



Ireland National Report 2001

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FOREWARD

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New material for this year's report is presented in italics, except where almost all the material is new i.e. Part 4 Key Issues.

Dr. Hamish Sinclair
Head of Division

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SUMMARY

Main trends and new developments

- In April 2001 the Irish Government approved the National Drugs Strategy 2001-2008. The new Strategy endorses the Irish Government's existing approach to tackling the drugs issue. The four 'pillars' of the new Strategy - supply reduction, prevention (including education and awareness), treatment (including rehabilitation and risk reduction), and research - focus on the same four issues as in the Government's previous Drugs Strategy.
- To sharpen the focus of the National Drugs Strategy 2001-2008 specific objectives and key performance indicators for each of the four pillars were specified. In addition, 100 individual actions to be taken across the full range of Departments and Agencies involved in the delivery of drugs policy have been developed. The actions are designed to address specific gaps in the current strategy, to strengthen each of the four pillars which underpin it and to ensure that the foregoing objectives are met thus driving the new strategy forward.
- According to the results of the second national survey of Drug-Related Knowledge, Attitudes and Beliefs in Ireland (commissioned by the Drug Misuse Research Division in 2000 and carried out as part of the 2000 Irish Social Omnibus Survey, unpublished) concern about the drug problem in Ireland remains high, especially regarding the threat to young people from the availability of illegal drugs. There is also growing concern regarding the availability of drugs in local neighbourhoods. Public support for harm reduction strategies (including availability of medically-subscribed heroin substitutes and the provision of syringes and needles free of charge) continues to increase.
- After alcohol and tobacco, cannabis is the most commonly used drug in the general population in Ireland, followed to a much lesser extent by amphetamine and ecstasy use.
- A main development is the stabilising and decreasing drug use among young people at school. The lifetime experience of cannabis use, in particular in the general population of young people in Ireland, is one of the highest in Europe, but recent results show a levelling off of use.
- Misuse of solvents among young people is relatively high at around one-fifth of the population.
- There is evidence of polydrug use from a number of sources – treatment data, information on intoxicated drivers, death statistics.
- A survey to investigate factors underlying international variations in youth drug use undertaken in five cities including Dublin, found that sporting activities by young people were linked with low rates of drug use.

- It is now recognised at official level that homeless young people are seriously at risk of becoming involved in drugs, prostitution and crime. As a result a strategy on youth homelessness has been drawn up.
- Services need to be developed for drug users in the prison setting that take account of the particular nature of the prison environment. They also need to address the needs both of those who continue to engage in drug use and the associated risk behaviours; and those who wish to cease their drug use while incarcerated.
- Studies indicate the need for more imaginative education initiatives in harm reduction interventions. Greater attention needs to be paid to the social context of injecting drug use and the sharing of injecting equipment. Outcomes of harm reduction interventions could be improved by exploring the perceptions surrounding unsafe injecting practices.
- Treatment demand monitoring, the most developed of the five key indicators of drug misuse in Ireland, has been adversely affected in 2000, mainly due to lack of commitment/priority given to data collection by drug treatment service providers.
- As a result of growing concern over the over-prescribing of benzodiazepines a Committee was established in 2000 by the Minister for Health and Children to explore the nature and extent of benzodiazepine prescribing in Ireland. This Committee will examine current trends and make recommendations on good prescribing practices, paying particular attention to the management of drug users. The Committee is due to make its report to the Minister at the end of 2001.
- There are more seizures of cannabis than any other drug in Ireland. However, in 2000 while the number of cannabis seizures increased, the quantity dropped very significantly. This may be due to a change in the nature of the cannabis market, which now seems to involve a larger distribution network trafficking in smaller amounts of the drug.
- Special studies need to be undertaken to explore issues, such as availability, sources of supply and trafficking patterns, involved in drug markets in Ireland.
- The emphasis on rehabilitation has received a more focused approach in recent years, particularly within the Eastern Regional Health Authority (ERHA) area. A 'blueprint' was drawn up in 2000 to guide the development of rehabilitation services within the remit of the ERHA. Central to the measures set out in the aforementioned blueprint, was the creation of "re-integration centres" in the three health board areas under the ERHA. It was proposed that these centres would provide a base for integration workers to support individual clients towards re-integration into mainstream social activity. In pursuit of this aim the centres would provide career guidance and counselling, personal skills development, and educational/training opportunities.

- Aftercare and reintegration progressively come to the fore as key areas of intervention in the drug field. For example, FAS the key statutory training agency in training people for employment offered a substantial number of 'special FAS training schemes' for former drug users seeking reintegration. In addition a number of community projects under the Local Drug Task Forces provided aftercare and reintegration services.
- Interventions aimed at reducing the harmful consequences of drug misuse were also key to the demand reduction field. In this regard the provision of needle exchange, an increase in outreach services and the placing of mobile clinics in areas badly affected by the drug issue have been some of the key developments during the year.
- A key recommendation included in the National Drugs Strategy 2001-08 is the creation of a number of Regional Drug Task Forces (RDTFs) in each of eleven regional health board areas. The RDTFs will consist of representatives from the statutory, voluntary and community sectors. It is anticipated that the RDTFs will be place by the end of 2001.
- Northside Partnership an area-based company working for the social inclusion of marginalised groups have developed a number of innovative initiatives that aim to assist ex-drug users in the process of re-integration. For example, The Labour Market Inclusive Project (LIP) provides work placements for ex-drug users that in some cases have led to longer-term employment.
- An emerging trend from the National Drug Treatment Reporting System (NDTRS) data shows employment among drug treatment contacts increasing from 14% in 1997, to 20% in 1998 with 26% roughly one in four treatment contacts reporting to be in 'gainful employment' in 1999.
- A Drug Court was established in January 2001 on a pilot basis in one area of Dublin City. The purpose of the court is to provide a scheme for rehabilitation of offenders who are before the court on drug offences of a minor nature. To date 44 offenders have been referred to the Drug Court, from this group 15 were either deemed unsuitable or failed to comply with the court's direction, the remainder are currently before the court.

Part 1

National and Local Policies & Legal Frameworks

1. Developments in Drug Policy and Responses

1.1 Political framework in the drug field – Hamish Sinclair and Brigid Pike

(a) Objectives and priorities of the national drug policy

In April 2000, the Cabinet Committee on Social Inclusion requested that a review of the current national drugs strategy be undertaken. The overall objective of the review was to identify any gaps or deficiencies in the existing strategy and to develop revised strategies and, if necessary, new arrangements through which to deliver them. A sub-group of the Inter-Departmental Group on Drugs and the National Drugs Strategy Team – known as the Review Group – managed and oversaw the process.

The review set out to identify the latest available data on the extent and nature of drug misuse in Ireland as a whole and attempt to identify any emerging trends and pinpoint the areas with the greatest levels of drug misuse. The review also involved extensive consultations through invited written submissions (189 received), discussions with key players in the state, voluntary and community sectors, and a series of eight public regional consultative fora (attended by approximately 600 people) held throughout the country during June 2000. In addition, a total of 34 agencies and organisations were invited to make detailed presentations to further assist in the identification of any gaps or deficiencies in the current strategy. To be as comprehensive as possible, the review also looked at international trends, developments and best practice models.

The resulting Report of the Review Group was adopted by the Government in April 2001 and the National Drugs Strategy 2001-2008 “Building on Experience” was launched in May 2001 (Department of Tourism, Sport and Recreation 2001).

The overall strategic objective of the National Drugs Strategy 2001-2008 is:

to significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment, and research

The new Strategy endorses the Irish Government's existing approach to tackling the drugs issue. The four 'pillars' of the new Strategy - supply reduction, prevention (including education and awareness), treatment (including rehabilitation and risk reduction), and research - focus on the same four issues as in the Government's previous Drugs Strategy.

The new National Drugs Strategy, however, seeks to strengthen the strategy

and sharpen its focus, by:

- *welcoming the Government's positioning of the National Drugs Strategy within the wider Social Inclusion policy and the strong commitment to areas of disadvantage in the NDP 2000 - 2006. The Review Team recognises that the best prospects for communities affected by the drugs problem, in the longer term, rest with a Social Inclusion strategy which delivers much improved living standards to areas of disadvantage throughout the country; and*
- *requiring all state agencies involved in delivering the National Drugs Strategy to specify annual targets in terms of outputs and desired outcomes for their respective programmes and initiatives.*

With these broad considerations in mind, the Strategy has identified seven overall aims:

- *to reduce the availability of illicit drugs;*
- *to promote throughout society a greater awareness, understanding and clarity of the dangers of misuse;*
- *to enable people with drug misuse problems to access treatment and other supports in order to re-integrate into society;*
- *to reduce the risk behaviour associated with drug misuse;*
- *to reduce the harm caused by drug misuse to individuals, families and communities;*
- *to have valid, timely and comparable data on the extent and nature of drug misuse in Ireland; and*
- *to strengthen existing partnerships in and with communities and build new partnerships to tackle the problem of drug misuse.*

To sharpen the focus, the National Drugs Strategy 2001-2008 specifies objectives and key performance indicators for each of the four pillars – supply reduction, prevention, treatment, and research. These are outlined below:

Supply Reduction

The objectives in relation to supply reduction are:

- *to significantly reduce the volume of illicit drugs available in Ireland, to arrest the dynamic of existing markets and to curtail new markets as they are identified; and*
- *to significantly reduce access to all drugs, particularly those drugs that*

cause most harm, amongst young people especially in those areas where misuse is most prevalent.

The key performance indicators in relation to supply reduction are:

- *increase the volume of opiates and all other drugs seized by 25% by end 2004 and by 50% by end 2008 (using 2000 seizures as a base);*
- *establish a co-ordinating framework in relation to drugs policy in each Garda District by end 2001; and*
- *increase the level of Garda resources in Local Drugs Task Force areas by end 2001, building on lessons emanating from the Community Policing Forum model;*
- *strengthen and consolidate existing coastal watch and other ports of entry measures designed to restrict the importation of illicit drugs;*
- *co-operate and collaborate fully, at every level, with law enforcement and intelligence agencies, in Europe and internationally, in reducing the amount of drugs coming into Ireland.*

Prevention

The objectives in relation to prevention are:

- *to create greater social awareness about the dangers and prevalence of drug misuse; and*
- *to equip young people and other vulnerable groups with the skills and supports necessary to make informed choices about their health, personal lives and social development.*

The key performance indicators in relation to prevention are:

- *bring drug misuse by school-goers to below the EU average and, as a first step, reduce the level of substance misuse reported to ESPAD by school-goers by 15% by 2003 and by 25% by 2007 (based on 1999 ESPAD levels as reported in 2001);*
- *develop and launch an ongoing National Awareness Campaign highlighting the dangers of drugs, the first stage to commence by end 2001;*
- *develop formal links at local, regional and national levels with the National Alcohol Policy, by end 2001 and ensure complementarity between the different measures being undertaken;*
- *publish and implement a policy statement specifically relating to education supports for Local Drugs Task Force areas, including an audit of the level*

of current supports, by end 2001;

- *nominate an official from the Department of Education and Science to serve as a member of each of the Local Drugs Task Forces by end 2001;*
- *prioritise Local Drugs Task Force areas during the establishment and expansion of the services of the National Educational Welfare Board;*
- *have comprehensive substance misuse prevention programmes in all schools and, as a first step, implement the “Walk Tall” and “On My Own Two Feet” Programmes in all schools in the Local Drugs Task Force areas during the academic year 2001/02;*
- *complete the evaluation of the “Walk Tall” and “On My Own Two Feet” Programmes by end 2002; and*
- *deliver the SPHE Programme (Social, Personal & Health Education) in all second level schools nation-wide by September 2003.*

Treatment

The objectives in relation to treatment are:

- *to encourage and enable those dependent on drugs to avail of treatment with the aim of reducing dependency and improving overall health and social well being, with the ultimate aim of leading a drug-free lifestyle; and*
- *to minimise the harm to those who continue to engage in drug-taking*
- *activities that put them at risk.*

The key performance indicators in relation to treatment are:

- *have immediate access for drug misusers to professional assessment and counselling by health board services, followed by commencement of treatment as deemed appropriate, not later than one month after assessment;*
- *have access for under-18s to treatment following the development of an appropriate protocol for dealing with this age group;*
- *increase the number of treatment places to 6,000 places by end 2001 and to a minimum of 6,500 places by end 2002;*
- *continue to implement the recommendations of the Steering Group on Prison-Based Drug Treatment Services as a priority and implement proposals designed to end heroin use in prisons during the period of the Strategy;*

- *have in place, in each Health Board area, a service user charter by end 2002;*
- *have in place, in each Health Board area, a range of treatment and rehabilitation options as part of a planned programme of progression for each drug misuser, by end 2002; and*
- *provide stabilised drug misusers with training and employment opportunities and, as a first step, increase the number of such opportunities by 30% by end 2004.*

Research

The objectives in relation to research are:

- *to have available valid, timely and comparable data on the extent of drug misuse amongst the Irish population and specifically amongst all marginalised groups; and*
- *to gain a greater understanding of the factors which contribute to Irish people, particularly young people, misusing drugs.*

The key performance indicators in relation to research are:

- *eliminate all major research gaps in drug research by end 2003; and*
- *publish an annual report on the nature and extent of the drug problem in Ireland and on progress being made in achieving the objectives set out in the Strategy.*

Although not designated one of the 'pillars' of the National Drugs Strategy, key performance indicators relating to the establishment of an efficient and effective framework for implementing and evaluating the Strategy are identified. They include establishing an effective regional framework to support the measures; completing an independent evaluation of the effectiveness of the overall framework; requiring each agency to prepare a critical implementation path for each of the actions listed in the Strategy that are relevant to their remit; and reviewing the membership, workload and supports required by the National Drugs Strategy Team to carry out its terms of reference.

Apart from specifying objectives and key performance indicators the Review Group also recommended 100 individual actions to be taken across the full range of Departments and Agencies involved in the delivery of drugs policy. The actions are designed to address specific gaps in the current strategy, to strengthen each of the four pillars which underpin it and to ensure that the foregoing objectives are met thus driving the new strategy forward. Their implementation will be overseen by the Inter-Departmental Group on Drugs in consultation with the National Drugs Strategy Team. Six monthly progress reports will be made to the Cabinet Committee on Social Inclusion.

(b) Basic elements of drug policy at national, regional, local level

At national level, the policy and co-ordination tasks in relation to the drugs issue overlap with the mechanisms to promote Social Inclusion in general in Ireland. Foremost among these mechanisms is the Cabinet Committee on Social Inclusion, which gives political direction to the Government's Social Inclusion policies, including the National Drugs Strategy. Chaired by the Taoiseach, this committee receives input on the drugs issue from the Department of Tourism, Sport and Recreation, the Inter-Departmental Group on Drugs (IDG) and the National Drugs Strategy Team (NDST).

The Department of Tourism, Sport and Recreation has responsibility for the overall co-ordination of national policy to tackle drug misuse, including implementation of the National Drugs Strategy 2001-2008. The Department works in partnership with government departments, state agencies and the community and voluntary sectors, through the IDG and NDST. The Department's co-ordinating responsibilities also include the establishment of an evaluation framework for the National Drugs Strategy. The Department of Tourism, Sport and Recreation also has responsibility for local development, and the implementation of the Integrated Services Process (ISP). The aims of the ISP include the development of a more focused and better co-ordinated response by the statutory authorities to the needs of communities with the greatest levels of disadvantage. The ISP is aimed at developing an integrated framework within which ongoing programmes can be rationalised and enriched to do a better job of making services available to communities.

In early 2001 the Government launched the RAPID (Revitalising Areas by Planning, Investment and Development) Programme, under the aegis of the Department of Tourism, Sport and Recreation. RAPID is a focused initiative by the Government targeting the twenty-five most concentrated areas of disadvantage in the country. The targeted areas will be prioritised for investment and development in relation to health, education, housing, childcare and community facilities including sports facilities, youth development, employment, drug misuse and policing. The programme is based on ISP principles, involving an implementation team (comprising state agency personnel, the local Area Partnership and residents of the local community) and a co-ordinator. Under the National Development Plan, up to Ir£15 billion / E19.5 billion has been earmarked for Social Inclusion measures, and the RAPID programme will prioritise the twenty-five targeted areas and front-load a significant share of this money to them over the next three years.

The Department also has continuing responsibility for providing accessible, positive alternatives to drug misuse through the YPFSS, through arts and culture youth programmes, the schemes run by the Irish Sports Council and the facilities provided under the Sports Capital Programme. The National Drugs Strategy 2001-2008 states that LDTF areas should be prioritised and specific efforts made to ensure that the groups who are most at risk of drug misuse are actively engaged in recreational activities at local level.

The National Drugs Strategy Review Group noted that, in other countries, responsibility for co-ordinating drugs strategies usually resides either in the Department of the Prime Minister or the Department of Health. While the advantages of both these options were acknowledged (in terms of political authority, budget size and service-provision experience), the Review Group recommended retaining the responsibility in Tourism, Sport and Recreation. The Team considered that the Department of Tourism, Sport and Recreation can be objective in relation to all the thematic areas covered by the national policy. Moreover, given this Department's role in local development and co-ordination of a number of different programmes relating to Social Inclusion, and given the correlation between drug misuse and social exclusion, it was considered that it was strategically well placed to take the lead role in co-ordination. In other words, it can bring a holistic and integrated approach to the drugs issue.

The Inter-Departmental Group on Drugs (IDG) plays a key role on overseeing the implementation of the National Drugs Strategy. Strengthened under the National Drugs Strategy 2001-2008 to comprise senior level representatives from government departments, and the chair of the NDST, and to be chaired by the Minister of State at the Department of Tourism, Sport and Recreation, the IDG, inter alia, will advise the Cabinet Committee on Social Inclusion on critical matters of a public policy nature relating to the National Drugs Strategy; ensure timely and effective input by relevant Departments and agencies into emerging operational difficulties or conflicts; and approve the plans and initiatives of the LDTFs and the proposed Regional Drugs Task Forces - RDTFs, and monitor and evaluate the outcomes of their implementation, in conjunction with the NDST. By the end of 2001, the IDG, in conjunction with the NDST, is to develop formal links at local, regional and national levels with the National Alcohol Policy, to ensure complementarities between the different measures being undertaken.

The National Drugs Strategy Team (NDST) includes representatives from relevant government departments and agencies, and also two non-government representatives, one each from the community and the voluntary sectors, making the NDST a partnership between the statutory, community and voluntary sectors. Members of the NDST play a central role in overseeing the implementation of the Government's National Drugs Strategy by ensuring, inter alia, effective co-ordination between departments, agencies and the community and voluntary sectors, in delivering LDTF and the proposed RDTF plans; reviewing the need for LDTFs in disadvantaged urban areas (particularly having regard to evidence of localised heroin misuse); identifying and considering policy issues and ensuring that policy is informed by the work of and lessons from the LDTFs; overseeing the establishment of the proposed RDTFs; drawing up guidelines for the operation of, and evaluating the action plans of, LDTFs and RDTFs. The NDST has joint monthly meetings with the IDG, and they jointly report to the Cabinet Committee on Social Inclusion every six months.

The National Drugs Strategy 2001-2008 identifies the need for an Oireachtas Committee on Drugs. The Strategy includes an action to establish a dedicated

drugs sub-committee of the existing Select Committee on Tourism, Sport and Recreation. This Oireachtas committee would meet at least three times a year.

A number of government departments and agencies play lead roles in developing and implementing policy to tackle the drugs issue in Ireland. Their roles and responsibilities are outlined under the four pillars - supply reduction, prevention, treatment, and research.

Supply Reduction

Department of Justice, Equality and Law Reform

The Department of Justice, Equality and Law Reform has overall responsibility for policy and legislation relating to the reduction of the supply of drugs. In recent years Ireland has put in place one of the strongest legislative frameworks in Europe for countering drugs. Key pieces of legislation include the Criminal Justice Act 1994, the Criminal Justice (Drug Trafficking) Acts 1996 and 1999, the Criminal Assets Bureau Act 1996, and the Proceeds of Crime Act 1996.

The National Drugs Strategy 2001-2008 tasks the Department with overseeing the establishment of a framework to monitor the number of successful prosecutions, arrests and the nature of the sentences passed; establishing, after consultation, best-practice guidelines and approaches for community involvement in supply control activities with the law enforcement agencies; reviewing the ongoing effectiveness of crime legislation in tackling drug-related activity; and working with regional health boards in considering how best to integrate child-care facilities in treatment and rehabilitation centers and in residential treatment settings.

An Garda Síochána

An Garda Síochána has responsibility for the State security services and all traffic and criminal law enforcement functions, including those laws related to drug offences. Special units have been integrated into the organizational structure of An Garda Síochána in an effort to address the drugs issue. In each of the country's twenty-seven Garda Divisions, there is a specialised Drug Unit, which has responsibility for the enforcement of drugs legislation. There may also be a Drug Unit in a District where drugs present particular problems.

The Garda National Drugs Unit (GNDU) was established in 1995 with specific responsibility for drug law enforcement. The primary focus of the GNDU is to target major drug traffickers, as well as monitoring, controlling and evaluating all drug intelligence and policies within the force. As part of its focus on the national and international aspects of drug trafficking, the GNDU maintains close liaison with police forces from other jurisdictions, through various police networks and operational exchange programmes (An Garda Síochána, 1999). In 1996 the Criminal Assets Bureau was set up as an inter-agency response,

including An Garda Síochána, the Office of the Revenue Commissioners and the Department of Social, Community and Family Affairs, to target the proceeds of crime, especially drug trafficking. At a community level Community Policing Fora have been established on a pilot basis in several LDTF areas. The Garda have also been instrumental in implementing a number of operations addressing supply reduction, including Cleanstreet, Nightcap, Rectify, Tap and Dóchas. Under the National Drugs Strategy 2001-2008 it is intended to extend, and enhance the efficiency of, all the above initiatives - adding resources to existing drug units, and establishing drug units in areas where they don't exist; establishing a co-ordinating framework for drugs policy in each Garda District to liaise with the community and act as a source of information for parents and members of the public; increasing the level of Garda resources in LDTF areas, building on the lessons learned from the Community Policing Fora, and extending the Community Policing Forum model to all LDTF areas, if the evaluation of the pilot is positive.

