugs 1996) (Department of Tourism Sport and Recreation 2001).The local councils are represented on the LDTFs and RDTFs within their areas. Elected representatives from the councils are also on some of the DTFs.

What services are funded by the cities?

All drugs services throughout the country, including in Dublin, are funded through central funds (Brendan Ryan, Drug Policy Unit, personal communication, July 2012).

Are there services unique to the cities (i.e. services for ethnic minorities etc.)?

No.

Do large cities have local level drug policies/strategies/action plans? If yes, are these in written format? If yes, please provide web links (original and English where possible).

No. Cities do not have local level drug policies/strategies/action plans.

Do large cities have a municipal drug coordinator and/or other drug coordination bodies? In the absence of written drug policy documents, how is action developed and coordinated (formal or informal networking between stakeholders etc.)?

No. The actions in the NDS are coordinated through the Drugs Policy Unit of the Department of Health. The coordinators of the LDTFs and RDTFs meet on a regular basis and also liaise with the Drugs Programme Unit of the Department of Health (Brendan Ryan, Drug Policy Unit, personal communication, July 2012). The primary focus of the DTFs is on:

- monitoring the implementation of projects and evaluation with a view to mainstreaming;
- preparing action plans;
- identifying emerging strategic issues and developing proposals on policies or actions needed to address them; and
- providing for the implementation of a local/regional drugs strategy' (Department of Community Rural and Gaeltacht Affairs 2009) (p. 89)

Are city-level drug policies linked to other national and/or regional drug policies or are they stand-alone policies?

See response to preceding question.

Are there any city level networks at the national level that are concerned with drug issues? Describe the role of these networks.

Two primarily community-based networks that have a national focus are the CityWide Drugs Crisis Campaign[21] and the Family Support Network.[22] CityWide is a national network of community activists and community organisations involved in responding to Ireland's drugs crisis. CityWide was set up in 1995 by the Inner City Organisations Network (ICON), to bring together Dublin communities that were struggling with the heroin crisis. It now works on a national basis, linking communities across the country dealing with a range of substance issues.

CityWide works to promote and support a community development approach to the drugs problem: this means involving the people who are most affected by the problem – drug users, their families and communities – in dealing with the problem.

The aims of CityWide are to:

- develop the capacity of local communities to respond to the drugs problem in their area;
- provide ongoing support, facilitation and networking to local groups working on the drugs issue, either in areas already linked in to CityWide or other areas where communities may not be well organised;
- campaign and lobby on policy issues in relation to drugs and, as part of this role, to carry out a representative role on behalf of the community sector on policy bodies; and
- encourage an inter-agency response to the drug problem, including government departments and agencies, trade unions, community and voluntary bodies and other relevant agencies that may be identified.

The FSN is an autonomous self-help organisation that 'respects the lived experiences of families affected by drugs in a welcoming non-judgemental atmosphere. It endeavours to provide accurate information for families by developing personalised services that meet the real identified needs of families.' Like CityWide, the FSN operates within a community development ethos. It is a peer-led organisation committed to promoting the 'empowerment, inclusion and participation' of its members.

The overall objective of the FSN is 'to improve the situation of families coping with drug use by developing, supporting and reinforcing the work of family support groups and regional family support networks, by working for positive change in policy and practice and by raising public awareness about the problem of drugs for families and communities.' Its principal aims are to:

- raise awareness of family support work and its role within the community;
- highlight the importance and value of work done by family support groups;
- provide information to families and communities on existing services and supports;
- highlight the extent of the drugs problem and its effects on families and communities;
- campaign for better services for drug users and their families;
- support the involvement of the people most affected by the problem in the development and running of services and to ensure that adequate supports are put in place to enable this to happen; and
- remember and commemorate those who have died as a result of drugs;
- offer support to each other as members of the Network; and
- develop the Network as an autonomous, professional, national organisation.

Another important network is the Union for Improved Services Communication and Education (UISCE), a drug users forum based in the North Dublin Inner City.[23] It aims

[21] The following information on CityWide is taken from its web site at www.citywide.ie
[22] The following information on FSN is taken from its web site at www.fsn.ie
[23] The following information on UISCE is taken from the web site of the North Inner City Local Drugs Task Force www.nicdtf.ie

to ensure that those in need of drug services are heard by policy-makers and practitioners. UISCE represents drug users on many relevant fora, and engages in a number of key activities including highlighting relevant issues affecting drug users and users of drug services, gathering and disseminating information to relevant bodies, and facilitating the participation of drug users in local structures to improve access to, and quality of, services in the local area.

12.2 Case study: the capital city

12.2.1 Key features of the capital city's drug policy

Does this capital city have a written drug policy?

No.

Describe its main objectives and contents, and provide a web link (original and English if possible). Please insert the answers from questions 9 & 10 in section 3 of your response to SQ32 for 2011 or provide new information that differs from it.

Not applicable.

If there is no municipal drug strategy in the capital city, please discuss the way drug policy action is developed in the areas of demand and supply reduction.

The NDS has specific recommendations in relation to supply reduction and prevention (Department of Community Rural and Gaeltacht Affairs 2009). These areas represent two pillars of the overall five-pillar strategy. Responsibility for the implementation of the recommendations is assigned to a number of government departments, agencies and bodies. The government departments are Health; Justice, Equality and Defence; Environment, Community and Local Government; Transport, Tourism and Sport; Education and Skills; Children and Youth Affairs; Social Protection; and Foreign Affairs and Trade. The agencies and bodies include the Health Service Executive; Garda Síochána (Police); Courts Service; Irish Prison Service; Probation Service; Revenue's Customs Service; local authorities; Road Safety Authority; Medical Bureau of Road Safety; Irish Medicines Board; Medical Council; Pre-Hospital Emergency Care Council; An Bord Altranais (Nursing); National Advisory Committee on Drugs; and the Health Research Board.