Office of the Revenue Commissioners

The Office of the Revenue Commissioners includes the Customs and Excise Service. Customs have primary responsibility for the prevention, detection, interception and seizure of controlled drugs, intended to be smuggled or imported illegally into the State.

In 1992 a Customs National Drugs Team was established, with the principal role of directing the work of Customs on the prevention of drugs smuggling and the enforcement of legislative provisions regarding the import and export of controlled drugs and other substances. The Team's units are strategically located around the coast of Ireland in an effort to prevent drug trafficking.

In 1996 a Memorandum of Understanding was agreed between Customs and Excise and An Garda Síochána regarding drugs law enforcement. As a result, a joint task force comprising Customs, Garda and the Naval Service was established, and personnel are exchanged at national level, and liaise at local level. Customs also liaise with the Garda National Drugs Unit and the Criminal Assets Bureau. Customs have also entered into agreements with trade associations and individual companies regarding detection of illegal drug smuggling, and developed a Coastal Watch Programme, which enlists the help of coastal communities and seagoing personnel in reporting suspicious activities. At an international level, the customs services of all EU member states are linked electronically to facilitate quick and effective exchanges of information. A Customs official has been assigned to the Irish Embassy in London, and appointments are to be made to Europol in The Hague.

Under the National Drugs Strategy 2001-2008, these initiatives are to be strengthened and consolidated. Close liaison and collaboration, both nationally and in conjunction with enforcement and intelligence agencies in Europe, are to be developed; coastal watch and other port-of-entry measures to restrict importation of illicit drugs are to be strengthened; and a Customs official is to be assigned to the Europol National Unit. The Customs and Excise Service is also to develop benchmarks, in conjunction with the Gardaí,

against which seizures of heroin and other drugs can be evaluated under the EU Action Plan on Drugs (Commission of the European Communities, 1999), in order to establish progress on a yearly basis.

Prisons Service

The Prisons Service has responsibility for the provision and maintenance of a secure, efficient and progressive system of containment and rehabilitation for offenders committed to custody. This role is undertaken in a co-operative and co-ordinated way with prisoners, their families, the community, other Government Departments and statutory agencies. However, serious capacity problems have, in the past, led to overcrowding, particularly in Mountjoy prison, which was, until recently, the main committal prison in the State. This severely undermined the development of prison-based treatment services in the past. However, the current prison building programme will alleviate this situation and will, accordingly, facilitate the on-going development of these services. In the past year, two new prisons have come on stream, Cloverhill Prison in Clondalkin and the Midlands Prison in Portlaoise. In addition, extensive redevelopment work is planned for Cork, Limerick and Mountjoy prisons. In this regard, approx. 1,000 extra prison places have been provided and 1,000 more are planned.

Department of the Environment and Local Government

Under the 1997 Housing Act, the Department of the Environment and Local Government provides financial support to local authorities for housing management activities and other initiatives, on local authority estates, which are associated with problems of drug-related crime and anti-social behaviour.

Prevention

Department of Education and Science

The Department of Education and Science plays a role in relation to prevention, operating mainly through the formal education system. Its initiatives to combat drug use, such as 'Walk Tall' for primary level and 'On My Own Two Feet' for secondary level, and more recently the Social, Personal and Health Education (SPHE) programme, are linked to its overall package of measures to combat educational disadvantage. The National Drugs Strategy 2001-2008 stipulates that the Department is to ensure that every second-level school is to have an active programme to counter early school-leaving, with particular focus on areas with high levels of drug misuse.

In the non-formal education sector, the Department of Education and Science works closely with FÁS on joint-funded initiatives such as Youthreach, and in the running of workshops aimed at increasing drug awareness in areas where acute drug problems are apparent. In relation to LDTFs, the role of the Department of Education is to be strengthened under the National Drugs Strategy 2001-2008. The Department is to publish and implement a policy statement on education supports in LDTFs, including an audit of current

supports, by the end of 2001, and to nominate a departmental official to serve on each LDTF.

Department of Health and Children

The Department of Health and Children also places considerable emphasis on the need for education and prevention. The National Health Promotion Strategy, approved by the Government in 2000, has a strategic aim “to endeavour to reduce the numbers engaging in drug misuse”. The Health Promotion Unit (HPU) promotes a multi-faceted approach to drug awareness, education and prevention. A range of activities are supported, for example:

- *life-skills programmes;*
- *award programmes for schools;*
- *initiatives in the youth service;*
- *the dissemination of resource material;*
- *and local campaigns in ERHA areas.*

The HPU also formulates preventative policies. However, the implementation of these policies on the ground is very much a matter for the regional Health Boards, as the Department’s role – at the policy level – has been to monitor and oversee implementation and to provide resources. The Department situates its policy responses in the context of UN efforts to combat drugs through establishing targets to be achieved by 2008.

An Garda Síochána

The Gardaí are also active in prevention, particularly in relation to young people involved in, or at risk of becoming involved in, drugs and crime. Initiatives include the Garda Youth Diversion Projects, generally managed by Foróige and/or the City of Dublin Youth Service Board; the Drug Awareness Programme for communities; Garda Schools Programmes; the Garda Mobile Anti-Drugs Unit; and the Juvenile Diversion Project. Garda Juvenile Liaison Officers are also assigned throughout the country. The National Drugs Strategy 2001-2008 identifies an opportunity for enhanced co-ordination, whereby incidences of early use of alcohol or drugs by young people coming to Garda attention are followed up by the Community Police and/or the health and social services, so that problem-drug misuse may be diagnosed/halted early on.

Young People's Facilities and Services Fund

In 1998, the Young People's Facilities and Services Fund (YPFSS) was set up to develop youth facilities, including sport and recreational facilities, and services in disadvantaged areas where a significant drug problem exists or has the potential to develop. The primary focus of the Fund is on LDTF areas and selected urban areas (i.e. Galway, Limerick, South Cork City, Waterford and Carlow) where a serious drug problem exists or has the potential to develop. A sum of £102 million has been provided under the National Development Plan (2000 – 2006) to support measures under the Fund, of

which approx. £46 million has been allocated to date in the first round of funding.

In establishing the Fund, the Cabinet Committee set up a National Assessment Committee to (i) prepare guidelines for the development of integrated plans in the target areas, which meet the overall aims and objectives of the Fund; (ii) facilitate the establishment of the local structures charged with developing plans; (iii) assess the plans emanating from each of the target areas and (iv) make recommendations on funding to the Cabinet Committee on Social Inclusion. The National Assessment Committee is responsible for monitoring on-going progress in implementing the plans and strategies approved and addressing any difficulties or issues arising. It is also overseeing an external evaluation of the Fund, in conjunction with the Department of Education and Science, which will provide a comprehensive and independent assessment of the Fund, taking account of its overall aims and objectives. The evaluation of the Fund commenced in April 2001.

Local Drug Task Forces

The Local Drug Task Forces (LDTFs), in the context of implementing their Action Plans, are delivering a range of measures in the education, prevention and awareness areas. Initiatives include community-based drug awareness programmes in schools, youth clubs and other places where young people congregate; drug awareness programmes for parents, teachers etc; peer education programmes and projects to prevent early school-leaving.

Treatment

Department of Health and Children

The Department of Health and Children has overall policy and legislative responsibility for health, social services and child welfare in Ireland, as well as various responsibilities for aspects of drug policy, principally treatment and rehabilitation services. In developing its policy on drug misuse, the Department has adopted a health promotion approach. The Department's national policy on the treatment of alcohol and drug misuse stresses the need for community based interventions rather than specialist in-patient approaches. These services include family support and community medical and social services.

Responsibility for the provision of treatment and rehabilitation services for drug misusers is vested with the ten Regional Health Boards. The Health Boards also provide support and training for community groups which are involved in drug - related prevention or rehabilitation activities, as both the community and voluntary sectors play a significant part in the provision of drug related services, especially in the LDTF areas. The Health Boards have appointed Regional Drug Co-ordinators and many have also established Regional Drug Co-ordinating Committees comprising representatives of the relevant Health Board, An Garda Síochána, Education Services and the community and voluntary sectors. There is regular contact between the NDST

and the Regional Drug Co-ordinators.

Growth in drug-related problems throughout the country has resulted in the need for many of the Health Boards to formulate a specific drug strategy for their region. This is especially the case in the area of development of services, which are local and tailored to the needs of particular communities. The majority of these strategies are being developed at present in accordance with emerging trends which are specific to the individual regions. Perhaps not surprisingly, the emphasis in many Health Boards outside of the Eastern region has been on education and prevention initiatives. However, because of the nature of the drug problem in the Eastern catchment area, the Eastern Regional Health Authority (ERHA) has been involved in a significant degree of activity and expansion of treatment services within its area. The expansion of services in the ERHA area has been a priority in order to protect the health of misusers themselves, to prevent the spread of infectious diseases and to reduce the effect of chaotic behaviour on certain neighbourhoods.

Prison Service

In October 2000, the Government approved in principle the implementation of the recommendations contained in the Report on Prison-Based Drug Treatment Services which was produced by a Steering Group, established by the Director General of the Prison Service. These proposals will result in a major overhaul of prison-based drug treatment services and should make a major contribution to breaking the cycle of drug dependency, crime and imprisonment which are inextricably linked at present. Perhaps the main conclusion of the report is that the Prisons Service must replicate in prison, the level of medical and other supports available in the community for drug dependent people, to the maximum extent possible.

In addition, the report proposes a multi-disciplinary approach to the drug problem in prisons and the appointment of a senior figure from the ERHA to co-ordinate the overall treatment service in the Dublin prisons, as well as drugs counsellors and extra nurses, psychologists and probation service staff. All staff in the relevant institutions will receive training in drugs-related issues and refresher courses every year thereafter. Links are also being established with local community and voluntary groups, through liaison committees, to enhance the throughcare and aftercare arrangements for prisoners in receipt of drug treatments in custody. Implementation of the recommendations of the report are progressing at present.

Probation and Welfare Service

The Probation and Welfare Service, although not a primary drug treatment agency, co-ordinates a range of drug treatment initiatives, in co-operation with a number of rehabilitation agencies and the community.

Drug Court

A Drug Court was established in January 2001 in the North Inner City of

Dublin. It has as its primary aim “the reduction of crime through rehabilitation of the offender but not excluding punishment should the circumstances so warrant”. Rehabilitation and structured supervision will be used to help participants to escape the cycle of offending with the ultimate objective of ending all criminal activity. It is hoped that best practice will be identified to allow for expansion, as appropriate.

FÁS

FÁS, the state training agency, operates specific drug-related programmes, including the Special Drugs Community Employment Programme, on which 1,000 places have been assigned for recovering drug misusers. Trained staff are available to work with stabilised drug misusers, to help them access employment or further training. Similarly, advocates, located in severely disadvantaged areas, provide a mentoring service to young people experiencing drug problems.

Acknowledging that the FÁS Community Employment Programme has been an important element of the existing approach to rehabilitation, the National Drugs Strategy 2001-2008 sets a target for increasing the number of training and employment opportunities for drug misusers by 30 per cent by the end of 2004. The Strategy also identifies the need to examine the potential to involve recovering drug misusers in Social Economy projects, and in other forms of vocational training.

Department of the Environment and Local Government

Special high support hostel accommodation is necessary for homeless people with drug dependence problems. Under the Homeless Strategy, funding has been provided by the Government for the provision of two high support hostels in Dublin for people with drug and alcohol dependence problems. In view of the number of people with such problems in Dublin, Dublin Corporation and the ERHA are taking the lead role in drawing up and implementing suitable proposals.

Voluntary Drug Treatment Network

The Voluntary Drug Treatment Network provides a framework for a number of voluntary drug groups working in the area of treatment to meet, share issues of concern and develop more comprehensive responses to the prevention and treatment of problem drug use. The Network is an umbrella group that aims to challenge drug misuse and related issues in a creative, caring and motivational way. It provides a comprehensive range of drug treatment methods that range from harm reduction intervention through to long-term residential drug-free programmes. There are two core strands to the composition of the Network. These are localized community-based treatment responses, that have emerged from local residents and individuals seeking to respond to issues in their areas and regional responses that provide treatment at national and, occasionally, at EU level.

The Network has representatives on the National Aids Strategy Committee, the NDST and the National Advisory Committee on Drugs (NACD). They are also members of the Community Platform that forms part of the Community and Voluntary Pillar of the Social Partnership. However, the Network itself does not have a national remit to represent all the voluntary drug treatment organizations in the country. It is primarily for the Dublin based organisations which deal with drug misuse but some of its members do have a national focus in terms of treatment and training. The Network engages with various Government Departments and Regional Health Boards who assist in the funding of its services.

Research

Drug Misuse Research Division

The Drug Misuse Research Division (DMRD) of the Health Research Board was established in 1989 and is responsible for operating the National Drug Treatment Reporting System (NDTRS) which is the main source of information on drug misuse in Ireland. The NDTRS is an epidemiological database, which provides data on people who avail of treatment services for problem drug use, on a nationwide basis. This provides information on the current patterns and trends of treated drug use and drug addiction in Ireland. Data is provided to the NDTRS through centers or service locations where drug misuse is treated.

The Government has designated the DMRD as the central point to which all research data and information should be channelled. In order to deliver on the role assigned to it, the DMRD is developing a National Documentation Centre which policy-makers and other interested parties can use to access all relevant and up-to-date information and research in the field of drug misuse in Ireland and internationally. In addition to existing data, all future research and information will be channelled or, as appropriate, its existence notified and recorded in a way which facilitates ease of retrieval by policy-makers and other interested parties. The Documentation Centre will build on the existing resources of the DMRD and will capitalise on its position as the National Focal Point for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

National Advisory Committee on Drugs

The National Advisory Committee on Drugs (NACD) was established in July 2000 to advise the Government in relation to the prevalence, prevention, treatment and consequences of problem drug use in Ireland, based on the Committee's analysis and interpretation of research findings and information available to it. The Committee is overseeing the delivery of a three year prioritised programme of research and evaluation on the extent, nature, causes and effects of drug misuse in Ireland, identifying the contribution which can be made by all the relevant interests. Its membership reflects statutory, community, voluntary, academic and research interests as well as representation from the relevant Government Departments. The Committee

operates under the aegis of the Department of Tourism, Sport and Recreation.

Health Promotion Unit of the Department of Health and Children

The Health Promotion Unit (HPU) of the Department of Health and Children is also involved in the publication and dissemination of information and literature which promotes the avoidance of drug misuse. In this regard, the National Health Promotion Strategy sets clear aims and objectives to support best practice models which promote the non-use of drugs and, where they are used, the minimisation of the harm done by them.

Conclusion

Ireland's National Drugs Strategy 2001-2008 has been developed in the context of various international and EU agreements, for example the Political Declaration on the Guiding Principles of Drugs Demand Reduction (UN Special Session on Drugs, held in New York, 1998)¹, the UN Conventions on Narcotic Drugs and Psychotropic Substances², the EU Action Plan on Drugs 2000 – 2004 (Commission of the European Communities, 1999), and the EU Drugs Strategy 2000 - 2004 (CORDROGUE 64, 1999). Development of the strategy has also involved extensive consultation, including public fora in a number of centers throughout the country.

The main changes and new directions in Irish drugs policy, strategies, implementation and evaluation can be summarised as follows:

- *publication of a major review of the National Drugs Strategy;*
- *adoption of the promotion of Social Inclusion as one of the priorities of the National Development Plan 2000-2006, and the situation of the drugs issue within this context;*
- *adoption of National Drugs Strategy for 2001-2008;*
- *greater devolution of power to regional structures, with which existing structures in the drugs area will co-operate;*
- *continued adoption of an integrated, inter-agency response to the drugs problem involving local communities;*
- *continued involvement of local communities in the development and implementation of drugs policy;*
- *increasing role of voluntary and community sectors;*
- *continued development of a culture of evaluation and increased resources of knowledge infrastructure to support same; and*
- *development of drug-related research and information capability.*

¹ At a UN Special Session on Drugs, held in New York in 1998, a Political Declaration on the Guiding Principles of Drug Demand Reduction was adopted. It put an onus on every member state to have in place a comprehensive drugs policy and an outline of how targets are to be achieved over the period 2000 to 2008.

² Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol Amending the Single Convention on Narcotic Drugs, 1961; the Convention on Psychotropic Substances, 1971; and the UN Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988. The conventions may be accessed through the website - www.incb.org/e/conv/

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

a) Law and regulations

Recent changes in legislation

Responsibility for the making of laws for the Republic of Ireland is vested in the Oireachtas (Parliament) subject to the obligations of European Union Membership as provided in the Constitution of Ireland. The Oireachtas consists of the President and two Houses, Dáil Eireann (House of Representatives) and Seanad Eireann (Senate). The Irish Statute Book³ is made up of Acts of the Oireachtas and Statutory Instruments (S.I.).

The legislation is drawn up by relevant government departments: Health & Children; Justice, Equality & Law Reform; and Environment and Local Government. It is implemented by An Garda Síochána (the Irish Police Force), the Revenue Commissioners and Customs authorities.

The Misuse of Drugs Acts 1977 and 1984 are the two central pieces of legislation under which the majority of prosecutions in relation to drug misusers are made. A brief description of these Acts and the relevant listing of Regulations can be found at Appendix 1. These Acts provide for a wide range of controls over drugs, which are liable to be misused. They include controls relating to cultivation, licensing, administration, supply, record keeping, prescription writing, destruction and safe custody. These laws also include provisions designed to deal with the irresponsible prescribing of controlled drugs by medical practitioners.

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

The Housing (Traveller Accommodation) Act, 1998, which is the legislative framework within which housing authorities provide for the accommodation needs of Travellers, is a key element in the Government's efforts to promote social inclusion and equality and to counter discrimination. This law applies

³ Electronic versions of the Irish Statute Book (*Acts of the Oireachtas and Statutory Instruments*) 1922-1998 may be viewed at the website of the Attorney General's Office www.irlgov.ie/ag/default.htm. Hard copies may be purchased from the Government Publications Sales Office, Sun Alliance House, Molesworth Street, Dublin 2.

relevant sections of the Housing (Miscellaneous Provisions) Act, 1997 in respect of the control of anti-social behaviour, such as drug dealing, to halting sites provided by local authorities or by voluntary bodies.

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

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

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

An order has been drafted (Misuse of Drugs Act, 1977 (Controlled Drugs) (Declaration) Order, 1999) to extend the list of substances controlled under the Misuse of Drugs Acts. The need to do this arose out of Ireland's obligations under the United Nations Conventions on Narcotic Drugs, Psychotropic Substances and Precursor Chemicals⁴, but also because of concerns about the abuse of amphetamine-type substances, and the use of certain drugs in sport. The drugs to be controlled include substances associated with ecstasy misuse (4-MTA, ketamine, ephedrine and pseudoephedrine), as well as a number of substances which are on the current International Olympics Committee list of prohibited substances in an effort to prevent doping in sport. This order is due to be brought into force before the end of 2001.

Health and social drug-related issues

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

⁴ The conventions may be accessed through the website – www.incb.org/e/conv/.

with the aim of providing healthcare and preventing HIV, to reach the women. This has serious implications for public health policy. The authors of the study recommend that a review of the current legislation be undertaken as soon as possible.

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

Other aspects of drug legislation were criticised at the public National Forum on Crime held in 1999. One such issue, is the provision under the Criminal Justice (Drug Trafficking) Act, 1996, which allows the police to detain a person accused of drug trafficking for a period of seven days. Some contributors to the Forum considered that this provision could prove to be counterproductive, resulting in more convictions of drug users and small-time dealers rather than curbing the activities of large-scale drug traffickers. Another was the then proposal (now law - Criminal Justice Act, 1999) to provide for a new drug offence related to the possession of drugs, with a value of IR£10,000 or more, for the purpose of sale or supply, and for a mandatory minimum sentence of ten years in prison. It was criticised 'both on grounds of principle relating to mandatory sentences generally and because of the difficulty of establishing the actual value of a seizure' (National Crime Forum Report 1998, p. 72).

Barry (2000) in a discussion paper writes that the supply of drugs and the legal framework in which drug policy is formulated in Ireland require examination. He poses the question as to what the benefits and disadvantages of current drug laws are to the health of the population. He suggests that posing such questions usually meets a blanket response of no softening of the laws on drugs. He also comments that there does not seem to be an acknowledgement of the fact that there is not necessarily a link

between whether something is legal, and whether it is good or not good for one. He proposes that the time is right to have an honest debate on the current legislative basis of drug policy in Ireland; and though such a debate may not be welcomed, he posits that it is necessary.

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

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

Sections 3 and 15 of the Misuse Drugs Act, 1997, are the sections most frequently used in drug prosecutions. Section 3 covers the possession of any controlled drug, and Section 15 concerns trafficking of controlled substances. The use per se of a drug, other than opium, is not a criminal offence.

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

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

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

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

While the legislative framework requiring an individual to undergo treatment for drug addiction as a non-custodial option in sentencing exists, in practice it

is rarely used by the courts. A Drug Courts system, initially on a pilot basis in Dublin, under the jurisdiction of the District Court, was established in January 2001. These courts are treatment oriented, where people with a drug problem and who are charged with non-violent offences, are diverted to treatment programmes rather than to prison. This development is likely to have major implications for treatment services and the success of the initiative will depend on the formulation and implementation of cohesive treatment and rehabilitation programmes.

The Medical Bureau of Road Safety at the Department of Forensic Medicine, National University of Ireland, Dublin, in collaboration with the Garda Síochána (police) has undertaken a study to examine the level and type of drug use among drivers and its contribution to accidents. All samples submitted between 1 July and 31 December 1999, which were under the legal limit for alcohol, were tested. Preliminary results from 338 samples showed that cannabis was most frequently found (34%), followed by benzodiazepines (25%). Cocaine was the drug least commonly found at 4% of the sample (Moane et al. 2000).