The community and voluntary sector, the Family Support Network, city development boards and joint policing committees and local policing fora also perform various roles in implementing actions under these pillars.

Are there local drug coordination bodies and/or a local drug coordinator in the capital city?

The LDTFS, discussed above, were set up in 1998 in areas identified as having the highest levels of drug misuse (Ministerial Task Force on Measures to Reduce the Demand for Drugs 1996). Originally, 12 LDTFs were established in the Greater Dublin area – North Inner City, South Inner City, Ballymun, Ballyfermot, Finglas/Cabra, Dublin 12 (Crumlin, Drimnagh, Kimmage and Walkinstown), Dublin North East, Canal Communities (Bluebell, Inchicore and Rialto), Blanchardstown, Clondalkin, Tallaght and Dun Laoghaire-Rathdown.[24]
Each LDTF should be chaired by an independent chairperson and, in their original form, were supposed to include representation from the following sectors/agencies:

- community sector

[24] An LDTF was also set up in North Cork City, with an emphasis primarily on prevention. Following a review of the LDTFs in 1999, Bray in County Wicklow was designated as the14th LDTF area.

- voluntary sector
- public representatives
- Department of Education and Skills/Vocational Education Committee
- FÁS (Former employment agency)
- Garda Síochána
- Health Service Executive
- local authorities
- Probation Service
- Revenue Commissioners (Customs and Excise Division)
- Department of Social Protection
- Area-based Leader and Partnership Companies/Community Development projects
- City/county development boards
- Service users
- Communities of interest

Each LDTF develops a local three-year strategy, reflecting local needs and circumstances, to support implementation of the national drugs strategy, and each year it identifies priorities and actions (an operational plan) for the coming year, in line with nationally agreed priorities. Each DTF reports on its activities and in particular on its effectiveness and efficiency, twice a year, to the Drug Programme Unit in the Department of Health. Each DTF also puts in place accounting arrangements, based on receipted expenditure, in relation to any public funds disbursed by it and reports annually to the Drug Programme Unit on its expenditure of public monies.

In 2008/2009 LDTFs were due to develop new strategic plans covering the next four years. Only three local drugs task forces have current strategies that are published: Tallaght (Tallaght Local Drugs Task Force 2008), South Dublin Inner City (South Inner City Local Drugs Task Force 2008), and Dublin12 (Dublin 12 Local Drugs Task Force 2009).

If available, please provide relevant information on budgetary /expenditure related to drugs policy at city level.

In 2011 approximately €250m was provided nationally across all Departments towards the implementation of the NDS. From this approximately €20m was allocated to the LDTFs. While national figures are available from other Departments and agencies, it is not possible to provide a breakdown on expenditure specific to Dublin (Brendan Ryan, Drug Policy Unit, personal communication, July 2012).

However, in response to a parliamentary question, Róisín Shortall TD, Minister of State at the Department of Health, with responsibility for the NDS, provided details of the funding allocated to the LDTFs. This data is presented in Table 12.2.1.

Table 12.2.1: Allocation of funding to the local drugs task forces, 2011 and 2012.

Local Drugs Task Force	2012 Allocation €	2011 Allocation €
Ballyfermot	1,569,489	1,608,413
Ballymun	1,180,695	1,209,976
Blanchardstown	1,124,343	1,152,227
Bray	1,573,101	1,612,114
Canal Communities	1,562,243	1,600,987
Clondalkin	1,421,577	1,456,832
Cork	1,578,581	1,617,730
Dublin 12	1,120,360	1,148,145
Dublin NE	1,228,782	1,259,256
Dun Laoghaire	926,167	949,136
Finglas Cabra	936,590	959,818
North Inner City	2,369,624	2,428,391
South Inner City	2,161,821	2,215,434
Tallaght	1,250,347	1,281,356

Total	20,003,720	20,499,815

Source: (Mitchell 2012, 14 February)

Is there a local/city level drugs monitoring system? Please describe.

No.

If available, please provide information about/refer to studies that detail the level of drug problems in the city.

The most recent information about drug prevalence and studies about drug-related problems in Ireland are reported in Ireland's National Report 2011 (Irish Focal Point (Reitox) 2011). However, much of this information is not specific to Dublin. In this section we report on a number of studies that have focused on drug-related problems in the capital city.

Crack cocaine in the Dublin region

A study by Connolly and colleagues (Connolly, J*, et al.* 2008) was commissioned by the Intersectoral Crack Cocaine Strategy Group in response to a number of seizures of crack cocaine made by the Garda Síochána in the north Dublin inner city in 2005. The report found that, despite targeted Garda interventions, crack use had increased and availability had spread throughout the Dublin region. The HRB conducted the research over a nine-month period beginning in August 2007, using a rapid situation assessment technique developed by the World Health Organization. This involved a multi-method approach, which brought together existing research, and drug treatment and criminal justice data, supported by interviews with key informants such as drug users, gardaí, outreach workers and treatment specialists.

The emergence of crack

Crack cocaine is produced from powder cocaine using readily available chemicals such as ammonia and baking soda. A number of factors may explain the rise in crack cocaine use in Dublin. These include the increased availability of powder cocaine; the presence of problematic opiate users who had used crack cocaine in the UK or in Europe and had resumed crack consumption while living in Dublin; and the presence of non-Irish nationals who had access to cocaine supply routes and experience of preparing crack cocaine.

Drug-using characteristics of crack users

The majority of crack users used more than one drug, with opiates (mainly heroin) being the most common drugs used alongside crack. Smoking was the predominant route of administration. A proportion of intravenous users made a transition from injecting powder cocaine to smoking crack cocaine because of the physical harms of injecting. Frequency of use ranged from daily to weekly and was largely dependent on available financial resources.

Dublin crack market

The north Dublin inner city was found to be the primary crack market in Dublin; the market in 2007 was dominated by non-Irish national dealers who imported small amounts of cocaine via couriers. However, a growing number of Irish dealers were reported to be involved in the distribution of crack throughout the Dublin region, and prepared crack has been available throughout the city since 2006. Findings indicated that the crack market was a closed market, meaning that dealers did not sell to strangers, exchanges were generally arranged using mobile phones, and buyers were directed to exchange points outside the inner city. The price of crack was found to be relatively stable and uniform, with prepared quantities or 'rocks' being sold for €50 or €100. Crack houses were reported as locations where crack was used and in some cases prepared in exchange for free crack; they were not reported as major venues for crack dealing or as sites for sex work.

Social profile of crack users and consequences of crack use

A high proportion of crack users were homeless, unemployed and did not have formal educational qualifications. According to data from treatment services, the majority of crack users were male and half were aged between 20 and 29 years. However, females involved in sex work and single mothers were reported to develop the most chaotic addiction. Common physical side effects of crack use are breathing problems, heart problems and rapid weight loss, and the most common psychological consequences are paranoia, aggressiveness and depression. Compulsive crack users reported neglecting their children, often diverting their financial resources towards buying crack. Shoplifting, burglary and robbery were reported as common means for users to sustain their crack cocaine habit. Service providers also reported an increase in the numbers of women returning to or beginning sex work to fund their crack use.

Drug use in the Canal communities

Saris and O'Reilly undertook an ethnographic study of drug use in a number of locations within the Canal communities area in Dublin (Bluebell, Inchicore and Rialto on the south side of the city) (Saris and O'Reilly 2010). These locations are characterised by pockets of socio-economic disadvantage and have been designated as areas experiencing high levels of illicit drug use. Data was collected between September 2007 and the end of 2008, with some follow-up work in 2008. The purpose of the study was to improve knowledge and understanding of the changing nature of illicit drug use in the areas.

Data were collected using a variety of ethnographic methods, including informal and in-depth interviews, focus groups, survey questionnaires and extensive field notes. Interviews were conducted with 51 people, 24 life histories were collected and eight group discussions with 29 young people. Return interviews were recorded with six interviewees. Twenty-four interviews were completed with service providers. Survey questionnaires were completed during face-to-face interviews with 92 people attending drug treatment services. Data collection lasted approximately 12 months. The researchers employed a number of tools to improve the quality of this work including periods of reflexive practice and cross-checking data sources.

The study painted a picture of significant poly-drug use among the participants in the study and suggested that methadone was merely perceived to be another 'street drug' among many used by the participants. According to Saris and O'Reilly, '...most users are ambivalent about both [methadone] and the treatment regime. The majority of users with whom we spoke, for example, do not consider methadone "treatment" as such. Some talk about replacing "one addiction with another" or even more severely, being "a government junkie"....' (p. 19). Seventy-nine per cent of those who had used crack in the past three months were also using heroin. In the last three months 98% of the participants had used prescribed methadone and 50% had taken prescribed tranquillisers. Fifty-nine per cent of those who had taken prescribed methadone in the last 3 months also reported using heroin during this time.

Drug misuse in south inner city Dublin

In May 2011 the South Inner City Drugs Task Force commissioned research to assess the prevalence of drug misuse in South Inner City Dublin (Giaquinto 2011). The research was based on two sources of information – focus groups and personal interviews with service users attending some of the DTF projects, and information obtained from HSE and HRB reports and other literature.

A total of 26 service users agreed to participate in either a personal interview or a focus group. They were asked four questions about (1) their previous or current drug use, (2) their perception of the prevalence of drug misuse, (3) the nature of drug dealing, and (4) young people's use of drugs in the South Inner City.

Among the findings were the following:

- Young people were at high risk from the adverse effects of legal highs, alcohol and tablets, which they may use in combination.
- Some legal highs had become a drug of choice.

- Service providers should be on high alert for crystal meth.
- There was a very high prevalence of prescription drugs on the market, including locally manufactured tablets which might contain dangerous substances.
- The number of women engaged in treatment in South Inner City over the last three years had decreased, whereas the number of males in treatment had increased.

Dublin City drug market

In 2011 a Strategic Response Group (SRG) was established because of concerns raised in the media and elsewhere about perceived drug-related anti-social behaviour in Dublin city (see Section 9.4 for more detail). To inform its response the SRG commissioned research on aspects of the city centres illicit drug trade (Strategic Response Group 2012).The following is a summary of some of the findings in relation to problematic drug and alcohol use and street-level drug dealing.