1.3 Developments in public attitudes and debates – Hamish Sinclair and Brigid Pike

a) Public perceptions of the drug issues and public debates carried out by civil society, national Parliament, organizations, NGO's

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

A second national survey of Drug-Related Knowledge, Attitudes and Beliefs in Ireland was commissioned by the Drug Misuse Research Division in 2000 and carried out as part of the 2000 Irish Social Omnibus Survey. A total of 1,000 adults 18 years and over, randomly selected from the 2000 Register of Electors for Ireland, took part in the study. Data was collected using face-to-face interviews between November and December 2000.

Some of the main changes in the public's drug related attitudes and beliefs between 1998 and 2000 are summarised below.

Concern about the drug problem in Ireland remains high, especially regarding the threat to young people from the availability of illegal drugs (Table 1.3a).

Table 1.3a. Changes in the perceived extent and nature of the drug problem in Ireland, 1998 and 2000

Statement	Survey year (number of responses)	Agree (%)	Disagree (%)	Don't Know (%)
<i>Alcohol abuse causes more problems in society than drug abuse</i>	1998 (n = 998) 2000 (n = 999)	56.1 54.8	30.5 25.5	13.4 19.7
<i>Drugs are not really a problem to us here in this neighbourhood</i>	1998 (n = 999) 2000 (n = 996)	46.9 36.8	38.7 46.0	14.3 17.2
<i>Most people are concerned about the drug problem in Ireland</i>	1998 (n = 998) 2000 (n = 1000)	91.0 88.3	5.2 8.6	3.8 3.1
<i>The drug problem in Ireland is out of control</i>	1998 (n = 996) 2000 (n = 998)	75.0 74.4	15.1 13.2	9.9 12.3
<i>Drug related crime is a major problem in Ireland today</i>	1998 (n = 998) 2000 (n = 996)	94.4 88.6	2.0 6.1	3.6 5.3
<i>The availability of illegal drugs poses a great threat to young people nowadays</i>	1998 (n = 995) 2000 (n = 995)	94.4 96.9	2.1 0.3	3.5 2.8

Source: 1998 data Bryan et al 2000, 2000 data unpublished

Concern regarding the availability of drugs in local neighbourhoods has increased, with only 36.8% of respondents in 2000 agreeing with the statement that drugs were not really a problem in their neighbourhood compared with 46.9% in 1998.

Sympathy for drug-addicted individuals has grown, with fewer people (30.4% in 2000 compared to 39.7% in 1998) agreeing that many drug addicts exaggerate their troubles to get sympathy and fewer (43.4% in 2000 compared to 52.5% in 1998) agreeing that almost all drug addicts are dangerous (Table 1.3b). However, while 45.6 per cent disagree that they would see drug addicts more as criminals than as victims in 2000, a growing proportion (61.7% in 2000 compared to 56.9% in 1998) agree that people who end up with a drugs problem have only themselves to blame.

Table 1.3b. Changes in the attitudes towards drug addicts, 1998 and 2000

Statement	Survey year (number of responses)	Agree (%)	Disagree (%)	Don't Know (%)
<i>I would see drug addicts more as criminals than victims</i>	1998 (n = 999) 2000 (n = 998)	42.6 37.8	45.2 45.6	12.1 16.6
<i>I would tend to avoid someone who is a drug addict</i>	1998 (n = 999) 2000 (n = 998)	71.1 69.0	21.6 21.8	7.3 9.1
<i>Drug addicts are not given a fair chance to get along in society</i>	1998 (n = 999) 2000 (n = 995)	30.5 30.1	50.7 48.6	18.8 21.3
<i>People who end up with a drugs problem have only themselves to blame</i>	1998 (n = 999) 2000 (n = 998)	56.9 61.7	33.9 26.0	9.2 12.3
<i>Drug addicts really scare me</i>	1998 (n = 997) 2000 (n = 999)	66.4 61.1	26.0 29.9	7.6 12.1
<i>Many drug addicts exaggerate their troubles to get sympathy</i>	1998 (n = 998) 2000 (n = 995)	39.7 30.4	29.1 36.9	31.3 32.8
<i>Almost all drug addicts are dangerous</i>	1998 (n = 998) 2000 (n = 997)	52.5 43.4	34.7 42.6	12.8 13.9
<i>It would bother me to live near a person who is a drug addict</i>	1998 (n = 995) 2000 (n = 998)	69.9 63.0	22.4 24.0	7.6 12.9

Source: 1998 data Bryan et al 2000, 2000 data unpublished

Social avoidance and fear of drug addicts remains high in 2000, with around two thirds of respondents agreeing that they would tend to avoid someone who is a drug addict (69%), that it would bother them to live near a person who is a drug addict (63%), and that drug addicts really scare them (61.1%).

The results summarised in Table 1.3c indicate that societal attitudes towards those who use or misuse illegal drugs still tend to be negative, with 64.8% of respondents in 2000 believing Irish society is too tolerant towards drug users compared to 70.1% in 1998. The proportion believing tougher sentences for drug misusers are the answer to the drugs problem still remains about half.

Table 1.3c. Changes in the attitudes towards those who use or misuse illegal drugs, 1998 and 2000

Statement	Survey year (number of responses)	Agree (%)	Disagree (%)	Don't Know (%)
<i>Our society is too tolerant towards drug users</i>	1998 (n = 998) 2000 (n = 995)	70.1 64.8	21.1 23.6	8.7 11.6
<i>I would be nervous of someone who uses illegal drugs</i>	1998 (n = 998) 2000 (n = 999)	75.5 70.0	19.1 19.1	5.4 10.9
<i>Tougher sentences for drug misusers - is the answer to the drugs problem</i>	1998 (n = 998) 2000 (n = 998)	51.3 49.4	37.7 35.4	11.0 15.2

Source: 1998 data Bryan et al 2000, 2000 data unpublished

Support for drug prevention strategies remains high (Table 1.3d), though there was a slight drop in the proportion agreeing with the statement that 'money well spent in the prevention of drug use, is money well spent'.

Table 1.3d. Changes in the support for drug prevention strategies, 1998 and 2000

Statement	Survey (number responses)	year of	Agree (%)	Disagree (%)	Don't Know (%)
<i>Money spent in the prevention of drug use, is money well spent</i>	1998 (n = 997)		91.6	4.1	4.3
	2000 (n = 998)		87.3	3.8	8.9
<i>Drugs education in school should start at primary level</i>	1998 (n = 996)		94.5	2.3	3.2
	2000 (n = 999)		93.5	2.9	3.6

Source: 1998 data Bryan et al 2000, 2000 data unpublished

While support for treatment being available to all drug addicts according to their needs remains high (90.5% in 2000), Table 1.3e reveals that support for the statement that 'treatment should only be given to drug addicts who intend to give up drugs for good' has increased by over 9 per cent, from 64.5% in 1998 to 73.8% in 2000.

Table 1.3e. Changes in the support for drug treatment strategies, 1998 and 2000

Statement	Survey (number responses)	year of	Agree (%)	Disagree (%)	Don't Know (%)
<i>Treatment should only be given to drug addicts who intend to give up drugs for good</i>	1998 (n = 999)		64.5	27.3	8.2
	2000 (n = 997)		73.8	18.4	7.8
<i>Treatment should be available to all drug addicts, according to their needs</i>	1998 (n = 999)		90.2	3.7	6.1
	2000 (n = 999)		90.5	3.1	6.4

Source: 1998 data Bryan et al 2000, 2000 data unpublished

Support for harm reduction strategies (including availability of medically-subscribed heroin substitutes and the provision of syringes and needles free of charge) has increased to over 70 percent.

Table 1.3f. Changes in the support for harm reduction strategies, 1998 and 2000

Statement	Survey (number responses)	year of	Agree (%)	Disagree (%)	Don't Know (%)
<i>Medically prescribed heroin substitutes [such as methadone/physeptone] should be available to drug addicts¹</i>	1998 (n = 933)		64.8	16.1	19.1
	2000 (n = 963)		70.9	14.3	14.7
<i>Society should provide syringes and needles free of charge to drug addicts to avoid the spread of HIV/AIDs</i>	1998 (n = 998)		66.7	17.3	15.9
	2000 (n = 998)		72.3	14.4	13.2

Source: 1998 data Bryan et al 2000, 2000 data unpublished

¹. Question only applies to those who had heard of heroin

b) Media presentation and imaging drug use

NO INFORMATION AVAILABLE

Note no research has been carried out in this area on a national basis in Ireland.

1.4 Budget and funding arrangements – Hamish Sinclair

a) Funding (figures) at national level

The cost of drug misuse at a societal level is extremely difficult to quantify as it encompasses areas like the public health costs of disease associated with drug dependence, the cost of acquisitive crime and associated losses and insurance costs which are borne by both business and individuals. The level of State spending on drugs-related issues is also difficult to estimate and is complicated by the fact that expenditure is spread across a number of Departments, Local Authorities, Agencies and other statutory organisations. Even within Departments and Agencies, it is difficult to arrive at an accurate estimate of costs associated specifically with drug misuse as services such as An Garda Síochána, the Prisons, the Courts and Probation and Welfare Services and the various health agencies deal with drugs issues as part of their wider daily services.

Bearing these limiting factors in mind it is estimated that the development, co-ordination and delivery of the National Drugs Strategy approximated to 183 million Euros in 2000. This is broken down by Departments and Agencies in Table 1.4.

Table 1.4. Direct public expenditure on the National Drugs Strategy in 2000

Department/Agency	Expenditure (Euros)
Dept. of Justice, Equality & Law Reform	123.2
Dept. of Health & Children	32.0
Dept of Enterprise, Trade & Employment	6.0
Dept of Education & Science	7.5
Dept of Tourism, Sport & Recreation	11.6
Revenue Commissioners (Customs and Excise)	1.9
State Laboratory	0.5
Total	182.7

Notes: The expenditure for the Department of Education and Science includes the YPFSS. The expenditure for the Department of Tourism, Sport and Recreation is mainly for the implementation of the LDTF action plans and is paid through the implementing Departments and Agencies. The expenditure figure for the Department of Enterprise, Trade and Employment represents funding for the Special Drugs Community Employment Programme run by FÁS for recovering drug misusers. Expenditure for the Department of Health and Children comprises the additional funding granted to Health Boards from 1996 to 2000 plus the 2000 funding allocated (from other sources as well as the Department of Health and Children) to the DMRD.

No detailed breakdown of national expenditure relating to drugs in the requested areas i.e. law enforcement, epidemiological research, prevention and treatments, evaluation, quality and training is available.

b) Geographical differences

Geographical differences in the nature and extent of drug misuse exist in Ireland. Problematic drug use, in particular the heroin problem is

concentrated in inner city areas of our larger cities. Consequently the major policy programmes and financial resources are targeted at these areas of need.

No complete and comprehensive breakdown of national expenditure relating to drugs by geographical area is currently available.

PART 2

EPIDEMIOLOGICAL SITUATION

2. Prevalence, Patterns and Developments in Drug Use

2.1 Main developments and emerging trends – Mary O'Brien

The following is a summary of the main developments and emerging trends in drug use in Ireland. Supporting data and references are included in subsequent sections of the report.

a) Overview of most important characteristics and developments of drug situation

- *After alcohol and tobacco, cannabis is the most commonly used drug in Ireland, followed to a much lesser extent by amphetamine and ecstasy use.*
- *A main development is the stabilising and decreasing drug use among young people at school. The lifetime experience of cannabis use, in particular in the general population of young people in Ireland, is one of the highest in Europe, but recent results show a levelling off of use. Explanations are speculative and many factors are likely to be involved. For example, the impact of drug prevention policies or the availability of cannabis at street level could be factors associated with the decrease in prevalence.*
- *Misuse of solvents among young people is relatively high at around one-fifth of the population.*
- *There is evidence of polydrug use from a number of sources – treatment data, information on intoxicated drivers, death statistics.*
- *Drug use is most prevalent among young Dublin males.*
- *Heroin is the least used illicit drug in the general population, but it is the most problematic from a health and social point of view.*
- *Problem heroin use is mainly confined to the Dublin area but there are pockets of heroin use in other urban areas of the country.*
- *Injecting drug use continues to be a problem in Dublin and surrounding areas, and is one of the main risk categories to which new HIV positive cases are attributed each year.*
- *The profile of the typical problematic drug user is young, unemployed male, leaving school at an early age and living in a socially and economically disadvantaged area.*
- *On a positive note the level of employment among problem drug users in treatment has increased considerably.*
- *A significant proportion of prisoners, who have a history of drug use, continue to engage in illicit drug use once incarcerated.*
- *A survey to investigate factors underlying international variations in youth drug use undertaken in five cities including Dublin, found that sporting activities by young people were linked with low rates of drug use.*

- *It is now recognised at official level that homeless young people are seriously at risk of becoming involved in drugs, prostitution and crime. As a result a strategy on youth homelessness has been drawn up.*
- *Services need to be developed for drug users in the prison setting that take account of the particular nature of the prison environment. They also need to address the needs both of those who continue to engage in drug use and the associated risk behaviours; and those who wish to cease their drug use while incarcerated.*
- There are indications of increasing homelessness among young drug users.
- There has been a decrease in high-risk behaviours – needle sharing decreased and safe sex (use of condoms) practices increased among clients attending a needle exchange programme over an eight-year period. This could be due to increase in service provision and the freer availability of clean needles and condoms
- Women are more at risk than men, but while women tend to be involved in more risky behaviours than male drug users, they do present earlier for treatment
- Patterns of problem drug use are changing. Over a number of years (1990-1996), among those presenting to treatment for the first time, there was a trend towards the smoking, rather than injecting, of heroin. Smoking seems to have been the preferred route for young people starting to use heroin, at least in the initial year or so of their drug careers. However, trends since 1997 show that the route of administration for heroin is tending again towards injecting. The explanation is likely to be a complex one, involving many factors such as the availability of heroin, fluctuations in the price of heroin, but it may be that young people who originally preferred to smoke heroin are now no longer reluctant to inject.
- *Studies indicate the need for more imaginative education initiatives in harm reduction interventions. Greater attention needs to be paid to the social context of injecting drug use and the sharing of injecting equipment. Outcomes of harm reduction interventions could be improved by exploring the perceptions surrounding unsafe injecting practices.*

b) Emerging trends

Changing patterns

- Patterns of drug use are changing. Over a number of years, among those presenting to treatment for the first time, there was a trend towards the smoking, rather than injecting, of heroin. Smoking seems to have been the preferred route for young people starting to use heroin, at least in the initial year or so of their drug careers. However, trends since 1997 show that the route of administration for heroin is tending again towards injecting. The explanation is likely to be a complex one, involving many factors such as the availability of heroin, fluctuations in the price of heroin, but it may be that young people who originally preferred to smoke heroin are now no longer reluctant to inject.
- There has been a decrease in high-risk behaviours – needle sharing decreased, safe sex (use of condoms) practices increased among clients attending a needle exchange programme over the eight-year period 1990-

1997. This is probably due to increases in service provision and the freer availability of clean needles and condoms.

- *While the decrease in risk behaviours is a welcome development, nonetheless studies indicate that there is a need for more imaginative education initiatives if harm reduction intervention outcomes are to be further improved.*
- *The quantity of cannabis seized fell significantly in 2000, while the number of seizures rose, and has been rising over several years. The number of seizures is usually a better indicator of trends at user level, suggesting an increasing use of cannabis. Although it is too early to indicate a trend, there are anecdotal suggestions of a shift in the nature of the cannabis market, which now seems to involve a greater number of individuals trafficking smaller amounts of the drug.*

New user groups

- *In the absence of research and information based evidence there are no up-to-date indications of new drug using groups emerging.*

New drugs

- *There are no indications of the use of new drugs among drug users in Ireland. Apart from seizures of MDMA, and relatively small amounts of MDEA, MDA, ephedrine and ketamine, which are sold as ecstasy, there is no evidence of the use of new drugs, such as 4MTA or MBDB.*

New problems

- *There is no evidence of the emergence of new problems related to drug misuse.*
- *The prevalence of Hepatitis C among injecting drug users over the past decade has been consistently high.*
- *Women are more at risk than men, but while women tend to be involved in more risky behaviours than male drug users, they do present earlier for treatment.*

c) Analysis of drug trends in wider social context

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

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

- *Irish people have a good general awareness of commonly used illegal drugs. However, their perception of the general harmfulness of these drugs indicated a lack of accurate knowledge about the different effects of different types of drugs.*
- *Societal attitudes to drugs were mostly negative. Younger members of society and those with personal experience of someone with a drug problem tended to have less negative attitudes.*

- The public generally perceived drug taking to be common among young people, and there was a high level of concern about the current drug situation in Ireland.

Not many qualitative studies have been carried out in the general population of young people in Ireland. Such studies to date have tended to concentrate on problematic drug use. It is important that there is a general awareness, and in particular awareness among policy makers of the social context of young people's drug taking if suitable and appropriate prevention measures are to be adopted (see Section 2.2c for a summary of the results from one such study).

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

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

2.2 Drug use in the population – Mary O'Brien

a) Main results of surveys and studies

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

What is evident from survey results (SLÁN; HBSS; Rhatigan and Shelley 1999; Kiernan 1995; Hibell et al. 1997; Hibell et al. 2001) is that alcohol and tobacco are the most widely used drugs in Irish society. Cannabis is the most commonly used illicit drug, followed to a much lesser extent by amphetamine and ecstasy use, and their use is widespread (see Sections 2.2c and 2.2b below). Where there is evidence from general population survey data (Table 2.2c), it seems that cannabis use is decreasing. Among young people of school-going age this is also the case. The relatively high lifetime prevalence

of cannabis use (37%) among 15-16 year old school pupils in 1995 (Hibell et al. 1997), had decreased to 32% in 1999 (Hibell et al. 2001).

From the available general population survey data it is apparent that, generally speaking, young men in urban areas are the most likely to have misused drugs, mainly cannabis. However, a distinction must be made between the adult population and young people. Among adults aged 18 years and over, after cannabis, amphetamines and ecstasy are the drugs most commonly used, though to a much lesser extent. On the other hand, among young people there is some disparity between different age groups. For example, among young people in general (ages 9-18) after cannabis, solvents are the most widely used substances. However, adolescents between 11-14 years of age are more likely to use solvents (see Section 2.2c). Anecdotal evidence suggests that the recreational use of cocaine is on the increase. Heroin, which is generally considered to be the drug that causes the most problems for individuals, communities and society, is the drug least used in the general population (see Section 2.3).

b) General population

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

Cannabis was the most commonly used drug, followed to a much lesser extent by amphetamines and ecstasy (Tables 2.2a and 2.2b). The use of amphetamines was just slightly higher than ecstasy use. Cocaine use is quite rare at 3% among 18 to 34 year-olds. Heroin use was found to be the drug least used (less than one percent) in the general population.

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

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

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

*includes benzodiazepines

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

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

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

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

Young men under 25 were the most likely to have used drugs. This was the case for all drug types in the 18-24 age group (see EMCDDA 2000 Standard Table 1a). In the older age groups women were slightly more likely to have used hypnotics and sedatives which include benzodiazepines. Interestingly, there were no gender differences in the 55-64 year olds for cannabis use during the past year and the past month, although the rates were small at 0.5%. Geographically, drug users were more likely to live in an urban location.

In the same year (1998) a general population survey (KAB1 survey), using a much smaller sample (n=1,000), was undertaken by the Drug Misuse Research Division, Health Research Board (Bryan et al. 2000). The fieldwork was carried out by an independent research organisation as part of a broader social omnibus survey. The aim of the survey was to investigate the attitudes of the general public towards drug use and drug users, and to determine the extent of cannabis use. As in the SLÁN study, the sampling frame was the register of electors, target population adults aged 18 years and over. The sampling procedure was a two-stage proportionate to size random sample. The questionnaires were administered face-to-face in the respondents' homes. The final sample size was 1,000 (response rate was 64.5%). Prevalence information on lifetime use of cannabis only was collected.

A follow-up to this survey - KAB2 - was carried out in 2000, for which preliminary results are available. The findings of KAB1 were quite similar to those found in SLÁN, particularly so in the case of the 18-24 age group. As mentioned above, SLÁN found that lifetime prevalence of cannabis use among 18-24 year olds was 33.4% (Table 2.2b), the KAB1 figure was 32.3% (Table 2.2c). This was not the case in KAB2 where the lifetime prevalence of cannabis use among the same age-group had fallen to 21.5% (Table 2.2c).

Table 2.2c. Ireland 1998 & 2000. KAB Surveys. Lifetime prevalence of cannabis use by age groups. Percentages

Prevalence	Age Groups		
	18-64	18-34	18-24
KAB1 – 1998			
Lifetime	14.2	26.2	32.3
KAB2 – 2000			
Lifetime	11.4	19.8	21.5

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

c) School and youth population

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

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

In 1995 nation-wide school surveys of 15-16 year old (born in 1979) post-primary pupils (ESPAD95) were carried out in a number of European countries (Hibell et al. 1997, p. 12). The Irish lifetime prevalence rate for cannabis use was found to be 37%. This was among the highest of the countries participating in the study – UK was higher at 40%. However, this relatively high rate has not been found in subsequent surveys.

A follow-up to this survey (ESPAD99) was conducted in 1999 in schools throughout Ireland (Hibell et al. 2001). Cannabis, which is by far the most commonly used illicit drug, was down in 1999 as compared to 1995.

Table 2.2d. Ireland 1995 & 1999. Schools Surveys - ESPAD. Lifetime, Last Year, and Last Month Prevalence of cannabis use by Gender. Percentages

	Lifetime			Last Year			Last Month		
	M	F	Total	M	F	Total	M	F	Total
ESPAD95	42	31	37	39	27	33	25	12	19
ESPAD99	35	29	32	31	22	26	18	11	15

Source: Hibell et al. 1997, 2001

Lifetime use of cannabis, as well as more recent use, in the past year or the past month, among both males and females all show downward trends (Table 2.2d). Lifetime use was down by 5% (from 37% in 1995 to 32% in 1999); use in last year was down from 33% to 26%; and use in the last month had decreased by 4% - from 19% to 15%.