Open drug scenes

Congregations of drug users and loitering were particularly visible during 'walkabouts' on a number of streets and near specific Luas (urban rail system) stops. It was also apparent that the greater the footfall on streets, the less visible the congregations of problematic drug users. During 'walkabouts' it was noticed that there was an increase in congregations of drug users at lunchtime when drug-related services were closed. Qualitative narratives revealed concerns about aggressive and vocal behaviour occurring owing to withdrawals and use of prescribed medication and alcohol.

Drug dealing in the research area appeared transient owing to the changing nature of the drugs that were available at a given time (i.e. heroin, cannabis, new psychoactive drugs (such as mephedrone), prescribed medication, zopiclone (zimovane), diazepam (valium), crack cocaine, methadone and crystal meth. Open drug scenes were also mobile with both users and dealers walking and cycling in the research area. Service user interviews described increasing competitiveness with child and youth involvement in drug dealing and greater numbers of individuals dealing. Surveyed drug user street intercepts and service user narratives reported knowledge of 'hotspots' for drug dealing, often outside treatment centres.

Injecting in the street and other public places

The research found that injecting in public places was only done by a small number of drug users who were homeless or rough sleepers. Drug-related litter was observed during 'walkabouts' in a number of streets and alleyways. Interviews and focus groups highlighted concerns about unsafe injecting practices, particularly during times when needle exchanges were closed. The researchers photographed deterrents including fluorescent lighting to restrict injecting, and notices placed on service doorways.

Prescription medication use

The issue of prescription medication use by a variety of drug-using groups and dealing in visible and transient open drug scenes and identified 'hot spots' (i.e. Luas stops) were discussed in interviews and focus groups. Prescription medication use contributed to dis-inhibition and vocal intimidation of passers-by on the street. Service users described use of prescribed medication as helping to pass the day. Discarded benzodiazepine packaging was noted and photographed during 'walkabouts' in the research area. Garda sanctioning and control of use was viewed as problematic owing to lack of powers in relation to prescribed drugs. The market in anti-anxiety and sedation medication is sustained by purchase via web-based outlets serving Ireland, or by stealing from pharmacies or factories. Respondents also raised concerns about the importation of counterfeit medicines with unidentified contents and their potential to harm the user. Interviews with service users identified the need for greater service support for those with depression, anxiety or at risk of suicide.

Are there any drug policy agreements or declarations the city is a signatory to (such as the Prague Declaration on the principles of effective local drug policies)? Describe.

No. The city is not a signatory to any drug policy agreements or declarations.

Describe the main actors involved in developing and delivering policy (i.e. city council, police, NGOs, lobby groups, business, communities etc.)

Responsibility for the implementation of the NDS recommendations is assigned to a number of Departments, state agencies and other bodies. The government departments are Health; Justice and Equality; Environment, Community and Local Government; Transport, Tourism and Sport; Education and Skills; Children and Youth Affairs; Social Protection; Foreign Affairs and Trade. The agencies and bodies include the Health Service Executive; Garda Síochána (Police); Courts Service; Irish Prison Service; Probation Service; Revenue's Customs Service; local authorities; community and voluntary sectors; Family Support Network; Road Safety Authority; Medical Bureau of Road Safety; Irish Medicines Board; Medical Council; Pre-Hospital Emergency Care Council; An Bord Altranais (Nursing); National Advisory Committee on Drugs; and the Health Research Board. The local and regional drugs task forces also play an important role in implementing the NDS.

12.3 Four areas of drug policy in capital cities

12.3.1 Local policing strategies against drug scenes/drug trafficking.

Joint policing committees and local policing fora
Following the Garda Síochána Act 2005, Joint Policing Committees (JPCs) were established in all 114 local authorities (Alcohol and Drug Research Unit 2008). They comprise representatives of local authorities and the Garda Síochána (national police force), members of the Oireachtas (Houses of Parliament) and community representatives, who together make recommendations on matters concerning the policing of areas, including measures to address the levels and patterns of anti-social behaviour. While JPCs cover all aspects of local policing, one of their functions is to establish Local Policing Fora (LPFs), which focus on the problem of drugs misuse in LDTF areas (Connolly, Johnny 2006a) (Connolly, Johnny 2006b).

The NDS assigns responsibility to, among others, the Department of Environment, Community and Local Government (DECLG), the Department of Justice, Equality and Defence, the Garda Síochána and local authorities, for the following supply-reduction actions:

- establish LPFs in all LDTF areas and other areas experiencing serious and concentrated problems of drug misuse (Action 2);
- include drugs issues in a central way in the work of JPCs to ensure that there is a concerted effort against drugs in the areas involved (Action 3); and
- the issue of drug-related intimidation from the lower level to the most serious should be raised at both the JPCs and the LPFs with a view to devising appropriate and sustainable local responses to the issue (Action 3).

Strategic response group - a partnership approach to address public substance misuse and perceived anti-social behaviour in Dublin city centre
The Strategic Response Group (SRG), a partnership-based group, whose work is also described in sections 9.4 and 12.2, was an innovative approach to addressing public substance misuse and perceived anti-social behaviour in Dublin city centre. At the end of June 2012 the Lord Mayor of Dublin launched its report, entitled *A better city for all* (Strategic Response Group 2012).
The issue of substance-misuse-related anti-social behaviour in Dublin city centre has for a long time been a source of media focus and public concern. Following the establishment in 2010 of the Dublin City Local Business Policing Forum (DCLBPF), this issue became a recurring item for discussion. A number of agencies and organisations

were invited to make presentations on the topic. In January 2011, in his capacity as chairman of the DCLBPF, the former Lord Mayor of Dublin called a meeting of representatives of some of Dublin City's key stakeholders. Arising from this, the Strategic Response Group (SRG) was formed with the objective of developing ways to build sustainable street-level drug services and address related public nuisance. The SRG was independently chaired and its membership included representatives of the four main drug treatment centres in Dublin city centre (Ana Liffey Drug Project, the City Clinic, the Drug Treatment Centre Board, and Merchants Quay Ireland); Garda Síochána; Dublin City Business Improvement District; Dublin City Council; Dublin Simon Community; the North Inner City LDTF; the South Inner City LDTF and the Union for Improved Services, Communication and Education (UISCE).