Use of other drugs is also decreasing: LSD fell from 13% to 5%; ecstasy from 9% to 5%; and hypnotics from 7% to 5% (Table 2.2g). The use of less popular drugs, such as heroin and cocaine is stabilising, with 1999 lifetime rates remaining similar to those of 1995 at around 2 % (Table 2.2g). Lifetime use of solvents was the exception: according to the results of ESPAD 1999 the lifetime use of solvents had increased slightly, from 19% in 1995 to 22% in 1999.

Similarly high levels of solvent use (19%) were found in a local survey of adolescent drug use in the north-east of the country (Department of Public Health 1999). The geographic area covered by this survey is located just north of Dublin. The survey was conducted in 1997 among 1,516 young people between 13 and 19 years of age (Table 2.2g). The stratified (by county and type of school) sample of 21 schools was randomly selected from a total of 57 schools in the area. Three classes were selected from each school.

Lifetime prevalence of cannabis use was less, at 25%, than the national figure of 32% found in ESPAD99. Other drugs used did not show such a difference. For example, national and local ecstasy prevalence was quite similar at 6% and 5%; in both cases LSD was 5%, cocaine was 2% and heroin 2%.

This survey was unusual in that it included a qualitative element to the research, which gave an interesting insight to young peoples' views about different aspects of drug use. It found that while young people seem to be au fait with illicit drugs, in fact knowledge about drugs was often vague and inaccurate, suggesting that current educational methods are falling short of getting the message across. Young people are not impressed with educational strategies currently in operation. The study concluded that 'the views and ideas of young people should form an integral part of future drug strategies' (Department of Public Health 1999, p. 58⁵). The central messages emanating from the study were as follows:

- So called 'soft' drug use was not a problem for most young people in the north-east. Those who were involved in illicit drug use felt in control of

⁵ Can be viewed at website: www.nehb.ie

their drug use. Under-age drinking is the area of concern where both parental and professional attention should be directed.

- *Young people do not see drugs as being on a continuum from soft to hard drug use.*
- *Drug use was not considered to be an isolated part of young peoples' lives, but one of a number of ordinary and unremarkable activities, which is part of growing up in contemporary Ireland.*
- *Current drug education strategies were deemed irrelevant because they do not reflect young peoples' realities.*

A survey, to investigate factors underlying international variations in youth drug use, was undertaken in five cities – Bremen, Dublin, Groningen, Newcastle-upon-Tyne and Rome (McArdle et al. 2000). The findings showed a higher level of drug use in the English-speaking compared to the continental populations. The authors also found a number of factors associated with drug use: peer affiliation, family structure and individual anti-social behaviour. Sporting activities were linked with low rates of drug use, supporting the view that when activities that include sport are increased in urban districts there is significant decline in problem behaviour in general (ibid.)

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

A national survey was conducted in 1998 (Irish Health Behaviours in Schools Survey [HBSS], Department Health Promotion, NUI Galway, unpublished) (Tables 2.2e and 2.2f). All types of schools were sampled – primary and post-primary schools - from Department of Education & Science lists. Pupils were selected using two-stage random sampling within health board regions and classrooms. The sample size was 8,497; the response rate was 73%. Respondents ranged in age from 9-18 years old. Lifetime prevalence of cannabis use was found to be much less (21.7% for 15-16 year olds) than the ESPAD findings of 1995 (37%) or 1999 (32%) (Tables 2.2d, 2.2e).

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

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

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

The highest prevalence was among 17-18 year olds; 28.5% had used cannabis at some time in the past (lifetime prevalence); 24% had done so in the past twelve months and 11% had used cannabis recently (in past 30

days). All drug types were more likely to be used by males. However, in the case of lifetime use of cannabis among this (17-18) age group there was very little gender difference – male 28.7%, female 28.5% (EMCDDA 2000 Standard Table 2a). Details on different types of drugs were not provided for drug use experience in the past 12 months.

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

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

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

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

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

Among 17-18 year olds (Table 2.2f) prevalence of recent cannabis use (11.0%) was followed by amphetamine use (4.9%). Solvents (4.1%) were the next most commonly used substances, and not ecstasy (3.7%) as might be expected. The prevalence of LSD use was the same as that of ecstasy use at 3.7%. The picture which emerged among younger age groups was quite different. Among 15-16 year olds the use of cannabis (10.5%) and solvents (5.9%) was followed by amphetamine use (2.4%). Solvents were the substances most commonly used by 11-14 year olds; followed by cannabis in the case of 13-14 year olds. Surprisingly, among 11-12 year olds, use of solvents (2.9%) was followed by cocaine use (1.9%), even before cannabis use (1.3%). Cocaine use was in fact highest among 11-12 year olds (1.9%). Heroin use seems higher than would be expected, especially among 17-18 year olds at 2%.

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

for cocaine use among the whole group are the same, both in the HBSS and the EHB surveys, at 2%.

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

Table 2.2g. Ireland 1995-1999. Comparison of school/youth surveys of drug use. Lifetime prevalence of drug use by type of drug.

Survey / Year	ESPAD 1995 National	WHB 1994 Local	MHB 1996 Local	HBSS 1998 National	EHB 1998 Local	NEHB 1997 Local	ESPAD 1999 National
Sample size	1,849	2,762	1,654	8,497	6,081	1,516	2,277
Age group	15-16	13-18	16-18	9-18	10-18	13-19	15-16
Cannabis	37%	16%	26%	12%	21%	25%	35%
Amphetamine	3%	2%	5%	3%	5%	6%	3%
Ecstasy	9%	2%	7%	2%	3%	6%	5%
LSD or other hallucinogens	13%	9%	9%	4%	3%	5%	5%
Hypnotics & sedatives	7%	2%	4%	3%	3%	-	5%
Cocaine	2%	1%	na	2%	2%	2%	2%
Crack	3%	na	na	na	na	-	2%
Solvents/inhalants	19%	14%	17%	10%	13%	19%	22%
Heroin	2%	1%	na	1%	1%	2%	2%

na=not available

The results from the 1999 ESPAD survey show lower lifetime prevalence rates for most drug types (cannabis, ecstasy, LSD, and hypnotics). The exception was solvents. While the rate for these substances was the same in the ESPAD95 and 1997 NEHB surveys (19%), it increased slightly in the 1999 ESPAD study to 22%. Amphetamine use was slightly higher in the north east of the country at 6% (Table 2.2g) (Department of Public Health 1999). Cocaine use remained stable at the low rate of 2%.

Table 2.2h. Ireland 1995-1999. Comparison of school/youth surveys of drug use. Recent prevalence (past 30 days) of drug use by type of drug.

<i>Survey / Year</i>	<i>ESPAD 1995 National</i>	<i>WHB 1994 Local</i>	<i>MHB 1996 Local</i>	<i>HBSS 1998 National</i>	<i>EHB 1998 Local</i>	<i>NEHB 1997 Local</i>	<i>ESPAD 1999 National</i>
Sample size	1,849	2,762	1,654	8,497	6,081	1,516	2,277
Age group	15-16	13-18	16-18	9-18	10-18	13-19	15-16
Cannabis	19%	9%	Na	6%	11%	10%	15%
Amphetamine	Na	1%	Na	2%	3%	1%	Na
Ecstasy	Na	1%	Na	1%	3%	2%	Na
LSD	Na	Na	Na	1%	2%	1%	Na
Hypnotics & sedatives	Na	na	Na	2%	2%	-	Na
Cocaine	Na	1%	Na	2%	2%	0%	Na
Solvents/inhalants	Na	Na	Na	5%	7%	2%	4%
Heroin	Na	0%	Na	1%	1%	0%	Na

* Na=not available

More recent use, for which very little comparable information is available, also seems to be decreasing. Cannabis was down from 19% in 1995 to 15% in 1999 ESPAD.

The explanation for the decrease in the prevalence of drug use is likely to be a complex one. For example, anecdotal information from street level sources suggests that in the past year there is less cannabis available at street level than formerly. The impact of drug prevention policies could also be a factor. In the absence of research on drug markets, availability, trafficking patterns, etc., it is difficult and unwise to speculate on explanations for changes in trends, such as the decrease in cannabis use.

What is very apparent is the importance of carrying out research, such as population surveys on the use of all types of illicit drugs. This should be done at regular intervals using comparable methodologies, if meaningful comparisons and interpretations are to be made. It should include information on lifetime use (ever used), and recent use (past 30 days/past month) of drugs – the latter being a better indication of the current situation. Also qualitative research studies, such as drug use and its social context, the perceptions of drug users, would enhance the findings of survey work by providing insight for the formulation of effective drug policies, particularly in relation to prevention interventions and the reduction of demand for drugs.

d) Specific groups – Mary O’Brien & Lucy Dillon

Homeless people: *It has been suggested that the extent of drug use among the homeless population ‘is substantially higher than it is among the rest of the population’ (Costello and Howley 2001, p. v). Holohan (2000) found that the lifetime prevalence of drug use among homeless people in Dublin was 28%, which compares with 20% in the general population (see Table 2.2b). Costello and Howley (2001) carried out a feasibility study to explore the idea of setting up a direct-access hostel in Dublin for drug users who sleep rough, using a qualitative methodology. Fifteen in-depth interviews were carried out with homeless drug users exploring their contact with services, their drug use, physical and mental health and accommodation alternatives. A number of*

personal reasons were cited, such as family and domestic problems, as precipitating their homeless state, as well as drug use itself which forced some to leave home. All of their experiences were against a backdrop of social disadvantage and exclusion. While no attempt was made to measure the extent of homeless drug users in Dublin, the study did identify a gap in homeless services for people using drugs. It concluded that "without the committed and consistent challenging of barriers to housing for people who are homeless and using drugs, efforts of homeless services are severely limited" (Costello and Howley 2001, p. 70).

A small scale pilot study examined the health status of 14 families with 31 children in Dublin. The families were living in a transitional housing project (O'Brien et al. 2001). Only two of the families had both parents, the other twelve were headed by mothers alone. The aim of the study was to examine the mental health status of homeless children and their families. The findings show that the study group were socially isolated and lacked support from fathers and wider family members. High addiction levels and poor parenting skills were other features of the group. Heroin addiction was the main reason cited for four of the families' homelessness. The authors concluded that there should be targeted services to support vulnerable families. A comprehensive and integrated approach by housing, childcare, education and family support services is needed to address the need of homeless families.

As a result of recognition at official level that homeless young people are seriously at risk of becoming involved in drugs, prostitution and crime, a strategy on youth homeless has been drawn up, stressing the need for a cross-sectoral approach involving health boards, education and local authorities, voluntary organisations and local communities. (Department of Health and Children 2001).

Ethnic Minorities : Research in Ireland continues to be limited in the area of drug use among minority groupings. However, one study has been carried out on drug use among the Travelling Community (Hurley 1999). Data were collected using a range of data collection methods that focussed on exploring perceptions of members of the Travelling Community on the extent and nature of drug use among the Travelling Community. The study does not in fact provide information on prevalence rates. It does however, report a number of interesting findings on the perceptions of drug use:

- The main drug used by young members of the Travelling Community was perceived to be cannabis rather than alcohol, 'and is normalised and not perceived to be an illegal activity' (Hurley 1999, p. 41)
- Heroin use was perceived to be a problem for 'a minority of Travellers' (Hurley 1999, p. 41)
- Travellers who either mixed with members of the settled community or had spent time in prison were perceived to be particularly at risk of becoming involved in illicit drug use.

Recent years have seen a significant change in the migration profile of Ireland. Net migration in Ireland has gone from 8,000 in 1996 to an estimated 20,000 for the year 2000. Furthermore, there has been a large increase in the

numbers of people applying for asylum in Ireland. In 1992 there were only 39 applications made, whereas for 2000 the figure had increased to 10,938 (Table 2.2i below).

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

1992	1993	1994	1995	1996	1997	1998	1999	2000
39	91	362	424	1,179	3,883	4,626	7,724	10,938

Source: Department of Justice, Equality and Law Reform

However, there is no evidence-based information on drug use among the immigrant population. A change in the nationality profile of people presenting for treatment is not evident from data recorded in the National Drug Treatment Reporting System. For example, in 1999 only 36 of the total number of first treatment contacts (N=1852) were non-nationals (other than Irish). Twenty-five of these were from Great Britain.

There is, therefore, a need to explore drug use in this context. It is important that the necessary information be available to facilitate Irish services to address any specific needs that drug users from minority groups may have, and to offer services in a way that will encourage these users to access them.

Prisoners: Research has found that a significant proportion of Ireland's prison population has a history of drug use, and that a number of prisoners continue to use drugs while incarcerated. Two studies (Allwright et al. 1999; Long et al. 2000) concerned with the prevalence of HIV, hepatitis B and hepatitis C among the Irish prison population, explored the related risk behaviours and drug use engaged in by prisoners. Allwright et al. (1999) found that of 1,205 respondents, 630 (52.3%) reported that they had used heroin and 43.2% reported that they had ever injected drugs. Furthermore, the authors concluded that "drug use within prison was common" (Allwright et al. 1999, p. 18). Forty-five percent of the 334 respondents who reported that they had a history of drug use and had been in prison for longer than three months, reported that they had injected drugs in the previous month. Thirty one percent (n=103) reported that they had injected between 1 and 19 times in the previous month, while 14% (n=48) said they had injected more than 20 times in the previous month (Allwright et al. 1999). The subsequent study of a sample (n=604) of committal⁶ prisoners found lower rates of prisoners reporting drug use (Long et al. 2000). Thirty five and a half percent of the sample reported that they had ever smoked heroin and/or injected drugs, 29% reported that they had ever injected drugs. Both of these studies suggest that there is a significant proportion of prisoners who have a history of drug use and, furthermore, a significant proportion continues to engage in illicit drug use once incarcerated.

⁶ Committal prisoners were defined as "prisoners who have been admitted to the prison within the preceding 48 hours, accused or guilty of a new crime, excluding those on temporary release or transferred from another prison. The committal population includes individuals entering on remand, following sentence, committed as a result of a bench warrant, and non-nationals without valid documentation" (Long et al 2000).

2.3 Problem drug use – Mary O'Brien

a) National and local estimates

NO NEW INFORMATION FOR NATIONAL OR LOCAL ESTIMATES OF PROBLEM DRUG USE IS AVAILABLE.

The National Advisory Committee on Drugs [NACD] has issued a call for expressions of interest in conducting a study of opiate users in Ireland. The aim of the study is 'to provide data on a number of aspects of opiate use in Ireland which can be used to develop multipliers for use in assessing changes in the prevalence of opiate use'⁷. The specified methodologies are to be network analysis or nomination technique. The final report is expected in 2003.

Studies on national and local prevalence estimates of problem drug use are quite limited in Ireland. An exploratory study was carried out (Comiskey 1998) to estimate the prevalence of problematic opiate use. Using the capture recapture methodology with three samples of data (methadone treatment list, hospital inpatient data and police record data), this local study in Dublin estimated that there were between 10,655 and 14,804 opiate users in Dublin in 1996. There were difficulties with the samples used in this study - 12% of the Garda (police) sample contained ambiguous data (7% were non-opiate users; and 5% were identified by unspecified means). The Garda data were originally collected for a study to examine drug-related crime (Keogh 1997), with different definitions to those used in the prevalence study. Prevalence studies such as this should be regarded as an exploratory exercise in the development of methodologies to estimate the prevalence of problem drug use, and the resultant estimates of opiate use should be viewed in this light.

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

More problematic drug use is represented by the treated population of drug users. This information is collected by the Drug Misuse Research Division, Health Research Board for the National Drug Treatment Reporting System (NDTRS) and refers to people who receive treatment for problem drug use. In recent years there has been an extensive increase in the services provided for problem drug users. Compared to ten years ago services are now decentralised and have become more diversified and dispersed both locally and nationally. Data collected by the National Drug Treatment Reporting System

⁷ Tender for network analysis study

give a good profile of the characteristics of clients, patterns of use and trends over time (see Section 3.1a). Problematic opiate use, mainly heroin, continues to be concentrated in the Dublin area, in localities with high levels of social and economic disadvantage. Pockets of heroin use are being reported in recent times in a number of areas throughout the country.

b) Risk behaviours and trends

Risk behaviours are very important in the transmission of HIV infection; injecting with shared equipment is the crucial transmission route among injecting drug users; sexual contact is likely to be the most common transmission route to the wider population. A retrospective examination of data from the Needle Exchange Programme (NEP) in the Eastern Health Board area was carried out to identify the factors associated with high-risk behaviours (Mullen and Barry 1999, 2001). The NEP was set up in 1989. Drug users who attended for the first time between 1990-1997 were included – 6025 in total. The number of first attenders increased from 350 in 1990 to 1039 in 1997. Four needles, on average, were distributed to first attenders; all were offered condoms, 45% accepted. First-time attenders were predominantly male, but over the eight-year period the proportion of women increased from 18% in 1990 to 24% in 1997 - this increase was particularly noticeable in young women under 20 years of age. The mean number of years of injecting drug use of the study group was 4 years. The overall prevalence of needle sharing in the year prior to attendance was 39%, but women (44%) were more likely to share than men (38%). Women (51%) were also more likely to engage in unsafe sex than men (44%). Young injectors under 20 years old, were just as likely as all attenders to share injecting equipment (39%). Those who did not share injecting equipment were more likely to use condoms, than those who did share. Young attenders under 20 years old, were less likely to be involved in unsafe sex than the overall group (Table 2.3).

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

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

Source: Mullen and Barry (1999)

* Na=not available

Trends over the time period 1990-1997 showed a significant decrease in high-risk behaviours – needle sharing practices fell and safe sex (use of condoms) practices increased. Women engage in more risky behaviours, and with the proportion of women increasing over time this has serious health implications. Young injecting drug users are a particularly at-risk group. However, they do seem to present quite early in their drug using careers to needle exchange programmes. The authors state that ‘it is crucial that young people do not encounter barriers to protecting themselves, such as parental permission, mandatory treatment, and statutory notification’ (Mullen and Barry 1999, p.29). The authors argue that this would defeat the purpose of a low threshold service, to which young people are more likely to present. The profile of the attenders at the NEP highlights the importance of providing prevention and early intervention programmes particularly for young people. The authors recommend that more in-depth/qualitative research is needed to increase understanding of injecting drug users – ‘the issues surrounding drug use, risk management and sexual relationships’ (ibid. p. 25) – in order to make prevention strategies more effective.

While the Mullen and Barry study did not provide details on the sharing of injecting equipment, another study in Dublin did examine the frequency of syringe borrowing among young intravenous drug users (Smyth et al. 2001). The study was carried out between September 1997 and June 1999 in a number of treatment settings in Dublin. Consecutive new attenders, who had injected in the preceding 6 months, were eligible to participate in the study. The perception of danger involved in borrowing syringe equipment was measured using ‘a 100-mm visual analogue scale’ (Smyth et al. 2001, p. 719). Three-hundred-and-ten candidates were identified, and 294 participated.

Sixty percent of the participants were male; heroin was the primary substance injected in 97% of cases. Cocaine (in 30% of cases) and benzodiazepines (in 60% of cases) were injected as secondary drugs. Over half (56%) had on average re-used ones own syringe; 70% had borrowed a syringe or needle; and 87% had borrowed spoons or filters from other intravenous drug users. All indicating a high level of recent unsafe behaviours, and also explaining the very early acquisition of hepatitis C infection by IDUs in Dublin. The study found that poly-drug users are more likely to inject unsafely; and that those who inject benzodiazepines in addition to heroin appear to be a particularly high-risk group. Social factors such as early school leaving and parental unemployment were associated with increased reporting of syringe borrowing. While social deprivation and social exclusion are generally accepted to be associated with increased occurrence of drug use and general health risk behaviour, this study found that these social markers are predictors of current unsafe injecting within populations of intravenous drug users. The authors suggest that greater attention needs to be paid to the social context in which individuals inject and share equipment, and that exploration of perceptions of unsafe injecting practices could prove to be a useful area of focus for harm reduction interventions.

Another study also highlights the fact that women, although in a minority, are a very at-risk group among drug users (Geoghegan et al. 1999). Taking a

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

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

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

Data from the National Drug Treatment Reporting System (NDTRS) were used in a study (Smyth et al. 2000) to examine trends in treated opiate use and to identify factors associated with the route of administration of heroin. Dublin clients presenting for the first time for treatment of an opiate problem over the six-year period 1991-1996 were included. The study population was 3981. Over the period there was a three-fold increase in the number of new clients and the proportion of females increased. The mean age of first opiate use declined and users began presenting for treatment earlier in their opiate-using careers. There was an increase in the proportion who were using heroin as distinct from other opiates, such as morphine sulphate tablets. There was a dramatic increase in heroin smoking after 1994 when it became the most common route of heroin use. Heroin was most likely to be smoked by young, employed people who were using heroin for less than three years.

The reasons for the increase in chasing (heroin smoking) are not clear. It is suggested that while awareness of AIDS and the risks of injecting may be a factor, it would be simplistic to assume that this alone accounts for the change in the pattern of heroin use (Smyth et al. 2000). In a later study of first time attenders at a needle exchange programme between May 1997 and February 1998, a comparative analysis of the risk behaviour of younger and older injectors, i.e. under 25 and over 25 years of age, was carried out. It was found that the younger group (under 25 years old) were significantly more

likely to have smoked illicit drugs prior to injecting and to report using heroin as their primary drug (Cassin et al. 1998). It may be that smoking is the preferred route for young people starting to use heroin, particularly for those reluctant to inject. The more acceptable nature of chasing, it was suggested, may attract increasing numbers to use heroin and concern was expressed that 'chasing may prove to be a dragon in sheep's clothing' (Smyth et al. 2000, p. 1223).

Data from the NDTRS for 1997-1999, suggest that these concerns were warranted. The data show (EMCDDA Standard Table 4) that between 1990 and 1996 the proportion of all treated drug users who injected their main drug decreased from 66% to 37%. However, since then the proportion who inject has increased a little, from 45% in 1997, to 49% in 1998 and 51% in 1999. The explanation is likely to be a complex one, involving many factors (sub-group norms, availability, price of drugs, etc.) but it may be that the young people who preferred to smoke heroin initially are no longer reluctant to inject. In other words they have 'progressed' to injecting.