The SRG report acknowledged that for historical reasons there is a clustering of drug treatment and homelessness services in or adjacent to the inner city. According to the Drug Policy Unit in the Department of Health, 'there are 52 clinics within the four Dublin Local Authority areas of which 6 are city centre based. The city centre clinics cater for 1,082 people, just less than a quarter of the overall Dublin figure. Some concentration of services in the city centre is needed as some people wish to avail of services outside their local area and 85% of those availing of services in the Dublin city centre clinics are from the local area' (Brendan Ryan, Drug Policy Unit, personal communication, July 2012).

The SRG report also acknowledged that these services play a major role in the provision of effective treatment to problematic drug users, but recommended that there should be greater access to prompt provision of treatment options nationally and that people should be treated and accommodated in the most appropriate setting for their circumstances and provided with support services as close to their home as possible. The report took a holistic approach to addressing the issues of the city centre, setting out its recommendations in the short, media and long term under the headings of treatment, rehabilitation, homelessness, policing responses, planning and urban design, legislation and regulation, and implementation.

Key recommendations of the report included the following:

- There should be greater access to and prompt provision of treatment options nationally. People should be treated and provided with support services as close to their home as possible. The treatment provided should be of the level of complexity required to meet their needs. This should ensure that people are only using services that are essential and appropriate to meet their needs and that are local to their place of residence. This should involve, where possible, a relocation of service provision for some people from the city centre area.
- Gardaí need to be given powers to deal with street dealing of prescription drugs so as to initiate prosecutions. The SRG supports the current proposals by Róisín Shortall TD, Minister of State at the Department of Health with special responsibility for the National Drugs Strategy, to update the Misuse of Drugs legislation in relation to benzodiazepines. Provisions should also be made for the scheduling of Z-Hypnotics (Zimmovane).
- Emergency accommodation should only ever be used in an 'emergency'. This is often not the case: owing to a lack of suitable long-term housing options, people often spend long periods in emergency accommodation. Private bed-and-breakfasts (B&Bs) are a form of emergency provision which is not regulated and is often not fit for purpose.
- To discourage street-drinking, to reduce harm and to offer safer alternatives, accommodation options should be offered where people who wish to consume alcohol can do so under regulated conditions.
- Enhanced public lighting is required to increase public perceptions of safety in particular locations
- The links between the North Inner City and South Inner City LDTFs need to be strengthened, including exploring the possibility of a LDTF Partnership Group to implement the recommendations in the SRG's report.

- Community-based residential crisis stabilisation/detoxification unit(s) need to be made available.

Treatment services in the city centre operate 'good neighbour' policies in order to address anti-social behaviour involving their clients that impacts on the neighbourhood. The policies in place in the two main low-threshold services in Dublin city to reduce drug-related public nuisance and open drug scenes are described below in Tables 12.3.1 and 12.3.2.

12.3.2 Interventions in recreational nightlife settings

This is a matter, in the first instance, for the Garda Síochána. However, specific Garda operations are put in place in relation to major events taking place both throughout the country and in Dublin (Brendan Ryan, Drug Policy Unit, personal information, July 2012).

12.3.3 Low threshold services for problem drug users

Drug-specific services are funded through the Health Service Executive (HSE) and LDTFs. In Dublin, needle exchange services and other low-threshold services are provided by both the HSE and voluntary organisations. Local authorities have an involvement in providing homeless shelters (Brendan Ryan, Drug Policy Unit, personal communication, July 2012).

The main low-threshold drop-in services in Dublin are provided by the Ana Liffey Drug Project and Merchants Quay Ireland (See Tables 12.3.1 and 12.3.2).

Table 12.3.1 Ana Liffey Drug Project: low-threshold services

Types of services offered	Description of the procedures in place to deal with inappropriate behaviour
Drop-in Key-working Case Management Medical Services Peer Support Group (Harm Reduction) Pre-entry Group (Preparing people for treatment and rehabilitation options) Family Support Assertive Outreach Adult Literacy and Communication skills Holistic Needle Syringe Programme Mountjoy Prison Programme	Ana Liffey has a proactive local neighbourhood policy, which ensures that it engages supports and advises its neighbours as appropriate. Interventions include regular outreach, removal of discarded drug paraphernalia where appropriate, monitoring of the surrounding area, promoting responsible behaviour within the area, one-to-one meetings with neighbours, attending neighbourhood forums and providing training to the staff of local businesses.