In a qualitative study of a group of prisoners (n=29) it was found that moving from smoking to injecting heroin was motivated by a more efficient use of a scarce commodity. Because of the limited quantity of heroin available in prison, drug-using prisoners managed their drug use in order to ensure that the maximum number of people were facilitated by the heroin which could be accessed. Since smoking was considered to be wasteful this meant that injecting rather than smoking the heroin was more acceptable. Furthermore, injecting was perceived to give a better 'buzz' than smoking, once an individual had become an habitual user (Dillon 2001).

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

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

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

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

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

The importance of more imaginative education initiatives in harm reduction interventions was demonstrated by a study conducted in a specialised treatment setting (Smyth *et al.* 1999b). The level of knowledge of intravenous drug users regarding hepatitis C (HCV) and the factors influencing this knowledge were assessed using an instrument developed by the research team. The results showed that there were prominent misconceptions about

the cause of transmission and natural history of HCV infection. Contact with services did not lead to any significant gain in understanding. The authors concluded that current education approaches in specialist treatment centres and by general practitioners are deficient. They recommend a move away from the 'typical didactic model of fact provision' (ibid. p. 263) to a more explorative approach where misconceptions are more likely to emerge, thereby providing the opportunity to correct and educate.

3. Health Consequences – Mary O’Brien

3.1 Drug treatment demand

*NO NEW INFORMATION AVAILABLE FOR THIS SECTION
TREATMENT DATA FOR 2000 NOT YET AVAILABLE (Oct 2001)*

a) Characteristics of clients, patterns of use and trends

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

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

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

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

Characteristics	1995	1996	1997	1998	1999*
Valid N	1886	2014	1465	1621	1852
Gender ratio Male:Female	80:20	73:27	72:28	74:26	73:27
Mean age	21.1	21.3	22.0	22.1	23.3
Living status – with parental family	78.9	76.5	71.6	71.1	68.9
Early school-leavers (<16 years old)	51.9	50.3	46.0	45.2	44.6
Regular employment	15.3	13.9	19.5	24.9	30.8
Mean age first used any drug (excl. alcohol)	15.6	15.4	15.9	15.5	15.6
Main drug - Heroin	54.5	63.2	58.4	56.1	58.2
Main drug - Route of administration- inject	23.6	24.0	29.2	28.9	35.3
Main drug - Route of administration- smoke	56.2	59.8	50.7	53.3	49.9

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

*NB changes, due to addition of extra data

Between 1995 and 1999 there was a fall in the proportion of clients living in the parental home (Table 3.1). There was a decrease in those who left school before the age of 16 years from 52% in 1995 to 45% in 1999. There was a sizeable increase in the level of employment among problem drug users, from a very low 15% in 1995 to 31% in 1999, again reflecting more general changes in Irish society in relation to improvements in the economy, *inter alia*, over the same period. The mean age of initial drug use was between 15-16 years of age and did not change much over the five-year period. Heroin was the main drug of misuse for over half of those presenting for treatment for the first time. Over the five-year period there was an increase in the proportion injecting their main drug of misuse and a decrease in smoking (see discussion on risk behaviours at Section 2.3).

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

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

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

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

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

c) Comments on treatment demand for different drugs

Heroin : A majority of people (around 6 out of 10 new cases each year) presenting to the treatment services have problems with the misuse of heroin, i.e. it is the main drug of misuse (National Drug Treatment Reporting System). This is mainly confined to the Dublin area but in recent years pockets of heroin use in other parts of the country are being reported. A sizeable proportion (59% in 1999) of those presenting to treatment services with problem heroin use for the first time are involved in intravenous drug using practices with very serious health and social consequences. This is the highest level in the past five years (37% in 1995; 37% in 1996; 49% in 1997; 50% in 1998) (EMCDDA Standard Table). See discussion at Section 2.3b.

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

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

Synthetic drugs : Demand for treatment for problem ecstasy use has decreased somewhat in recent years (from 11% in 1995 to 8% in 1999). The proportion of problem amphetamine users presenting for treatment for the first time has increased from 0.4% in 1995 to 2% in 1999. A worrying development is that in 1999, 6% of these were injecting the drug. The proportion presenting with problem LSD use has been falling (from 1.6% in 1995 to 0.2% in 1999).

3.2 Drug-related mortality

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

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

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

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

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

Data from the General Mortality Register at the Central Statistics Office show that drug-related deaths increased considerably between 1995 and 1997, and then levelled off in 1999 and 2000 (Table 3.2a). It should be noted that data for 1999 and 2000 are provisional, and are likely to change as late returns are recorded.

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

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999*	2000*
Ireland (All ages)	7	8	14	18	19	43	53	81	97	85	89
Male	6	8	11	16	18	37	44	67	70	64	71
Female	1	0	3	2	1	6	9	14	27	21	18
Under 30 years old	7	4	8	8	11	22	30	51	42	39	38
15-49 years old	7	7	14	16	19	39	50	75	86	75	76
Dublin (All ages)	6	8	14	16	17	39	43	70	73	68	69
Drug dependence (ICD-9 Code 304) (All ages)	4	5	13	13	15	38	42	69	91	80	81

Source: Central Statistics Office

* provisional data

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

The highest number (N=97) was recorded in 1998. It was in that year that an amendment was made to the information recorded, in the case of a sudden death, by the Garda Síochána (on Form 104): a question on drug/alcohol dependency was included on Form 104. This was as a result of the work of the National Task Force on Suicide (Department of Health and Children 1996; 1998). The increasing trend did not continue in 1999 and 2000 when the number of deaths was 85 and 89 respectively (Table 3.2a). In terms of geographic location the vast majority of deaths each year were in Dublin. The majority were males, between the ages of 15 and 49.

Indirect as well as direct drug-related death was the subject of an ad hoc retrospective study carried out in 1999 (Keating et al. 1999). Dublin City and County Coroners' files were examined to study the number of drug-related (direct and indirect) deaths in 1997. The criteria for inclusion were that the death had to have occurred in Dublin (city or county), between 1 January and 31 December 1997, and have positive toxicological evidence of the presence of drugs, and where drugs were implicated in the cause of death - this is a much broader definition than that used for the purpose of the GMR. Toxicological screens included testing for alcohol, opiates, benzodiazepines, tricyclics, barbiturates and cocaine. One-hundred-and-twenty cases were found to be toxicologically positive for drugs and 65 of these were known to be drug users. The gender ratio was 3:1 (male:female) and more than half of the deaths were in the 20-39 year age group. The drug most commonly identified was benzodiazepine (75 cases) mainly in combination with other drugs. The most common combination of drugs was opiates and benzodiazepines. Methadone was found in 47 cases; alcohol was found in 47 cases; cocaine in 7 cases; MDMA in 2 cases; and amphetamines in 2 cases. A similar study of coroners' files in 1992 (in Keating et al. 1999) found no cocaine, MDMA nor amphetamines in drug-related deaths. The 1992 study found a similar number of drug-related deaths recorded (in Dublin coroners' files) to that recorded in the GMR for that year. However, the total number (120) found in the 1997 study did not correspond with the number (49) recorded in the more narrowly defined GMR for the same year.

A more recent study in Dublin in 1999 also found that statistics recorded in the GMR fell short of those found in the coroners' records (Ward and Barry 2001). The study definitions, which included indirect as well as direct drug-related deaths, were somewhat different from the GMR definition. One of the aims of the study was to determine the number of opiate-related deaths in Dublin city and county in 1999. Eighty-four drug-related deaths were found: methadone and/or morphine were detected in 72; benzodiazepines in 52; alcohol in 26; codeine cocaine, amphetamines and ecstasy were found in 14 cases. Toxicological analyses showed that 2 or more drugs were identified in 73 of 84 cases. The majority was young males who had been involved in benzodiazepine or alcohol co-abuse.

Table 3.2b. Dublin 1999. Drug-related death by cause of death. Numbers.

Cause of death	ICD Code	Number
Drug dependence	304.0-304.9	63
Poisoning by opiates & related narcotics	965.0-965.2, 965.9	2
Violent & accidental (hanging, gunshot wound, fall etc.)	994.7, E922.0, E888	13
Miscellaneous (not established, vasculitis, alcohol dependence, liver disease)	799.0, 447.5, 303.0, 571	6
Total		84

Source: Ward & Barry 2001

The cause of death was recorded as drug dependence in 75% of cases (N=63), and violence accounted for a sizeable minority (15%, N=15) (Table 3.2b).

These study findings show that polydrug use is a serious problem. They also highlight the fact that the full extent of drug-related death is not evident from GMR statistics, suggesting the need for a Special Register to record indirect as well as direct drug-related deaths

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

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

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

3.3 Drug-related infectious diseases – Lucy Dillon

This section will summarise the Irish situation in relation to drug-related infectious diseases and report and comment on updated figures and any new research carried out in the area⁸.

a) HIV and AIDS

As described in the National Report for 2000, the majority of data collected on drug related infectious diseases in Ireland are related to HIV. Two sources of data exist: the routine data on HIV positive tests that are reported by the Department of Health and Children⁹; and special studies which have been

⁸ An in-depth account of the Irish situation in relation to drug-related infectious diseases was given as a Special Topic in the National Report for Ireland, 2000- this has subsequently been published in a collection of papers produced by the DMRD (Moran, Dillon, O'Brien, Mayock, Farrell & Pike, 2001).

⁹ The National Disease Surveillance Centre (NDSC) took over statutory responsibility for sexually transmitted infections (STIs), including HIV/AIDS, from the Department of Health and Children (DOHC) on July 1st 2000. Data on HIV/AIDS are now provided directly to the NDSC by the Departments of Public Health of each health board. Quarterly STI reports for 2000 are now available on this website. The DOHC provided finalised data for quarter 1 (Q1) and quarter 2 (Q2), 2000. Data for quarter 3 (Q3) and

carried out estimating the prevalence of HIV among particular cohorts of drug users.

Routine data on HIV testing

Up until July 2000, the Department of Health and Children, in collaboration with the Virus Reference Laboratory, was responsible for producing statistics on HIV positive tests which are published every six months. On 1st July 2000, the Infectious Diseases (Amendment) Regulations, 2000 (S.I. No 151 of 2000) came into force. Under these regulations the National Disease Surveillance Centre (NDSC) was assigned responsibility for the collation and analysis of weekly notifications of infectious diseases, taking over from the Department of Health and Children. In their first six months of data collation (July 2000-December 2000), data were collected in the same manner as previous years. However, in July 2001 a new HIV case-based reporting system has been developed. The aim of the new HIV case based reporting system has been noted as “to ensure the collection of accurate and complete epidemiological data on the distribution and mode of transmission of HIV infection” (O’Donnell, Cronin and Igoe 2001, p. 21). The socio-demographic data that will be collected within this new system are the patient’s age, gender, county of residence (if Dublin, then the postal code) and country of birth (if not Ireland then year of first arrival in Ireland). Furthermore, an expanded list of probably routes of transmission is included. The new list reads as follows:

**Probable route of transmission
(please tick one)**

- Men who have sex with men (MSM)/Bisexual
- Injecting Drug User (IDU)
- IDU and men who have sex with men (MSN)/Bisexual
- Heterosexual

If heterosexual (please circle)

1. From a country with a generalised HIV epidemic
2. Sex with a bisexual male
3. Sex with an injecting drug user
4. Sex with a haemophiliac or a transfusion recipient
5. Sex with a person from a country with a generalised HIV epidemic
6. Sex with a person known to be HIV infected (not number 1-5 above)
7. Infected through heterosexual transmission, no further information

Mother-to-child

If mother-to-child please indicate status of mother (please circle)

1. Injecting drug user
2. From a country with a generalised HIV epidemic
3. Infected through heterosexual contact (not number 2 above)
4. Transfusion recipient
5. Other/undetermined

- Haemophiliac
- Transfusion recipient
- Nosocomial infection
- Occupational

Other/undetermined (if other please state)

Source: HIV/AIDS Surveillance Report Form, NDSC.

quarter 4 (Q4) 2000 was provided to NDSC by the Departments of Public Health. The figures for the Q3 and Q4 2000 reports are provisional and will not be regarded as final until all returns are received and data has been validated.

This new system of data collection for HIV will be evaluated in Spring 2002, and any necessary changes made.

In considering the data available for 2000, the remainder of this section refers to data gathered on positive test by the Virus Reference Laboratory and collated by the Department of Health and Children, and, from July 2000, the NDSC. Within this system figures relating to HIV tests are broken down according to risk category, one of which is injecting drug use. As noted in the National Report for 2000, while it is possible to get a breakdown of the number of positive HIV cases attributable to injecting drug use in a given year, there continue to be a number of limitations to this data source:

- *It is limited to the tested population. Nothing can be inferred for those drug users who have not been tested.*
- *It is not possible to identify non-injecting drug users within the data set.*
- *No socio-demographic data is collected on those who are tested.*
- *There is only a limited geographical breakdown available.*
- *A gender breakdown has only been made available since 1997.*
- *Both risk behaviours (e.g. injecting drug use) and test locations (e.g. prison) are used as categories. This makes the data somewhat unclear. For example, it is not known through what risk activity those tested in the prison setting became infected with HIV.*
(National Report 2000)

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

The cumulative figures for the positive cases of HIV from the start of data collection in 1982 up until 1985, show that just over 60% (n=221) of all positive cases (n=363) were attributed to injecting drug use (see table 3.3a). Since 1985, injecting drug use has continued to be one of the main risk categories, accounting for 38.6% of the cumulative number of positive cases up until December 31st 2000 (see table 3.3a).

As can be seen in Table 3.1 the proportion of positive HIV cases attributed to the intravenous drug user category generally decreased from 1992 through to 1998. The proportion of positive HIV tests attributed to intravenous drug use fell from 49.7% in 1989, to a low of 17.6% in 1997 (see Table 3.3a). It was noted in the National Report for 2000 that 1999 had seen a significant rise in the numbers of injecting drug users testing positive for HIV. The number of positive tests has remained stable in 2000 with 70 positive tests being attributed to injecting drug use. Proportionately, in 2000 injecting drug use decreased to representing 20.5% compared to 33% of all positive tests in 1999- this was primarily due to the significant increase in the number of positive tests attributable to the heterosexual sex/risk unspecified category- this more than doubled during 2000, increasing from 59 in 1999 to 129 in 2000.

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

Year	IVDUs n (%)	Homosexual Sex n (%)	Heterosexual Sex/ Risk unspecified n (%)	Other n (%)	Total n (%)
1985*	221 (60.9)	39 (10.7)	0	103 (28.4)	363 (100.0)
1986	112 (66.3)	11 (6.5)	21 (12.5)	25 (14.8)	169 (100.0)
1987	72 (49.7)	21 (14.5)	26 (17.9)	26 (17.9)	145 (100.0)
1988	58 (50.4)	17 (14.8)	20 (17.4)	20 (17.4)	115 (100.0)
1989	57 (49.1)	33 (28.5)	0	26 (22.4)	116 (100.0)
1990	50 (45.1)	25 (22.5)	24 (21.6)	12 (10.8)	111 (100.0)
1991	34 (36.9)	27 (29.4)	25 (27.2)	6 (6.5)	92 (100.0)
1992	82 (40.8)	58 (28.9)	50 (24.9)	11 (5.5)	201 (100.1)
1993	52 (38.0)	48 (35.0)	21 (15.3)	16 (11.7)	137 (100.0)
1994	20 (23.5)	31(36.5)	22 (25.9)	12 (14.1)	85 (100.0)
1995	19 (20.9)	33 (36.3)	30 (33.0)	9 (9.9)	91 (100.1)
1996	20 (18.9)	41 (38.7)	27 (25.5)	18 (17.0)	106 (100.1)
1997	21 (17.7)	37 (31.1)	40 (33.6)	21 (17.7)	119 (100.1)
1998	26 (19.1)	37 (27.2)	47 (34.6)	26 (19.1)	136 (100.0)
1999	69 (33.0)	40 (19.1)	59 (28.2)	41 (19.6)	209 (99.9)
2000	70 (20.5)	72 (21.1)	125 (36.4)	75 (22)	342 (100)
Total	983	500	537	447	2537

Source: Department of Health and Children and National Disease Surveillance Centre.

As discussed in the National Report for 2000, anecdotal evidence suggests a couple of explanations for the increase in the number of positive cases being attributed to injecting drug use during 1999 which may also offer an explanation for the 2000 figures. Firstly, leading on from the *Protocol for the Prescribing of Methadone* issued in 1993, guidelines were developed for GPs prescribing methadone within the general practice setting and for pharmacists in their dispensing of methadone. Following the completion and evaluation of a pilot programme, in January 1998 the Report of the Methadone Treatment Services Review Group made a number of recommendations on tightening control on both the prescribing and dispensing of methadone, in accordance with the 1993 protocol. Consequently, the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations, 1998. The regulations aim to create a more controlled environment for the prescribing and dispensing of methadone. Within this context, all those who were receiving methadone in Ireland were integrated into a structured programme. Furthermore, drug users were integrated into a structured programme setting where there is an active policy of carrying out virology in relation to HIV and hepatitis. It is suggested therefore, that this may have resulted in an increase in the number of injecting drug users being tested for HIV and, in turn, an increase in the number of positive cases being attributed to injecting drug use during 1999 and 2000. Secondly, it has also been suggested anecdotally that perceptions may be beginning to change among the drug using population in relation to HIV. It is argued that the availability of new treatment (HAART) and the visibility of individuals in the community for whom treatment has been effective, has encouraged people to come forward for testing so that they can avail of treatment if necessary.

* Cumulative figures

Gender: As discussed in the National Report for 2000, gender is the only socio-demographic data collected on those who are tested for HIV from the Department of Health and Children's Data source, but has only been reported since 1997. An examination of the figures by gender suggests a possible change in the profile of those who are testing positive for HIV in Ireland (see Table 3.3b). In 1997, females only accounted for 3 of the 21 new positive cases attributed to injecting drug use. In 1998 this had increased to 10 of the 26 positive cases among injecting drug users, and in 1999 it had increased further to account for 34 of the 69 positive cases. However, in 2000 only 29 of the 70 new positive cases were women. Speaking in percentage terms, women had increased from representing 14.3% of the positive tests among injecting drug users in 1997, to 38.5% in 1998 and up to a high of 49.3% in 1999. However, in 2000 they decreased proportionately to 41.4% of new cases. Due to the lack of information on gender prior to 1997, it is not possible to explore trends over a more extended period of time. Furthermore, research has not been carried out in the Irish context into the spread of HIV among female and male injecting drug users. As discussed in the National Report for 2000, anecdotal evidence suggests that the overall increase in the number of positive tests among women with a history of injecting drug use since 1997, may reflect a real increase in the number of female injecting drug users who are becoming infected with HIV. However, it is also suggested that these women may be becoming infected through their sexual behaviour rather than their injecting drug use. Once identified as an injecting drug user however, their infection will tend to be attributed to their injecting drug using behaviour. Anecdotal evidence also suggests that a growing number of women may be attending for testing in order to be able to minimise the risk of infection to their baby were they to become pregnant.

Table 3.3b Ireland 1997-2000. HIV seropositive intravenous drug users by gender. Numbers and percentages.

Year	Male n (%)	Female n (%)	Total n (%)
1997	18 (85.7)	3 (14.3)	21 (100)
1998	16 (61.5)	10 (38.5)	26 (100)
1999	35 (50.7)	34 (49.3)	69 (100)
2000	41 (58.6)	29 (41.4)	70 (100)

Source: Department of Health and Children and NDSC

AIDS

Since 1983 and up until December 31st 2000, there have been 707 AIDS cases reported in Ireland, and 362 AIDS related deaths (see Appendix 2, Table 3.3). It has been noted that injecting drug use has accounted for approximately 40% of the AIDS cases reported between 1983 and 1999 (O'Donnell et al., 2000). In 2000 there were 21 new AIDS related cases recorded and 13 AIDS related deaths. Intravenous drug users continue to represent one of the main risk categories recorded in this data source. In 2000, intravenous drug users accounted for 28.6% of new AIDS cases, and 38.5% of the year's AIDS related deaths.

Special Studies

A number of special studies have been carried out which have explored the prevalence of HIV among cohorts of drug users in a range of study locations.