Source: (Strategic Response Group 2012)

Table 12.3.2 Merchants Quay Ireland: low-threshold services

Description of services	Description of the procedures in place to deal with inappropriate behaviour
Provision of needles, syringes, sterile water, citric acid and other equipment and materials aimed at reducing risks of infection and other drug related harm Provision of condoms and advice on safer sex to reduce risk of transmission of STDs and BBVs Referral to primary health care services Provision of safer injecting advice/workshops Referral to community based and residential drug treatment services Pre and post HIV /HCV test counselling CBT, MI and other brief counselling Interventions for clients with a range of issues	From 6.30 am, 2 staff would enable clients to access an off street queuing area, before the service opens at 7 a.m. To reduce loitering and friction with the public, Dublin Bus have relocated the bus stop. A CCTV system is installed to supervise the facility's vicinity. Should any issues appear, two staff will be dispatched to deal with the matter. If this fails to resolve the issue the Gardaí will be called. Streetlink team engages with Persons causing nuisance in the immediate vicinity whereby individuals would be asked to move on and offered referral to the appropriate services. The Streetlink Team will also engage with local community groups to apprise them of the service and to ensure their support. A mobile outreach unit makes daily tours of the immediate area outside the treatment centre. The particular "using places" or hot-spots are liable to change from day to day and local information and engagement is vital in this regard. The service will respond to a wide range of calls for assistance in relation to issues of drug users congregating, public drug use or discarded injecting equipment.

Source (Strategic Response Group 2012)

12.3.4 Responses to head/smart shops

The Criminal Justice (Psychoactive Substances) Act 2010 was implemented in response to the emergence of 'head shops' selling 'legal highs' (Irish Focal Point (Reitox) 2010) (Section 1.3) (Irish Focal Point (Reitox) 2011) (Section 1.3). Headshops emerged initially in Dublin and later throughout the country. However, most head shops were based in the capital city. The Act includes the following provisions:

- Section 3 provides for the offences of selling, importing and exporting psychoactive substances for human consumption. Section 3 (1) provides for the offence of selling a psychoactive substance, knowing or being reckless as to whether it is being acquired or supplied for human consumption.
- Section 4 creates the offence of selling an object, knowing that it will be used to cultivate by hydroponic means any plant in contravention of s17 of the Misuse of Drugs Act 1977. Hydroponic cultivation is the cultivation of plants in liquid containing nutrients, without soil, and under controlled conditions of light, temperature and humidity. This method of cultivation is known to be used for growing cannabis indoors.
- Section 5 provides for the offence of advertising a psychoactive substance or object to which Section 4 applies.
- Section 7 provides that a Garda Superintendent (or higher) may serve a prohibition notice on a person where he or she believes that the person is selling, importing or exporting psychoactive substances for human consumption, selling objects for use in cultivating by hydroponic means any plant.
- Section 20 provides that a person guilty of an offence under the Act is liable on summary conviction to a fine of up to €5,000 or imprisonment for up to 12 months or both, or on conviction on indictment to a fine or to imprisonment not exceeding five years or both.

Also, in relation to the 'legal highs' phenomenon, on 11 May 2010 the government made the Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order 2010 (S.I. 199 of 2010), declaring a range of 'legal highs' to be controlled drugs. Under these statutory provisions, approximately 200 individual 'legal high' substances, which had been on sale in 'head shops' and which included the vast majority of products of public health concern, were declared to be controlled drugs. They include broadly:

- synthetic cannabinoids (contained in SPICE products),
- benzylpiperazine (BZP) and piperazine derivatives (commonly known as 'party pills'),
- mephedrone, methylone, methedrone, butylone, flephedrone, MDPV (i.e. cathinones, often sold as baths salts or plant food), and

- Gamma butyrolactone (GBL) and 1,4 Butanediol.

In addition, the Declaration Order made under the Misuse of Drugs Act 1977 included ketamine and tapentadol, substances that have legitimate uses as medicines but which can be subject to misuse.

The introduction of the Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order 2010 and the enactment of the Criminal Justice (Psychoactive Substances) Act 2010 in August 2010 have had a clear impact on the 'head shop' and 'legal high' phenomena. A Garda inventory of 'head shops' in Ireland indicated that, at their peak in early 2010, there were 113 'head shops' in the country, with at least one in every county. On 11 May 2010, when the government banned a range of 'head shop' products, there were 102 shops, 11 having already closed for various reasons. By 13 May there were 34 'head shops' selling psychoactive substances. Following the enactment of the Criminal Justice (Psychoactive Substances) Act 2010, the gardaí visited head shops in early September 2010 and found only 19 open and none selling psychoactive substances (Garda Síochána, personal communication, 2010). Currently, it is reported that there are just three head shops in Ireland, all of which are located in the south and south-eastern regions of the country (Garda National Drugs Unit, personal communication, July 2012).

12.4 Current issues

12.4.1 Policy concerns

The CityWide Drugs Crisis Campaign, along with the Services, Industrial, Professional and Technical Trade Union (SIPTU), voluntary organisations, community drug services, church organisations, members of the artistic community and others, launched a new broad-based drugs alliance in 2012 to give a renewed impetus to the response to the drugs crisis in Ireland (CityWide Drugs Crisis Campaign 2012, 17 February).

CityWide also launched a policy statement for 2012 which highlights some of the policy concerns currently impacting on the city (CityWide Drugs Crisis Campaign 2012). The policy statement is based on a broad consultation with people living and working in communities most affected by drug problems. It highlights a number of current drug-related issues and sets out an eight-point agenda to address them. According to the statement, 'Polydrug use has replaced heroin as the key concern of communities. Polydrug use involves the consumption of a number of substances at the same time, most commonly alcohol, cannabis and prescription drugs but also psychoactive substances, other tablets, cocaine, heroin and methadone', the availability of which is facilitated by 'their easier access, online, by mobile phones and, in the case of alcohol, over the counter at ever decreasing prices' (p. 3).