The studies have included drug users located in: the community, drug treatment centres, needle exchange programmes and prisons. A summary of the research findings on the prevalence of HIV infection among particular cohorts of drug users is presented in Table 3.3c below. An in-depth description of these studies was presented in the National Report for 2000. *There have been very few data made available since that report. In a retrospective study of a sample of client records in a treatment setting, it was found that 16.7% had tested positive for HIV (Fitzgerald, et al., 2001). This prevalence rate is significantly higher than those found in recent studies. No explanation for the high prevalence rate is offered in the paper reporting this figure. However, it is noted that the study was primarily an audit of screening for infectious diseases and therefore was of "limited value in estimating true prevalence rates" (Fitzgerald et al., 2001: 33). In a study of a sample of those receiving methadone treatment within a general practice setting, 30 of 343 clients were reported to have tested positive for HIV (Cullen et al., 2000).*

Table 3.3c Summary of research findings on the prevalence of HIV infection among particular cohorts of drug users

Author	Study period	Sample Source	Self Report/ Test	Serum/ Saliva	Sample size tested	% infected of those tested
Fitzgerald et al (2001)	1997	Drug treatment centre n=138	Test	Serum	n/a	16.7%
Cullen et al (2000)	1999	General practice n=571	Test	Not reported	n=343	8.7%
Long et al (2000)	1999	Committal prisoners n=593	Test	Saliva	IDUs ¹⁰ (n=173)	IDUs 5.8%
Allwright et al (1999)	1998	Irish Prison Population n=1178	Test	Saliva	IDUs (n=509)	IDUs 3.5%
Smyth et al (1998)	1992-1997	Drug treatment centre n=735	Test	Serum	IDUs (n=600)	IDUs 1.2%
Dorman et al (1997)	1992	Drug treatment centre & non-treatment IDUs n=185	Test	Serum and saliva	IDUs (n=180)	IDUs 8.4%
O'Kelly et al (1996)	1984-1995	IDUs in community n=82	Test	Serum	IDUs (n=66)	IDUs 65%
Johnson et al (1994)	1991	Needle exchange n=106	Test	Saliva	IDUs (n=81)	IDUs 14.8%

In summary, injecting drug use continues to be one of the main risk categories to which HIV positive cases are attributed each year. Despite the rates of new HIV positive cases attributed to injecting drug use plateauing in the early and

¹⁰ IDUs: Injecting drug users

mid 1990s, recent figures suggest that there is an upward trend in the number of new HIV positive cases among Irish drug users. The information available on those who are testing positive for HIV remains limited. Analysis of the figures highlights the need for more information, in particular of a socio-demographic and behavioural nature, to facilitate comprehensive epidemiological analysis of the trends.

b) Hepatitis B and C

Hepatitis B

There is very little information in Ireland on the prevalence and incidence of hepatitis B among both the general population and the injecting drug using population. While data are collected on the number of positive tests carried out for hepatitis B by the Virus Reference Laboratory, no behavioural data is collected and therefore those infected through drug use cannot be identified. Information on prevalence rates is therefore confined to a small number of special studies that have been carried out in the field. A summary of the research findings is given in table 3.3d. *Only one study has addressed the prevalence of hepatitis B among drug users since last year's report. Cullen et al. (2000) found that 43 of 316 clients attending a general practice for methadone prescription had tested positive for hepatitis B. Overall, the prevalence rates of hepatitis B among samples of injecting drug users range from 1% to 18.5%.*

Table 3.3d Summary of research findings on the prevalence of Hepatitis B infection among particular cohorts of drug users

Author	Study period	Sample Source	Self Report/ Test	Serum/ Saliva	Sample size tested	% infected of those tested
Cullen et al (2000)	1999	General practice n=571	Test	Not reported	n=316	15.7%
Long et al (2000)	1999	Committal prisoners n=593	Test	Saliva	IDUs (n=173)	IDUs 17.9%
Allwright et al (1999)	1998	General prisoners n= 1178	Test	Saliva	IDUs (n=509)	IDUs 18.5%
Smyth et al (1998)	1992-1997	Drug treatment centre n=735	Test	Serum	IDUs (n=729)	IDUs 1%

Hepatitis C

In Ireland, there is no routine data collection in the area of hepatitis C. Only total numbers of individuals who tested positive in a given year are available-it is not possible to differentiate those who have become infected through injecting drug use. However, there have been a number of special studies carried out among samples of drug users in a variety of study settings (see table 3.3e). These were discussed in detail in the National Report for 2000. Three papers presenting findings of special studies have been published since last year's report. In a study of a sample of clients (n=119) attending drug treatment services, of 48 injectors tested, 54% tested positive (Smyth,

2000). Another study of 138 clients in a treatment centre with a history of injecting drug use, found a prevalence rate for hepatitis C of 78.8% (Fitzgerald et al, 2001). Finally, Cullen et al (2000) found that of 372 clients attending a general practice setting for methadone treatment, 270 had tested positive for hepatitis C. In summary, prevalence rates among samples of injecting drug users have been found to range from 52.1% to 89%- clearly indicating hepatitis C among injecting drug users as an issue of concern for public health.

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

Table 3.3e Summary of research findings on the prevalence of Hepatitis C infection among particular cohorts of drug users

Author	Study period	Sample Source	Self Report/ Test	Serum/ Saliva	Sample size tested	% infected of those tested
Fitzgerald et al (2001)	1997	Drug treatment centre	Test	Serum	n/a	IDUs 78.8%
Cullen et al (2000)	1999	General practice n=571	Test	Not reported	n=372	72.6%
Smyth et al (2000)	08/1996-01/1997	Drug treatment centre n=138	Test	Serum	IDUs n=48	IDUs 54%
Long et al (2000)	1999	Committal prisoners n=593	Test	Serum	IDUs (n=173) Non IDUs (n=420)	IDUs 71.7% Non IDUs 1.4%
Allwright et al (1999)	1998	General prisoners n=1178	Test	Serum	IDUs (n=509) Non IDUs (n=669)	IDUs 81.3% Non IDUs 3.7%
Smyth et al (1999a)	1993-1996	Drug treatment centre n=353	Test	Serum	IDUs n=353	IDUs 52.1%
Smyth et al (1999b)	1997	Drug treatment centre n=84	Self-report	n/a	IDUs n=84	IDUs 89%
Smyth et al (1998)	1992-1997	Drug treatment centre n=735	Test	Serum	IDUs n=733	IDUs 61.8%
Smyth et al (1995)	1992-1993	Drug treatment centre n=272	Test	Serum	IDUs (n=272)	IDUs 84%

c) Other drug related infectious diseases

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

Chronic drug effects: The most obvious consequences of HIV and hepatitis B and C are the impact these diseases have on the individual's health. There are no data available on the number of drug users who develop chronic hepatitis C or require care for hepatitis B infection. The only routine data collected on the health consequences of drug related infectious diseases are those on AIDS related cases and deaths. *Since 1983 and up until December 31st 2000, there have been 707 AIDS cases reported in Ireland, and 362 AIDS related deaths. In 2000 there were 21 new drug-related AIDS cases recorded. Intravenous drug users continue to represent one of the main risk categories recorded in this data source. In 2000, intravenous drug users accounted for 28.6% of new AIDS cases, and 38.5% of the year's AIDS-related deaths (see appendix 2, Table 3.3).*

3.4 Other drug-related morbidity – Mary O'Brien

a) Non-fatal drug emergencies

NO INFORMATION AVAILABLE

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

b) Psychiatric co-morbidity

NO NEW INFORMATION AVAILABLE

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

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

areas and/or more willingness in certain areas to admit people with drug problems to psychiatric hospitals.

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

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

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

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

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

c) Other important health consequences

The Medical Bureau of Road Safety (MBRS) in collaboration with the Garda Siochana (police) has undertaken a study to determine current trends in driving under the influence of drugs in Ireland. A survey being carried out in the year 2000 will investigate the presence of amphetamines, benzodiazepines, cannabis, cocaine, opiates and methadone in blood and urine samples taken by the Gardai under the Road Traffic Act, 1994. One thousand samples will be randomly selected and another 1,000 from those who are *under* the legal alcohol limit for driving. Preliminary results (Table 3.4b) from 338 samples (under the legal alcohol limit) showed that cannabis was most frequently found (34%), followed by benzodiazepines (25%). Cocaine was the drug least commonly found at 4% of the sample (Moane et al. 2000).

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

Type of Drug	Percentage Prevalence
Cannabis	34
Benzodiazepines	25
Amphetamines	16
Opiates	14
Methadone	7
Cocaine	4
Total N=338	

Source: Moane et al. 2000

These results indicate that there has been a significant increase in driving under the influence of drugs since 1987, when a similar study was carried out and 14.6% of samples (under the legal alcohol limit) tested were found positive for drugs. The current preliminary study found that the percentage had risen to 37%. The results of this survey, which will be available in 2002, will identify the types of drugs including alcohol, and their combination with other drugs, being used by Irish drivers.

The MBRS is responsible for analysing blood and urine specimens taken from people suspected of driving under the influence of an intoxicant, for prosecution purposes. The number of specimens analysed has been increasing for both alcohol and drugs.

Table 3.4c. Ireland 1995-2000. Toxicological analysis of blood/urine specimens. Numbers.

Year	Alcohol	Drug
1995	4766	8
1996	5514	16
1997	6591	24
1998	7812	32
1999	8476	50
2000	10134	78

Source: Flynn et al. 2001

Analyses of specimens for drug concentrations increased from 8 in 1995 to 78 in 2000. Of the 78 tested in 2000, 71 were found to be positive for drugs; 23 for one drug; 48 for more than one drug.

Table 3.4d. Ireland 2000. Toxicological analysis by type of drug found in blood and urine specimens*. Percentages.

Type of Drug	Percentage
Cannabinoids	32
Benzodiazepines	19
Methamphetamine	18
Amphetamine	15
Methadone	8
Other opiates	7
Cocaine	1
Total N=71	

Source: Flynn et al. 2001

*using Cozart immunoassay kits.

The drug most frequently found was cannabis in almost a third of cases (32%), followed by benzodiazepines (19%). Amphetamine-type drugs were identified in 33% of cases. This study of a small sample of blood/urine samples illustrates the occurrence of polydrug use among of Irish drivers.

Summary:

- *There is great disparity in patterns of drug use in different regions of Ireland. Problematic drug use is mainly in the eastern region of the country, but in recent years heroin use is being reported in other areas. Cocaine use accounted for 7 percent of new treated drug users with multiple drug problems. Demand for treatment for problem ecstasy use declined between 1995 and 1999.*
- *The most comprehensive data available on drug related infectious diseases in Ireland are for HIV. While the number of new positive tested cases for HIV, which were attributable to injecting drug use, appeared to stabilise in the mid-1990s, figures for 1999 showed an increase in the number of cases, which has remained stable in 2000. For both hepatitis B and C, analysis is dependent solely on data from special studies. Despite the absence of comprehensive data it appears from the evidence available that hepatitis C continues to be highly prevalent among Irish injecting drug users. Overall, it would appear from the data that is available that drug-related infectious diseases continue to be an issue of concern in relation to Irish injecting drug users. Furthermore, this highlights the need for more comprehensive data collection in the area of all drug related infectious diseases in order to monitor changes in the trends over time.*
- *The sharp rise in the number of drug-related deaths in the 1990s was partly attributable to more accurate recording procedures, but undoubtedly there was also a real increase in drug-related deaths. In the late 1999 and 2000 the increases of earlier years levelled off.*
- *Findings of ad hoc studies show that the full extent of drug-related deaths is not apparent from the GMR data. These studies also show that polydrug use is a problem among drug users and highlights the need to create more awareness of the risks involved and thereby prevent or at least reduce such deaths.*
- *Given that the full extent of deaths, in particular those related to opiate use, is not evident from official statistics, the need for a Special Register to record indirect as well as direct drug-related deaths has been recognised. Discussions, between the Department of Health & Children, the Department of Justice, Equality & Law Reform, and the Focal Point, are taking place about the establishment of such a Special Register.*

4. Social and Legal Correlates and Consequences

4.1 Social problems

a) Social exclusion

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

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

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

the foregoing, includes violence, threats, intimidation, coercion, harassment or serious obstruction of any person.

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

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

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

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

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

b) Public nuisance, community problems

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

In another study of a local authority estate, Corcoran (1998) similarly reported that all aspects of the drug problem, including drug-taking in public areas and the sale and distribution of drugs, were perceived as the biggest problem. Both Corcoran (1998) and O'Higgins (1999) note that the activities surrounding the distribution of drugs draw a steady stream of non-residents onto estates. This among other factors, exacerbates the "palpable sense of tension" (Corcoran, 1998: 21) in the area. There was a widespread belief among residents that the drug situation was out of the control of both residents and the Gardai (McAuliffe and Fahey 1999). Reporting on research carried out in another large inner-city flat complex with a long history of social problems, Morley (1998) also highlighted the perceived negative impact of drug problems on the quality of life in the community. The socio-economic profile of this estate revealed in the research - high rates of long-term unemployment, low educational attainment levels and high rates of early school leaving - is again indicative of a community struggling with the issues of social exclusion and marginalisation. This estate also hosted a large number of problem opiate users.

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

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

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

The use per se of drugs, excluding opium, is not a criminal offence in Ireland. Under the Misuse of Drugs Acts, 1977 and 1984 (MDA), possession (MDA Section 3) and trafficking/dealing/supplying (MDA Section 15) are illegal activities. In 2000 prosecutions for ‘possession’ of an illegal drug made up 73% of total MDA prosecutions; 24% were prosecuted under Section 15 of the Misuse of Drugs Acts for drug-related trafficking offences (Table 4.2a). A breakdown by Garda regions¹¹ shows that most offences (34%) were committed in the Dublin Metropolitan area (N=2995), followed by 22% in the Southern region (N=1961). The proportion of ‘possession’ offences was almost the same in these two areas: in Dublin 26% (N=1705); in the Southern region, 23% (N=1516). Over half (53%, N=1116) of trafficking (supply/dealing) offences were in Dublin.

Table 4.2a. Ireland 2000¹². Drug law offences by type of offence and region. Numbers and percentages.

Region/Offence Type	Possession (Section 3 MDA)	Supply/Dealing (Section 15 MDA)	Obstruction (Section 21 MDA)	Other offences	Total
Eastern	1376	222	0	1	1599
Dublin metropolitan	1705	1116	95	79	2995
Northern	514	117	11	10	652
South Eastern	749	156	28	7	940
Southern	1516	395	29	21	1961
Western	644	119	13	15	791
Total N	6504	2125	176	133	8938
%	72.8	23.8	2.0	1.5	100.0

Source: Annual Report of An Garda Síochána 2000

With regard to the type of drug involved nationally, more than half (59%) were cannabis offences; in fact cannabis accounted for most of drug law offences in each region of the country (Table 4.2b). Nationally, ecstasy accounted for 25% of drug offences; after cannabis it was the drug implicated in most cases, except, that is, in the Dublin region where heroin accounted for over a quarter (28%) of offences. This is in contrast to the national situation where heroin was implicated in 10 percent of cases. In the Dublin region cocaine offences

¹¹ Since 1996 a regional command structure has been in place in An Garda Síochána and the country is divided into six separate regions – Eastern, Dublin Metropolitan, Northern, South-Eastern, and Western.

¹² Provisional data

were 5 percent of the total; nationally cocaine accounted for 2 percent of offences.

Table 4.2b. Ireland 2000¹³. Drug law offences by type of drug and region. Numbers and percentages.

Region/Drug Type		Cannabis	Heroin	LSD	Ecstasy	Amphetamine	Cocaine	Other	Total ¹⁴
Eastern	N	819	24	5	656	75	19	0	1598
	%	51.2	1.5	0.3	41.1	4.7	1.2	0.0	100.0
Dublin metropolitan	N	1481	778	0	346	47	128	41	2821
	%	52.5	27.6	0.0	12.3	1.7	4.5	1.5	100.0
Northern	N	372	4	7	234	11	2	1	631
	%	59.0	0.6	1.1	37.1	1.7	0.3	0.2	100.0
South Eastern	N	580	3	0	255	55	11	1	905
	%	65.2	0.3	0.0	28.2	6.1	1.2	0.0	100.0
Southern	N	1253	5	10	530	91	21	1	1911
	%	65.6	0.3	0.5	27.7	4.8	1.1	0.1	100.0
Western	N	551	2	7	156	36	7	4	763
	%	73.5	0.3	0.9	20.4	4.7	0.9	0.5	100.0
Total	N	5056	816	29	2177	315	188	48	8629
	%	58.6	9.6	0.3	25.2	3.7	2.2	0.5	100.0

Source: Annual Report of An Garda Síochána 1999

Trends over the six-year period between 1995 and 2000 show an increase in the number of drug charges, from 4146 in 1995 to 8938 in 2000 (Table 4.2c). There was a rise in the number of cannabis offences in 1999 (N=4185) and again in 2000 (N=5056). In 1998 cannabis offences (N=2190) made up 39% of total drug law offences, increasing to 59% in 1999: the proportion decreased a little to 57% in 2000. Heroin offences which had been steadily increasing between 1995 and 1999 dropped slightly in 2000 (N=816), accounting for 9% of total drug law offences. Amphetamine offences increased from 138 in 1995 to 464 in 1999 and dropped in 2000 to 315. The most dramatic jump was in relation to ecstasy offences which more than doubled in 2000 to 2177, accounting for nearly a quarter (24%) of all offences.

Table 4.2c. Ireland 1995-2000. Drug law offences by type of drug. Numbers.

Type of Drug	1995	1996	1997	1998	1999	2000
Cannabis	2600	1834	2671	2190	4185	5056
Heroin	296	432	564	789	887	816
Cocaine	30	42	97	88	169	188
Amphetamine	138	152	239	273	464	315
LSD	70	24	39	13	26	29
Ecstasy	645	340	475	439	1023	2177
Other offences	385	454	65	1839	383	357
Total	4146	3278	4156	5631	7137	8938

Source: Annual Reports of An Garda Síochána 1990-1999

In 2000 cannabis and ecstasy offences accounted for the majority (81%) of offences against the Misuse of Drugs Acts. It is likely that the increase in cannabis and ecstasy offences in 1999 and 2000 was related to intensive

¹³ Provisional data

¹⁴ Total for classification by drug type. There were 309 'other' offences – obstruction etc..

police activity, at large-scale music events at a number of venues in the country. Heroin and cocaine offences were more likely to be detected in the Dublin region.

b) Convictions and court sentences for drug offences

NO INFORMATION AVAILABLE

c) Drug-related crime

THERE IS NO NEW INFORMATION AVAILABLE ON DRUG RELATED CRIME

In a study of the general healthcare of the Irish prison population (sample size = 777: 718 males, 59 females) Hannon *et al.* (2000) found that 51 percent of males and 69 percent of females stated that they were under the influence of drugs when they committed the crime for which they were incarcerated.

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

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

The authors of the National Crime Forum Report (1998, p. 74) stated that they were 'deeply concerned with the impact of drug abuse on crime and the response of the criminal justice system to that issue'. The authors were impressed by suggestions to keep otherwise law-abiding young people out of the criminal justice system – that young experimental users of cannabis and ecstasy should be diverted to the Juvenile Diversion Programme. (The aim of this programme, which was established by the Garda Síochána, is crime prevention and to provide an alternative for juvenile offenders. Rather than being dealt with under criminal law, they enter the programme and thus are diverted from the formal criminal justice system). The case for the decriminalisation of certain drugs was presented to the Forum which agreed

that the issue was important and required more careful study. Those against decriminalisation argued that public opinion was opposed to such a change. A general population survey (Bryan et al. 2000) to examine drug-related knowledge, attitudes and beliefs, could be interpreted to support this view – 66 percent agreed that cannabis should be against the law. Results from the same study found that drug-related crime is considered to be a major problem in Ireland by 94 percent (n=998) of those interviewed, and three-quarters of the sample felt that the drug problem was out of control.

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

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

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

Source: Garda Research Report No. 7/98

Summary

- *Most offences under the Misuse of Drugs Acts are committed under Section 3, that is, for possession of a controlled drug. During 2000 prosecutions involved 'possession' offences in almost three-quarter of cases (73%).*
- *One-third of all MDA offences were prosecuted in the Dublin metropolitan region of the country. Cannabis accounted for the majority of drug law offences in each region of the country, varying from 51 percent in the*

Eastern region, to 74 percent in the western region. Nationally, ecstasy accounted for 25% of drug offences, and after cannabis it was the drug implicated in most offences committed under the MDA, throughout the country. One exception to this was the Dublin region where heroin offences were more likely to be detected, accounting for over a quarter (28%) of offences in that region. Nationally, heroin was implicated in 10 percent of prosecutions.

- *It is likely that the increase in cannabis and ecstasy offences in 1999 and 2000 was related to police activity at large-scale music events in the country.*

4.3 Social and economic costs of drug consumption

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

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

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

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

expressed concern about the quality and consistency of care-giving by drug using parents.

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

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

5. Drug Markets - Mary O'Brien

5.1 Availability and supply

a) Availability of different drugs, trends and possible reasons

The ESPAD 1999 nation-wide school survey of 15-16 year-old post-primary school pupils (Hibell et al. 2001) found that many illicit substances were perceived as being easy to obtain in Ireland. However, in most cases perceptions of availability were lower in 1999 than in the previous ESPAD survey in 1995. Throughout Europe the proportion that thought that inhalants were easy to obtain, was highest among Irish students (63%). This was a decrease from 80 percent since the previous ESPAD study in 1995. Fifty-nine percent of Irish students thought that cannabis was easy to obtain, this was less than the 1995 figure of 62 percent. Irish students were at the top of the list in Europe for perceived availability of LSD (30%): this had diminished from 43 percent in 1995.

Table 5.1 Ireland 1995 & 1999. Perceived availability of substances. Percentages

Substance/Year	1995	1999
Inhalants	80	63
Anabolic steroids	15	19
Marijuana	62	59
Amphetamines	31	28
LSD or other hallucinogens	43	30
Crack	23	23
Cocaine	20	21
Ecstasy	54	35
Heroin	28	21
Magic Mushrooms	-	38
Tranquilisers	31	21

Source: Hibell et al. 1995, 1999.

Qualitative information from a survey in the north-east of the country (an area that is geographically proximate to Dublin), to explore the experience and knowledge of adolescents in relation to barriers and motivating factors to illicit drug use, found that drugs are readily available, in particular cannabis and acid (Department of Public Health 1999). However, unlike the adult world of drug trafficking/dealing where distribution networks revolve around large quantities of money, 'procurement of drugs in adolescent worlds, for the most part, revolves around friendship, reciprocity and sharing, where money is pooled and drugs are shared among friends. The stakes involve friendship not profit' (Department of Public Health 1999: 30).

In a qualitative study of illicit drug use by young people in an inner city community, a sample (n=57) of 15-19 year olds considered to be particularly at risk were interviewed. Thirty-nine were drug users and 18 did not use drugs (Mayock 2000). Both users and non-users were exposed to the drug culture in the locality and for them 'procuring drugs was a largely uncomplicated matter, provided they had the necessary financial resources at their disposal' (Mayock 2000, p. 34). They could identify specific areas in the locality where they could get a range of drugs with relative ease.

Another qualitative study in Mountjoy Prison involving 29 prisoners, found the prison atmosphere to be 'characterised by a drugs culture' (Dillon 2001, p. 3). While availability of drugs within the prison was said to fluctuate, it was reported in the Dillon study that when they are available the drugs are not sold for cash, but are distributed through a reciprocal network system (ibid.).

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

In Ireland there was a sizeable increase in the *quantity* of drugs seized in 1995 over previous years. This can be partly attributed to the setting up of the Garda National Drugs Unit and the Customs National Drugs Team in 1995. In that year there were two major seizures of cannabis, and one seizure of ecstasy contained 40,000 tablets. More recently, the reported ban on opium production by the Taliban in Afghanistan does not appear to have had any impact on the availability of heroin at street level.