Another issue identified by CityWide is what it sees as a weakening by the current NDS of the partnership between government and affected communities, an approach followed by successive Irish governments since the 1990s. Speaking in advance of the launch of the policy statement and in support of the new drug policy alliance, Fergus McCabe of CityWide said:

> Citywide and the communities we represent have always tried to cooperate with Government in the promotion and implementation of the national drugs strategy. But over the past few years this has become more and more difficult. Government are moving away from a partnership approach and this is undermining the delivery of the strategy. We are confident that our coming together as an alliance will help strengthen the voice of the NGO drug sector and will locate the drugs issue squarely back on the political agenda. (CityWide Drugs Crisis Campaign 2012, 17 February)

Another issue highlighted as a key current concern is on-street drug dealing and the impact of drug-related gang violence and intimidation in local communities (CityWide Drugs Crisis Campaign 2012). According to CityWide, 'Often related to drug debt, intimidation includes threatened and actual damage to property, physical assault and in some cases murder, against debtors and their families' (p.3). Fear of gang reprisals means that many of these incidents go unreported and therefore unchallenged by the authorities. A related issue is the grooming of vulnerable children and young people' to join gangs.

The CityWide policy statement concludes with the following eight-point proposed agenda for action (pp.4–5):

- make partnership work;
- improve protection, reporting and prosecution of debt intimidation;
- systematically tackle gang activity;
- support families, children and young people most at risk;
- build community resilience;
- strengthen information and harm reduction messages;
- direct 'profits' from problem drug use (i.e. funds seized by the Criminal Assets Bureau) Introduce a social responsibility levy (on drinks industry); and
- debate decriminalisation.

In calling for an 'open debate about decriminalisation in Ireland', CityWide states that 'much of the harm related to drug use and drug dealing occurs because of their illicit nature…. …the global war on drugs has failed and it is time for us to challenge rather than reinforce common misconceptions about drug markets, drug use and drug dependence' (p. 5).

In relation to the partnership structures underpinning the NDS, two major reviews of governance structures relevant to this selected issue are currently under way – one by Department of Environment, Community and Local Government on the integration of governance structures at local level, including city development boards which play a role in relation to drugs, and one by the Department of Health on the drugs task forces. See section 1.3.4 for more information.

Part C

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13.2 List of relevant databases available on internet

- Central Statistics Office interactive tables Census 1996, 2002, 2006 and 2011 www.cso.ie
- Hospital In-Patient Enquiry scheme data 2000–2010 www.esri.ie/health_information/hipe/
- National Drug Treatment Reporting System interactive tables 2004–2010 drugsandalcohol.ie

For descriptions of relevant databases not currently available on-line, see introductions to chapters 5, 6, and 7.

13.3 List of relevant internet addresses

http://aldp.ie
http://addictionireland.ie
http://www.citywide.ie
http://www.communityplatform.ie/
http://www.coolmine.ie/
http://www.crimestoppers.ie/
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http://drugsandalcohol.ie
http://www.environ.ie/en/
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http://www.hbsc.org/
http://www.hpsc.ie
http://www.hrb.ie
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http://inef.ie
http://iprt.ie
http://www.irishprisons.ie

http://www.justice.ie
http://www.mqi.ie
http://www.nacd.ie
http://www.nicdtf.ie/
http://nuigalway.ie/hbsc/
http://www.otc.ie/
http://www.poisons.ie
http://www.probation.ie
http://www.progressionroutes.ie/
http://www.quit.ie/
http://www.saolproject.ie/
http://www.sphe.ie/
http://www.socialinclusion.ie/
http://www.taoiseach.ie

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Communications (Retention of Data) Act 2011
Criminal Justice Act, 1951
Criminal Justice Act 1999
Criminal Justice Act 2006
Criminal Justice Act 2011
Criminal Justice (Amendment) Act 2009
Criminal Justice (Community Service) Act 2011
Criminal Justice (Drug Trafficking) Act 1996
Criminal Justice (Psychoactive Substances) Act 2010
Criminal Justice (Public Order) Act 1994
Criminal Justice (Public Order) Act 2011
Garda Síochána Act 2005
Housing (Miscellaneous Provisions) Act 2009
Intoxicating Liquor Act 2003
Intoxicating Liquor Act 2008
Misuse of Drugs 1977
Misuse of Drugs ACT 1984
Public Health (Tobacco) Act 2002
Public Health (Tobacco) Act 2004
Public Health (Tobacco) (Amendment) Act 2004
Public Health (Tobacco) Act 2009
Road Traffic Acts 1961 to 2002
Road Traffic Act 2011

Bills
Criminal Justice (Search Warrants) Bill 2012
Spent Convictions Bill 2012

14.6 List of abbreviations

ACAMH	Association for Child and Adolescent Mental Health
ADHD	Attention-Deficit Hyperactivity Disorder
ADRU	Alcohol and Drug Research Unit
AIDS	Acquired Immunodeficiency Syndrome
ALDP	Ana Liffey Drug Project
ARG	Audit Review Group
BAC	Blood Alcohol Concentration
BYAP	Ballymun Youth Action Project
BZP	Benzylpiperazine
CAB	Criminal Assets Bureau
CAMHS	Child and Adolescent Mental Health Service
CAN	Swedish Council for Information on Alcohol and Other Drugs
CANSAS-P	Camberwell Assessment of Need Short Appraisal Schedule – Patient-rated version
CAPE	Community Assessment of Psychic Experiences
CDLE	Customs Drug Law Enforcement
CDBs	City Development Boards
CE	Community Employment
CFSA	Child and Family Support Agency
CEEU	Central Expenditure Evaluation Unit
CLAN	College Lifestyle and Attitudinal National Survey
CLAR	areas of rural regeneration
CRC	capture-recapture
CSO	Central Statistics Office
CSOs	Civil society organisations
CTC	Coolmine Therapeutic Community
CTL	Central Treatment List
CWIUH	Coombe Women and Infants University Hospital

DAIRU	Drugs and Alcohol Information and Research Unit (DHSSPS, NI)
DAG	Drugs Advisory Group
DCEGA	Department of Community, Equality and Gaeltacht Affairs (since March 2010)
DCLBPF	Dublin City Local Business Policing Forum
DCYA	Department of Children and Youth Affairs
DECLG	Department of the Environment, Community and Local Government
DES	Department of Education and Skills (since March 2010)
DEHLG	Department of the Environment, Heritage and Local Government
DEIS	Delivering Equality of Opportunity in Schools
DEWF	Drug Education Workers Forum
DHSSPS	Department of Health, Social Services and Public Safety
DLM	Drug Liaison Midwife
DML	Dublin/Mid Leinster
DMR	Dublin Metropolitan Region
DNE	Dublin/North East
DoH	Department of Health
DoHC	Department of Health and Children
DPU	Drugs Programmes Unit
DSH	Deliberate Self Harm
DSFA	Department of Social and Family Affairs
DTC	Drug Treatment Court
DTCB	Drug Treatment Centre Board
DTF	Drugs Task Force
DUID	Driving Under the Influence of Drugs
EAPN-Ireland	European Anti-Poverty Network Ireland
EHOs	Environmental Health Officers
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and Other Drugs
ESRI	Economic and Social Research Institute
ETS	Environmental Tobacco Smoke
EU	European Union
FÁS	Foras Aiseanna Saothair (Training & Employment Authority)
FES	Family Environment Scale
FSL	Forensic Science Laboratory
FSA	Family Support Agency
FSN	Family Support Network
GBL	Gamma butyrolactone
GNDU	Garda National Drugs Unit
GP	General Practitioner
GRO	General Register Office
HADS	Hospital Anxiety and Depression Scale
HBSC	Health Behaviour in School-aged Children Survey
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HIPE	Hospital In-Patient Enquiry scheme
HPSC	Health Protection Surveillance Centre
HRB	Health Research Board
HSE	Health Service Executive
ICDRG	Independent Child Death Review Group
ICGP	Irish College of General Practitioners
IDO	Intentional Drug Overdose
IHRC	Irish Human Rights Commission
INEF	Irish Needle Exchange Forum
IPRT	Irish Penal Reform Trust
IPS	Irish Prison Service
JCFJ	Jesuit Centre for Faith and Justice
JPC	Joint Policing Committee

LDTF	Local Drugs Task Force
LGBT	Lesbian, Gay, Bisexual and Transgender
LRC	Law Reform Commission
LPF	Local Policing Fora
MAOC-N	Maritime Analysis and Operational Centre – Narcotics
MDA	Misuse of Drugs Act
MDT	Mandatory Drug Testing
MTP	Methadone Treatment Protocol
MQI	Merchants Quay Ireland
NACD	National Advisory Committee on Drugs
NAS	Neonatal Abstinence Syndrome
NEAR	Neuroscience and addiction recovery
NDS	National Drugs Strategy
NDRDI	National Drug-Related Deaths Index
NDRIC	National Drugs Rehabilitation Implementation Committee
NDRF	National Drugs Rehabilitation Framework
NDTRS	National Drug Treatment Reporting System
NPIC	National Poisons Information Centre
NPIRS	National Psychiatric Inpatient Reporting System
NPIS	National Poisons Information Service
NSP	National Service Plan (of the Health Service Executive)
OCO	Ombudsman for Children's Office
OFD	Oversight Forum on Drugs
OMCYA	Office of the Minister for Children and Youth Affairs
OMD	Office of the Minister for Drugs
OTC	Office of Tobacco Control
PDST	Professional Development Service for Teachers
PHIRB	Public Health Information and Research Branch
PQ	Parliamentary Question
PULSE	Police Using Leading Systems
QuADS	Quality Standards in Alcohol and Drugs Services
RAPID	Revitalising Areas by Planning Investment and Development
RDTF	Regional Drugs Task Force
ROSIE	Research Outcome Study in Ireland
SAOL	Service Provision for Women with Addiction Problems
SBCU	Special Baby Care Unit
SFP	Strengthening Families Programme
SIPTU	Services, Industrial, Professional and Technical Union
SLÁN	Survey of Lifestyle, Attitudes and Nutrition in Ireland
SPHE	Social, Personal and Health Education
SRG	Strategic Response Group
SSIS	Suicide Support and Information System
STI	Sexually Transmitted Infection
TCD	Trinity College Dublin
TD	Teachta Dála (Member of Parliament)
TDI	Treatment Demand Indicator
THC	Tetrahydrocannabinol
UISCE	Union for Improved Services, Communication and Education
UK	United Kingdom
VEC	Vocational Education Committee
WHO	World Health Organization
YPFSF	Young People's Facilities and Services Fund