Measuring the availability of drugs is a very difficult task given the illicit nature of the activity. Special studies would need to be undertaken in order to explore the issues involved. Given that no such studies have yet been conducted in Ireland it is not possible to comment on drug availability trends.

b) Sources of supply and trafficking patterns within Ireland

The sources of supply vary according to the type of drug. Cannabis comes mainly from Morocco, while some smaller seizures are known to have originated in Pakistan, Afghanistan and Lebanon (Garda Síochána, personal communication). Most of the trafficking in cannabis to Ireland takes place between Morocco, up through Iberian peninsula to the south coast of Ireland. It is transported in freight trucks using cross-channel ferries; and on sea-going yachts. The south-west of Ireland is a major trans-shipment point. In recent years some cannabis seizures were known to have originated in South Africa. Heroin seized in Ireland is thought to come from Asia, mainly Afghanistan, Pakistan, India and Laos. The bulk of heroin seizures are transported to Ireland through the UK and some through the Netherlands. Individual drug couriers travelling by air, bring smaller amounts from Europe. Cocaine traffic is believed to originate in South America. The main place of origin for ecstasy seized in Ireland is the Netherlands and to a lesser extent Belgium (Garda Síochána, personal communication).

The police believe that most of the drugs seized in Ireland in recent years are for the home market. In the case of very large shipments it is speculated that

Ireland with its long coastline, isolated in many areas, is used as an access point for transit to the UK and Europe. The police also believe that the distribution of drugs within the country is organised by networks of criminal gangs. In some cases these gangs involve members of the same family.

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

In recent times the nature of the cannabis market seems to have changed to a larger distribution network, involving smaller amounts of the drug. In other words, there are many more carriers, trafficking smaller amounts of cannabis.

5.2 Seizures

Trends in quantities and numbers of seizures

In Ireland it is not possible as yet to distinguish between police and customs seizures in relation to the quantities and numbers of drugs seized. All seizures, by both police and customs, are included in published Annual Reports of An Garda Síochána (police). *Police and customs authorities increasingly work on a collaborative basis and data collection is being organised so that separate information on seizures will be provided in the future.*

Drug seizures are sometimes taken as an indirect indicator of the supply and availability of drugs, however they are more likely to reflect law enforcement resources, and police and customs activities. The quantity of drugs seized fluctuates from one year to the next, sometimes due to a small number of large seizures. The number seized is usually more useful as an indicator of trends at user level.

Between 1996 and 2000 the total number of seizures increased steadily from 5,244 to 7,706 (Table 5.2a).

Table 5.2a. Ireland 1996-2000¹⁵. Quantity (kgs) and number of seizures of illicit drugs.

Type of Drug	1996		1997		1998		1999		2000	
	N*	Q**	N*	Q**	N*	Q**	N*	Q**	N	Q**
Cannabis	3449	1935.4	4102	1282.7	4513	2201.7	4538	2577.3	4641	588
Heroin	664	10.8	599	8.2	884	38.3	767	17	598	24
Cocaine	93	642	157	11	151	333.2	213	85.6	206	18
Amphetamines	217	7.6	475	102.9	680	45	467	13.4	184	6
Ecstasy***	534	23012	423	20434	509	609301	1074	229101	1910	558588
LSD	42	5901	48	1851	19	798	29	577	31	1127
Benzodiazepines	152	7146	219	4942	181	2885	175	15393	99	2626
Other drugs	93		159		93		55		37	674
Total number seizures	5244		6182		7030		7318		7706	

Source: Annual Reports of Garda Síochána

* N=Number of seizures

** Q=Quantity seized in kilograms; number of tablets in the case of ecstasy, benzodiazepines; and number of doses in the case of LSD. Q of 'other drugs' for 2000 refers to methadone and dihydrocodeine tablets.

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

There are more seizures of cannabis than any other drug: the number increased from 3449 in 1996 to 4641 in 2000. During the same period the number of heroin seizures remained fairly stable dropping to 598 in 2000 from 767 the previous year. Cocaine numbers increased to 213 in 1999 and dropped slightly in 2000 to 201. The number of amphetamine seizures is falling, from the highest number seized (N=680) in 1998 to 184 in 2000. The number of ecstasy seizures increased quite considerably from 534 in 1996 to 1,910 in 2000. It should be noted that 'ecstasy' can include various substances such as MDMA, MDEA, MDA, ephedrine or ketamine, and the user is not necessarily aware of the content. There are no testing facilities at user level in Ireland. In 2000 the number of cannabis, ecstasy and LSD seizures increased over those of the previous year; seizures of all other drugs decreased.

The quantity of different types of drugs seized fluctuates from year to year. Between 1997 and 1999 the quantity of cannabis increased each year, but in 2000 this dropped significantly from 2,577kg in 1999 to 588kg in 2000. The amount of heroin seized in 2000 increased slightly to 24kg from 17kg the previous year. Except for the large amount seized in 1998, heroin seizures have remained fairly stable over the five-year period 1996 to 2000. Cocaine quantities are down considerably, as are amphetamines. The quantity of ecstasy seized in 2000 (558,588 tabs) increased over 1999 (229,101 tabs), but was less than the 1998 amount (609,301 tabs). LSD also increased in 2000 to 1,127 doses from 577 doses for 1999.

In 1999 there was a large quantity of benzodiazepines (15,393 tablets/capsules) seized. The majority of these (13,389) were diazepam and

¹⁵ Provisional data for 2000

one seizure alone that year constituted 7,800 diazepam. In 2000 the quantity of benzodiazepine seizures dropped to 2,626 tablets. The number of seizure also fell from 175 in 1999, to 99 in 2000. All benzodiazepines are controlled under Section 15 of the Misuse of Drugs Acts - it is illegal to supply or deal them other than by prescription. However, in the case of flunitrazepam (Rohypnol) and temazepam they are controlled under both Section 15 and Section 3 of the Misuse of Drugs Acts - it is illegal to supply or possess them other than by prescription.

NO NEW INFORMATION AVAILABLE ON PURITY OF DRUGS

Drug seizures by the police are analysed at the Forensic Science Laboratory of the Department of Justice, Equality and Law Reform, to ascertain purity levels of heroin, cocaine and amphetamine. Cannabis purity, for THC content, is not analysed. Between 1995 and 1999 the purity levels of heroin decreased and in 1999 a minimum purity level of 0.25% was recorded. Purity levels of amphetamine seizures have also decreased somewhat. Cocaine purity levels have fluctuated in the five-year period but the trend is downward (Table 5.2b).

Table 5.2b. Ireland 1995-1999. Purity of seized drugs. Average percentages

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

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

Summary

- The limited information that exists on availability, suggests that drugs are perceived to be easily obtainable. However, perceptions of availability among 15-16 year olds were lower in 1999 than in 1995.
- According to police the drug supply sources are the same as in the past – cannabis from Morocco, heroin from Asia and cocaine from South America. Ecstasy is believed to originate in the Netherlands, and to a smaller extent Belgium.
- Overall, the number of seizures in Ireland increased in 2000. Cannabis and ecstasy account for 85% (6,551/7,706) of the total number. Ecstasy seizures are increasing in both number and quantity. In the case of cannabis, the number of seizures increased but the quantity dropped very significantly. It is speculated that this may be due to a change in the nature of the cannabis market, which seems to have changed to a larger distribution network, trafficking in smaller amounts of the drug (Garda National Drugs Unit, personal communication). Heroin seizures remained stable. Cocaine and amphetamine seizures (number and quantity) were down in 2000.
- Special studies need to be undertaken in order to explore the issues involved in drug markets in Ireland, vis-a-vis availability, sources of supply and trafficking patterns.

6 Trends per Drug - Mary O'Brien

a) Information from different indicators and other sources plus comments on possible reasons and factors that may be associated to reported trends for each substance

There is great disparity in the pattern of drug use in different parts of the country. Overall cannabis is the most commonly used illicit drug. Problematic opiate/heroin use is mainly in the eastern region of the country, around Dublin (cf. Section 2).

b) Analysis for the following substances:

Cannabis

- *Cannabis remains the most widely available and the most commonly used illicit drug in Ireland. Use is more experimental than habitual (see Section 2.2). Latest available survey results show that cannabis use is decreasing. However, this is not borne out by the number of cannabis seizures which has been steadily increasing for several years.*
- *Around 20% of those aged between 18-64 years have tried cannabis at least once (see Section 2.2).*
- *Nine percent of those aged 18-64 have used cannabis in the past 12 months; 5% in the past month (see Section 2.2).*
- *Cannabis use is most prevalent among young people between 18-24 years; around a third have tried it at least once. A quarter of this age group used it in the past 12 months; and 15% in the past month (see Section 2.2).*
- *The relatively high lifetime prevalence rate among 15-16 year olds, found in the ESPAD 1995 study, was not sustained in subsequent research (see Section 2.2).*
- *The proportion of all contacts presenting for treatment for problem cannabis use remained stable at around 15% between 1995 and 1999 (EMCDDA Standard Table 4).*
- *Cannabis is the drug that features most frequently in prosecution and seizure data. Cannabis offences account for 59% of drug law prosecutions. The number of prosecutions increased from 1834 in 1996 to 5056 in 2000 (see Section 4.2). The number of cannabis seizures over the past five years has increased from 3449 in 1996 to 4641 in 2000 (see Section 5.2). The quantities of cannabis seized fluctuated between 1996 and 1999, and dropped considerably in 2000 to 588kg, from 2,577kg the previous year (see Section 5.2).*
- *Preliminary results from a study to determine current trends in driving under the influence of drugs found that cannabis was the drug most frequently found in 34% of cases (see Section 3.4c).*
- *Cannabis was the drug most frequently found (in 32% of cases) in toxicological analyses of blood and urine specimens for prosecution purposes (see Section 3.4c).*

Synthetic drugs (amphetamine, ecstasy, LSD, other/new)

- *After cannabis, although much less prevalent, amphetamines and ecstasy are the second most commonly used drugs in the general population.*
- *Amphetamine use is slightly more common than ecstasy in general population studies. Around 3 percent of those aged between 18-64 had used amphetamines in the past year (see Section 2.2). Among younger people between 18 and 24 years old the annual prevalence was 9 percent. However, the picture among school pupils between 9 and 18 years of age is quite different: recent use of amphetamine, ecstasy or LSD is quite similar (under 2 percent); but prevalence of solvent misuse is higher at 5 percent (see Table 2.2f at Section 2.2).*
- *The proportion presenting for treatment (for the first time) for ecstasy use has decreased, from 11% in 1995 to 8% in 1999 (EMCDDA Table 4).*
- *Treatment for amphetamine use is quite low but has increased a little; from 0.4% in 1995 to 2% in 1999.*
- *After cannabis, ecstasy is the drug that features next in prosecutions and seizures data. Up to 1998, the trend in ecstasy offences was fairly stable but in 1999 and 2000 the number of offences increased considerably (see Table 4.2c at Section 4.2).*
- *Ecstasy seizures come mostly from street or dance events, rather than from point of entry to the country. Tablets tested are composed mainly of a combination of ketamine, ephedrine and caffeine. Ketamine is due to be controlled in Ireland under the Misuse of Drugs Acts, as is 4MTA. There have been no seizures nor reports of use of 4MTA in Ireland; nor have there been reports of ecstasy production in Ireland in recent years.*
- *Preliminary results from a study to determine current trends in driving under the influence of drugs found that amphetamine was found in 16% of cases (Moane et al. 2000).*

Heroin/opiates

- *Heroin dependence is still mainly concentrated in and around the Dublin area, although this seems to be changing with diffusion to urban areas throughout the country. The 'visible' users have serious health and social problems. Unlike treated heroin users in other EU countries, they are a younger population: around 80% of all contacts presenting for treatment are between 15 and 29 years of age; up to 90% of those presenting for treatment for the first time are aged between 15 and 29. There are no indications of serious psychiatric problems among treated drug users.*
- *Heroin is the least used drug in Ireland but it is the most problematic with serious health and social consequences.*
- *The trend some years ago (among treated heroin users) towards smoking rather than injecting heroin now seems to be changing. Smoking was the preferred route for people starting to use heroin, at least initially. However, latest trends show that heroin is more likely to be injected. It seems that people who originally preferred to smoke heroin are now no longer reluctant to inject (O'Brien et al. 2000).*
- *In 2000 heroin offences constituted 10% of total drug law offences (see Section 4.2). The number of annual heroin seizures fluctuates from year to year but remains fairly stable. There were 598 heroin seizures in 2000, out of a total of 7,706 for all drug types. In the five years between 1996*

and 2000 the largest quantity was seized (38kg) in 1998. For other years the amount fluctuated between 11kgs in 1996 and 24kgs in 2000 (see Table 5.2 in Section 5.2).

- Preliminary results, from a study to determine current trends in driving under the influence of drugs, found opiates in 14% and methadone in 7% of cases (Moane et al. 2000).

Cocaine/crack

- Cocaine is used by about 2% of the general population in Ireland.
- Treatment demand for problem cocaine use has always been very low: less than 2%. Apart from addiction counselling, there are no specific treatments for problem cocaine users in Ireland right now. Of all those presenting for treatment for the first time in 1999 with multiple drug problems (64%), 7% were seeking treatment for problem cocaine use.
- *Up to 1999 the number of cocaine seizures was increasing. However, in 2000 there was a slight drop: there were 206 seizures of cocaine out of a total of 7,706 for all drug types. In 2000 there was also a considerable decrease in the quantity of cocaine seized from 86kgs in 1999 to 18kgs in 2000.*
- A small-scale (N=10) qualitative study of recreational cocaine users found that cocaine is more easily available in Ireland than previously, and that more people are perceived to be using it. It is used in private social settings, such as home-based parties, rather than in public settings (I Moran et al. 2001).
- Preliminary results from a study to determine current trends in driving under the influence of drugs found that cocaine was present in 4% of cases (Moane et al. 2000).

Multiple use

- In 1999, 64% of clients presenting for treatment for the first time were using two or more drugs. Heroin was the primary drug for which the majority of people sought treatment. Cannabis was the most frequently cited (26%) secondary drug of misuse followed by ecstasy (21%); benzodiazepines (10%); amphetamines (9%); cocaine (7%); and methadone (7%) (National Drug Treatment Reporting System, personal communication).
- *Concern was expressed from a number of quarters regarding the over-prescribing of benzodiazepines, in general, and in drug treatment settings. Benzodiazepines continue to be widely prescribed particularly to women, the elderly, the chronically ill, and other groups of people socially and educationally disadvantaged (Quigley 2000). Quigley states that 'benzodiazepine regulation is a crucial public health responsibility', and goes on to say that the medical profession should acknowledge its central role 'in the creation, as well as the solving, of drug problems'. In 2000 a Committee was established by the Minister for Health and Children to explore the nature and extent of benzodiazepine prescribing in Ireland. This Committee will examine current trends and make recommendations on good prescribing practices, paying particular attention to the management of drug users. The Committee is due to make its report to the Minister at the end of 2001.*

- A study on drug-related death in 1999 found that benzodiazepine was the drug most commonly identified (in 75 cases), and was mainly in combination with other drugs. The most common combination of drugs was opiates and benzodiazepines (Keating *et al.* 1999).
- Preliminary results from a study to determine current trends in driving under the influence of drugs found quite a high prevalence of benzodiazepines – in 25% of cases (Moane *et al.* 2000).

7. Conclusions

7.1 Consistency between indicators

The five key indicators of drug misuse are at different stages of development as tools to measure the drug situation in Ireland. For example,

- *Estimates of national and local prevalence of problem drug use are at initial stages of development, and studies on prevalence of problem drug use are limited*
- *General population surveys on the use of all types of illicit drugs are very scarce, which makes it very difficult to make comparisons or discuss trends in drug use. Where they are available comparability can be a problem.*
- *A number of ad hoc studies on the prevalence of infectious diseases among drug populations of drug users have been carried out, but no systematic monitoring of such populations for disease prevalence is currently taking place.*
- *Statistics on drug-related death, which are obtained from the General Mortality Register at the Central Statistics Office, are not, by their nature, all-inclusive of death related to drug use. Research on mortality among drug-using populations is only just beginning to be carried out in collaboration with the EMCDDA.*
- *Treatment demand monitoring, the most developed of the indicators, has been adversely affected in recent years, mainly due to lack of commitment/priority given to data collection by drug treatment service providers.*
- *Drug seizures over a number of years can indicate trends in drug use. Law enforcement data tend to be more of a reflection of police and customs activities than good indicators of drug use*

Despite all these drawbacks, there have been improvements in data collection and monitoring, for example, GMR data collection, law enforcement data, data on infectious diseases.

From the limited information that is available there does seem to be some consistency between indicators of drug misuse. For example, in the case of more problematic opiate use a number of indicators – treatment demand, deaths, HIV and survey data – point to a stabilisation in use. In the case of cannabis use, consistencies are not so evident: population surveys point to a decrease or a stabilisation in use; whereas law enforcement data, particularly the number of drug seizures, indicate increasing use. The quantity of cannabis seized, however, did drop very considerably in 2000.

7.2 Implications for policy and interventions

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

Against the background outlined above, the difficulties involved in attempting to make interpretations from the data that are available can be understood. Even taking the improvements in monitoring, data collection and institutional procedures, which initially partially contributed to increasing trends, into consideration, these trends have not been sustained. The rising trend in drug use seen over several years, now seems to be stabilising.

It is difficult to offer reasons, and explanations can only be speculative. Several factors are likely to be involved, such as the availability of drugs at street level, drug prevention policies. However in the absence of consistent, comparable and regular data collection, it is impossible to make meaningful interpretations.

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

The gaps in available information, particularly in relation to the main indicators of drug misuse, do not help in the formulation of good policies. Therefore the development of the five key indicators is vital. As well as this, more in-depth qualitative research studies are needed in order, for example, to understand more about different user groups, different patterns of use e.g. drug users involved in risky behaviours. This would help towards making prevention strategies more effective.

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

7.3 Methodological limitations and data quality

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

- General population surveys to study the extent of drug use in Ireland vary in objectives, methodologies, focus of data collection, questionnaire design, age groups studied etc.. Comparisons are therefore tentative and must be viewed with these variations borne in mind. If meaningful interpretations and comparisons are to be made a priority for future work should be that prevalence surveys are carried out using comparable methodologies. Information on recent and annual use should be available as well as lifetime experience of drug use. Surveys should be comparable nationally as well in the wider European sense where possible. It is also important that these surveys be replicated at frequent interval if trends over time are to be available.
- More work needs to be carried out on the improvement and evaluation of data quality, particularly in relation to the five key indicators of drug misuse.
- More in-depth qualitative research studies are needed to understand more about at-risk groups, such as injecting drug users, and thus help towards making prevention strategies more effective.
- Interest in the availability of drugs has been growing. However, measuring this is a very difficult task given the illicit nature of the activity. Special studies would need to be undertaken in order to explore the issues involved in drug markets in Ireland, vis-a-vis availability, sources of supply and trafficking patterns.
- In Ireland, there are no estimates of consumption or demand, or expenditure on drugs available. Nor are there any estimates of healthcare or other social costs available. This is an area that will need to be developed.

PART 3

DEMAND REDUCTION INTERVENTIONS

8. Strategies in Demand Reduction at National Level – Martin Keane

Demand reduction comprises interventions, which are aimed at decreasing the demand for drugs at an individual or at a collective level. Interventions aimed at reducing the harmful consequences of drugs are also included. The scope of demand reduction intervention is wide and consists of many facets. (EMCDDA 1996)

8.1 Major strategies and activities

The Irish Government's approach to combating drug misuse in the coming years has been set out in the National Drugs Strategy 2001-2008. The strategy includes four key areas that will receive focused attention from government and other relevant agencies, namely the areas of supply reduction, prevention, treatment and research. In terms of demand reduction, the areas of prevention, treatment and research are of particular relevance.

Prevention

A number of government departments are involved in delivering a range of education, prevention and awareness measures that aim to reduce the demand for drugs. For example, the Department of Education and Science oversee a number of initiatives, which are aimed at addressing the link between drug misuse and educational disadvantage. Such initiatives include The Disadvantaged Area Scheme, The Stay in School Retention Initiative and the Home-School Liaison Scheme. The rationale underlying these initiatives is that by seeking to improve educational opportunities for disadvantaged young people, a corresponding decrease in the demand for illicit drugs may materialise. The Department of Education and Science also oversee the provision of two key national prevention programmes which specifically aim to prevent school going individuals from engaging with illicit drug misuse. The Substance Misuse Prevention Programme "Walk Tall" is delivered to primary school pupils, while the Substance Misuse Prevention Programme "On My Own Two Feet" is provided to secondary school students.

The Department of Health and Children focuses on the need for education and prevention in terms of equipping young people with the skills and resources that may prevent engagement with illicit drug misuse. The Department through the Health Promotion Unit is responsible for disseminating information on drug misuse to the general public and in particular to groups that are designated at risk. The Department, through the regional Health Boards has developed extensive links with the Community and Voluntary sectors and is in a position to contribute to the provision of prevention, outreach and harm reduction programmes throughout the state.

Treatment

The Department of Health and Children has primary responsibility for developing aspects of drug misuse policy related to treatment, through the Drugs/AIDS/HIV Services Unit which is a sub-division of the Primary Health Care Division. Responsibility for the provision of treatment and rehabilitation services for drug misusers is vested in the ten Regional Health Boards. In particular, the Eastern Regional Health Authority (ERHA) which includes the Greater Dublin area has been involved in developing an expansive range of services, covering prevention, harm reduction and treatment/rehabilitation (See Section 9.3). In addition the health boards outside the ERHA region have also been involved in providing treatment services through the services of addiction counsellors, psychosocial therapy programmes and family support. Also, It must be noted that representatives from the voluntary sectors provide a range of services and supports in the areas of prevention and treatment of drug misuse.

Local Drug Task Forces

A key part of the National Drug Strategy is the development of the Local Drug Task Forces (LDTFs). The LDTFs were set up to provide a strategic local response to drug misuse in priority areas. There are currently 14 LDTFs operating under the direction of the National Drug Strategy. Twelve task forces operate in the Greater Dublin Area in what have been termed priority areas where drug misuse has been identified as an issue that merits attention. The remaining task forces are located in North Cork in the South of Ireland and in Bray, Co. Wicklow an area close in proximity to Dublin. Both areas have been linked with a serious drug misuse problem. Each task force is comprised of representatives from statutory, voluntary and the community sector. It is planned to develop the task force model by having a task force in each region by the end of 2001. (See section 8.2)

Each Task Force is involved in developing local action plans that are designed to respond to the issue of drug misuse at area level. Such responses include a range of measures such as treatment, education, rehabilitation and prevention. Funding is provided at government level to support the implementation of local initiatives under the respective task forces, for example, a sum of €154908045 has been provided in the National Development Plan to support the work of the Local Drugs Task Forces up to 2006.

Research

The National Advisory Committee on Drugs (NACD), that was established in July 2000, has collaborated with other groups and individuals on preparing a three-year research programme in the drug area. It is anticipated that the outcomes of research will contribute significantly to the development of policy on drugs, in particular in the field of demand reduction. For instance, priority areas for research have been identified to include prevalence, treatment outcomes and research into drug use and also marginalised groups in an Irish context. (See section 10.3)

The Drug Misuse Research Division (DMRD) of the Health Research Board (HRB) continues to be the designated central point to which all drug research data and information should be sent. In order to facilitate this process, the DMRD is developing a National Documentation Centre which will contain all relevant and up-to-date information and research in the field of drug misuse in Ireland and internationally. The centre when established will be accessible to the public and facilitate ease of access and retrieval of drug related research for policy makers and researchers with an interest in the field.

In addition the Eastern Regional Health Authority plans to conduct a number of evaluations during 2001 into the addiction services that they provide. For instance it is planned to carry out:

- An evaluation of the drug treatment services investigating adherence of service providers to prescribing protocols, assessment and referral procedures, methadone users' perception's of the quality of service, and the experience of heroin users not currently in treatment*
- A review of the drug treatment waiting list to validate the numbers awaiting treatment, to profile clients on the waiting list and to assess treatment personnel's views of the efficiency of the waiting list procedures.*

8.2 Approaches and New Developments

a) New and Innovative Approaches

Rehabilitation

In recent times there has been an increasing focus on developing the role of rehabilitation provision for recovering drug misusers. This is in part due to the increasing number attending treatment (See Section 9.3) plus the recognition that individuals who have been through or are progressing through primary treatment services very often require further support and intervention in order to access mainstream education and employment opportunities. The definitional boundaries between treatment and rehabilitation can quite often appear blurred. However, in relation to opiate addiction one approach can be to view treatment as the pre-stabilisation stage involving detoxification, and methadone maintenance. Whereas rehabilitation can be seen to occur in the post-stabilisation stage, covering the period when an individual is encouraged to engage with educational/training activities for instance. In both the treatment and rehabilitation phases, there is also a range of therapeutic options available.

The emphasis on rehabilitation has received a more focused approach in recent times, particularly within the Eastern Regional Health Authority area (ERHA). This is not surprising given that, by far the greatest number of individuals reporting for treatment is drawn from the ERHA region. (See NDTRS Data) In response, a blueprint was drawn up in 2000 to guide the development of rehabilitation services within the remit of the ERHA. Central to the measures set out in the aforementioned blueprint, was the creation of "re-integration centres" in the three health board areas under the ERHA. It was proposed that these centres would provide a base for integration workers to support individual clients towards re-integration into mainstream social

activity. In pursuit of this aim the centres would provide career guidance and counselling, personal skills development, and educational/training opportunities. The latest information would seem to suggest that the development of these centres is still on track in two of the three health board areas. In the Northern Area Health Board (NAHB) where the idea of a re-integration centre has been sidelined, a re-habilitation manager has been appointed to work in each of the five task force areas within their remit. In addition, the NAHB have appointed three re-habilitation co-ordinators to oversee policy creation, quality assurance and strategic planning for the area. Two facilitators will assist each co-ordinator.

Further recognition of the important role of rehabilitation for people recovering from drug misuse is evidenced by the recently produced recommendations from the South-Eastern Health Board's Regional Treatment and Rehabilitation Working Group 2001. Some of the key recommendations that have been documented by the Treatment and Rehabilitation Working Group are:

- That a Substance Misuse Unit should be established in each Community Care area. Such a unit would primarily play a co-ordinating role regarding substance misuse activities in each area.
- That a regional counselling policy is developed which would be community based and easily accessible, particularly to under eighteen-year-olds.
- That outreach services are developed to target at risk community members.
- That locally based treatment services should include harm reduction, counselling, support aftercare, rehabilitation and detoxification.
- That 'one-stop shops' be established where different services are represented and young people feel relaxed about making inquiries.
- The Health Board should support the development of supervised 'Halfway Houses'.
- The difficulties in accessing treatment for drug users who are homeless, in prostitution or pregnant need to be addressed.
- All hospitals in the South-East region should have clear protocols for the management and referral of drug misusers admitted hospital.
- A system of on-going evaluation needs to be developed for treatment services.
- A partnership approach should be developed for the provision of prevention, treatment and aftercare programmes.

(South Eastern Health Board Regional Treatment and Rehabilitation Working Group Recommendations 2001; South Eastern Health Board Drug Co-ordinating Unit)

Regional Drug Task Forces

A key recommendation contained in the National Drugs Strategy Programme for 2001-2008 is the creation of a number of Regional Drug Task Forces (RDTFs) to be established in each of the ten regional health board areas. The RDTFs will consist of representatives from the statutory, voluntary and community sectors and are being set up:

- To ensure the development of a co-ordinated and integrated response to tackling the drugs problem in their region;
- To create and maintain an up-to-date database on the nature and extent of drug misuse and to provide information on drug-related services and resources in the region;
- To identify and address gaps in service provision having regard to evidence available on the extent and specific location of drug misuse in the region;
- To prepare a development plan to respond to regional drugs issues for assessment by the NDST and approval by the Inter-Departmental Group (IDG);
- To provide information and regular reports to the NDST in the format and frequency requested by the team; and
- To develop regionally relevant policy proposals, in consultation with NDST. (Building on Experience: National Drugs Strategy 2001-2008, Department of Tourism, Sport and Recreation)

Social Inclusion Initiative

The Northside Partnership is an area-based company working in a designated area on the Northside of Dublin. The work of the partnership is primarily engaged in combating social exclusion and promoting social integration: the target area comprises over 100,000 people. The partnership has identified a number of specific priority groups that experience social exclusion. Through consultation with relevant agencies and organisations ex-drug misusers have been identified as a social group that have tended to be marginalised in terms of accessing education and employment opportunities. The partnership has recognised that an estimated 4,000 drug misusers are resident in the partnership area (New Frontiers 2000-2006). In response, the partnership has outlined a series of measures that aim to support existing social integration initiatives with ex-drug misusers. In addition, the partnership has developed a number of innovative initiatives that aim to assist ex-drug misusers in the process of reintegration. For example, The Labour-Market Inclusive Project (LIP) is designed to target recovering drug misusers referred by treatment centres. It aims to support participants before and after placement in employment. Additional work with ex-drug misusers will take place through the Targeted Outreach Initiative which aims to make contact with ex-drug misusers who are not contactable through treatment centres; and the Business Network Initiative which comprises of local business contacts that work to reintegrate ex-drug misusers into employment

Drug misuse and young homeless people

A new development to emerge in recent times has been the focus on service provision for young homeless people who misuse drugs. The Eastern Regional Health Authority (ERHA) has recently appointed a Director of Homelessness, and the three area health boards under the auspices of the ERHA have each appointed an Assistant Chief Executives for Child Care and Homelessness. The ERHA have identified a core of approximately 23 young people who continually present for emergency accommodation.¹⁶ Behavioural

¹⁶ See <http://www.erha.ie>

problems and substance misuse among these young people are seen as further obstacles to them securing accommodation.

Under the ERHA a large property in the north inner city of Dublin capable of providing a day treatment programme for up to a 100 young local drug misusers has been purchased. In addition, proposals are being formulated by the ERHA to provide a detoxification centre for young homeless people. Also a 12 bed residential service and two additional day services for drug users under 18 from the south inner city of Dublin is to be established at Cherry Orchard Hospital.¹⁷ According to the Service Development Plan of the ERHA for 2001, an allocation of €380921 is provided to enable initiatives to be developed for homeless young people who are drug misusers. It is envisaged that specific facilities will be developed in each of the three area health boards to ensure access by young homeless persons to the relevant drug services.

b) Socio-cultural developments relevant to demand reduction

In recent year's social policy analysis and the construction of policy in an Irish context has witnessed an increase in the usage of the term 'social exclusion'. In particular, policy developments in the drug area have come to embrace the idea that 'problematic drug users' primarily tend to experience high levels of 'social exclusion'. According to the Combat Poverty Agency of Ireland¹⁸

" Social exclusion is a process which pushes people out to the edge of society and distances them further and further from the chance of a job or an adequate income, from social and educational opportunities, from social and community networks , and from power and decision making."

It could be argued that one of the strengths of seeing the drug problem, as being influenced by social conditions, is that in responding the emphasis is as much on society as on the individual engaged in drug misuse. In terms of Irish society, in recent times the response has been to counteract the negative effects of social exclusion by focusing on the merits of social inclusion. A particular model of partnership has underpinned this move towards a more socially inclusive socio-cultural framework in the drug field. This has manifested itself, whenever possible, in promoting a coordinated approach between the statutory, voluntary and community sectors in pursuit of creating the social conditions that will enhance the chances of those involved in drug misuse to rehabilitate and reintegrate as far as possible into mainstream society. Much of this activity has taken place within a policy framework greatly influenced by the idea that it is necessary to support social inclusive initiatives if marginalised groups such as drug users are to be reintegrated. For example, the Cabinet Committee on Social Inclusion as part of its wide remit, has political responsibility for reviewing trends in the drugs problem, for assessing progress in implementing the National Drugs Strategy and for resolving policy or organisational difficulties which may inhibit effective responses to the problem.

¹⁷ See <http://www.erha.ie>

¹⁸ See <http://www.cpa.ie>

c) Developments in Public Opinion

The data referred to in this section comes from two studies that investigated public attitudes towards, and perceptions of, aspects of the drug issue in Ireland (Bryan et al, 2000, 2000 data unpublished). Both studies touched on many aspects of public opinion that have a bearing on how measures to reduce the demand for illicit drugs are perceived in Irish society. For example, both studies investigated public attitudes and perceptions towards:

- drug users and drug addicted individuals;
- drug treatment for individuals engaged in drug misuse;
- and aspects of current drug policy including drug prevention, harm reduction, drug education

A majority of the Irish people does not view drug addicts as criminals, and there has been little change to this viewpoint between the years 1998 and 2000. (Table 8.2a) This attitude could be taken as one indicator that the Irish public would be supportive of measures taken by the state to treat individuals who present for drug misuse treatment. Also, a further interpretation may be that a majority of people in Irish society has begun to question the links between drug addiction and criminality.

Table 8.2a. Changes in attitudes towards drug addicts, 1998-2000

Statement	Survey year (number of responses)	Agree %	Disagree %	Don't Know %
I would see drug addicts more as criminals than victims	1998 (n=999)	42.6	45.2	12.1
	2000 (n=998)	37.8	45.6	16.6

Source: 1998 data Bryan et al 2000, 2000 data unpublished

In supporting the view that drug addicts are more victim than criminal (Table 8.2a) it could be argued that a majority of the Irish people are implicitly questioning the efficacy of the use of prison as a criminal justice sanction for drug addicts. Indeed, this interpretation is given additional support by the findings recorded below. (Table 8.2b) This shows a majority of the Irish public agrees with the statement that drug addicts charged with a petty offence ought to be allowed to choose between treatment and prison.

Table 8.2b. Changes in the support for alternative policy interventions, 1998 and 2000

Statement	Survey year (number of responses)	Agree %	Disagree %	Don't Know %
Drug addicts charged with petty offences should be given a choice between treatment and prison service	1998 (n=997)	71.9	17.2	10.9
	2000 (n=994)	72.9	15.2	11.9

Source: 1998 data Bryan et al 2000, 2000 data unpublished

However, as (Table 8.2c. Below) shows an increasing proportion of Irish society agrees with the view that treatment should only be given to drug addicts who intend to give up drugs for good. Perhaps in some quarters this could be interpreted as a hardening of public attitude towards some drug

addicts whose intentions regarding drug treatment may sometimes be open to question. Nevertheless it would seem the case that the public is very much in favour of treatment provision for drug addicts (Table. 8.2c) and that treatment for drug addiction has become a legitimate and integral part of the demand reduction response in Irish society.

Table 8.2c. Changes in the support for drug treatment strategies, 1998 and 2000

Statement	Survey year (number of responses)	Agree %	Disagree %	Don't Know %
Treatment should only be given to drug addicts who intend to give up drugs for good	1998 (n=999)	64.5	27.3	8.2
	2000 (n=997)	73.8	18.4	7.8
Treatment should be available to all drug addicts according to their needs	1998 (n= 999)	90.2	3.7	6.1
	2000 (n=999)	90.5	3.1	6.4

Source: 1998 data Bryan et al 2000, 2000 data unpublished

There is widespread public approval towards the view that money spent on prevention of drug use is money well spent (Table 8.2d). In addition it would appear from that the Irish public express positive affirmation regarding drug education as a viable preventative strategy, whilst agreeing with the view that primary level in school is the most appropriate social location for the beginning of drug education.

Table 8.2d. Changes in the support for drug prevention strategies, 1998 and 2000

Statement	Survey year (number of responses)	Agree %	Disagree %	Don't Know %
Money spent in the prevention of drug use is money well spent	1998 (n=997)	91.6	4.1	4.3
	2000 (n=998)	87.3	3.8	8.9
Drug education in school should start at primary level	1998 (n=996)	94.5	2.3	3.2
	2000 (n=999)	93.5	2.9	3.6

Source: 1998 data Bryan et al 2000, 2000 data unpublished

Public support for the use of medically prescribed heroin substitutes such as methadone or physeptone among drug addicts has increased. (Table. 8.2e) However it should be noted that 29% of the Irish public either disagree with this position or are unsure of their attitude towards the issue. Public support for the provision of syringes and needles has also increased (Table 8.2e) but again there is a notable opposition and uncertainty on the part of the public regarding this aspect of harm reduction.

A further analysis (Table 8.2e.) raises some important questions regarding the dissemination of drug related information to the public which is crucial in gaining public support for demand reduction interventions. For example, it could be argued that the provision of methadone as a heroin substitute has been, to some extent at least, a relatively effective tool in reducing the commission of criminal acts by drug addicts. Yet, almost 30% of the public are either opposed to its provision or are uncertain of their position on the issue. This could be due to the fact that the public is not being made aware of the links between the use of methadone and a reduction in crime. Similarly, the provision of syringes and needles to drug addicts usually means that there is an exchange for 'dirty' needles, thereby reducing the risk of the spread of drug

related infectious diseases. Yet, almost 28% of the public either disagree or express a 'don't know' position regarding the provision of syringes and needles to drug addicts. This again suggests that the quality of information for public consumption may need some revision if harm reduction measures are to gain similar levels of public support as the provision of drug treatment and education enjoy.

Table 8.2e. Changes in the support for harm reduction strategies, 1998 and 2000

Statement	Survey year (number of responses)	Agree %	Disagree %	Don't Know %
Medically prescribed heroin substitute (such as methadone, physeptone) should be available to drug addicts	1998 (n=933) 2000 (n=963)	64.8 70.9	16.1 14.3	19.1 14.7
Society should provide syringes and needles free of charge to drug addicts to avoid the spread of HIV/AIDS	1998 (n=998) 2000 (n=998)	66.7 72.3	17.3 14.4	15.9 13.2

Source: 1998 data Bryan et al 2000, 2000 data unpublished

In the final analysis, it could be argued that by embracing drug treatment, and drug education as viable methods in addressing drug addiction, the Irish public is indicating their strong support for some of the key strands of official demand reduction strategy. The Irish public appear amenable to embracing aspects of harm reduction with similar enthusiasm and perhaps a more effective means of disseminating information to the public will enhance this process.

d) New Research Findings

People sleeping rough in Dublin and using drugs:

The Dublin Simon Community in partnership with the Merchant's Quay Project, initiated a feasibility study to explore the possibility of setting up a direct access hostel in Dublin, for people who are sleeping rough and using drugs (Costello and Howley 2000). As part of the study 15 people who were sleeping rough in Dublin and using drugs were interviewed in depth using a semi-structured interview. The interviews were conducted qualitatively with the focus on the experience of drug use and homelessness among the interviewees. Twelve of the sample was accessed while they were begging on the streets, and a €6.35 payment was offered as payment for their time. The three remaining interviewees were accessed through hostels.

All 15 interviewees reported injecting heroin on a daily basis. The extent of drug use varied from injecting twice a day to injecting eight times a day, with a daily cost varying from €101.50 to €254 per day. In terms of maintaining their drug use, the two primary options utilised were stealing or begging.

In addition, sixteen hostels, five transitional housing projects and two refuges were included in a survey of policies relating to illicit drug use in homeless services in Dublin (IBID). The study found that hostels and night shelters tended to limit access to people who were identified as active drug users. Additional factors such as charging high rents and barring individuals, who are

found to be drug users for long periods of time, contribute to many homeless people who are using drugs having no other options but to sleep rough on the streets. It was found that few transitional housing projects were willing to accommodate people who were using or had a history of using drugs. Overall, the authors of the study concluded that there is an urgent need for a direct access hostel which would overcome access barriers for homeless people using drugs and provide relevant support needs for residents.

e) Specific events during the reporting year

Perhaps the most significant event in terms of developing the field of demand reduction in an Irish context was the launch of the new National Drugs Strategy 2001-2008. This strategy has already been referred to in Section 8.1.

One of the key developments emerging from the Drugs Strategy in terms of providing tangible support for demand reduction was the announcement during the year of €4444083 in capital funding for Local Drug Task Force Projects. This money has been allocated primarily for the purpose of refurbishing premises being used by local drug projects. In total 16 separate projects have benefited through funding under the new Community Based Premises Initiative which has been underpinned to the value of €12697380 to cover the next three years.

f) Dissemination of information on demand reduction among professionals (networks, Internet, etc)

DrugNet Ireland

The Drug Misuse Research Division of the Health Research Board publishes and distributes the newsletter "Drugnet Ireland" twice yearly. This newsletter fulfils an important role in the distribution of information, news and research among health professionals and other interested parties involved in the drugs area in Ireland. Its readership includes community groups, policy makers, treatment providers and academics. The newsletter contains information on research, recent publications, and upcoming events. It also looks at developments in the drugs area within the EU, as well as local and world news.

EDDRA

The EDDRA project plays a key role in the demand reduction field by raising awareness on the different types of demand reduction activities that operate throughout the country. In order to facilitate this process further, an "EDDRA column" will be included in Drugnet Ireland, with effect from the next publication in November 2001. This column will include regular up to date information on developments relating to demand reduction initiatives at national level. Also included will be an assessment of 'best practice' models of demand reduction at national level, while the importance of impact/outcome evaluation of interventions will be emphasised. Significant attention will be given to encouraging local projects/initiatives to explore and develop the theoretical foundations on which their interventions are grounded.

9. Intervention Areas

a) Typologies of interventions with synthetic description of: objectives, target groups, settings and results.

9.1 Prevention

The field of prevention is very much dominated by interventions that target children 'at risk' and also the provision of initiatives to support parents by providing drug awareness courses, and in general seeking to improve the content of information on drugs that parents receive. A key source of funding for many initiatives in the preventative field has been the Young People's Facilities and Services Fund (YPFSF). This fund was established by the Government in 1998 to assist in the development of preventative strategies in a targeted manner through the development of youth facilities, including sport and recreation facilities and services in disadvantaged areas, where a significant drug problem exists or has the potential to develop. The aim of the fund is to attract "at risk" young people in disadvantaged areas into these facilities and activities, thereby diverting them from the dangers of substance misuse. Listed below is an example of some of the initiatives that are prominent in the prevention field.

9.1.1 Infancy and Family

(a) Intervention in different fields

During pregnancy and for future parents:

A number of drug liaison midwives have been appointed to work in three major hospitals in Dublin. The hospitals in question are the Coombe, the Rotunda and Holles St. hospital, with each providing an extensive maternity service. A large part of the workload of each midwife entails visiting the various drug treatment centres located around the city of Dublin, and making contact with women who are pregnant and misusing drugs. This work occurs on an almost daily basis and is viewed as being essential in building trust and positive relationships with the women involved. No evaluation has been carried out on this service yet and the limited amount of statistical information available indicates that in the case of one midwife during the first seven months of her work she worked directly with 40 women who were pregnant and misusing drugs.

Families with adolescent children/'children at risk'.

Category:	Primary prevention
Name of project:	The Springboard Initiative
Projects aims:	To support families with children 'at risk'
Activities:	Community supports

Category:	<i>Drugs information provision</i>
Name of project:	<i>Mid Tipperary Drugs Initiative Parenting Programme</i>
Projects aims:	<i>To inform local parents on drug misuse issues</i>
Activities:	<i>Group discussion led by facilitators</i>

Category:	<i>Drugs information provision</i>
Name of project:	<i>Carlow Community Awareness of Drugs (CCAD)</i>
Projects aims:	<i>To create awareness among local parents, children and teachers on drug misuse related issues</i>
Activities:	<i>Drug information courses for parents, drug projects for 1st year students in local schools, running Addiction Studies courses, presenting talks on drug issues in local schools</i>

Category:	Parent support programme
Name of project:	Fas Le Cheile
Projects aims:	To encourage inter-family dialogue, to provide accurate information on drugs and alcohol and to enhance parenting skills and confidence
Activities:	Group discussion, peer led facilitation, training parents to run courses for other parents

Category:	Parenting education and support programme
Name of project:	Family Communication and Self-Esteem
Project aims:	The enhancement of parents and children's self-esteem, develop responsibility for family health and raise awareness of drug related issues and provide accurate information on drugs
Activities:	Tutors receive specialised training to run health education and drug awareness courses for parents and children

(b) *Intervention in crèche, kindergarten and other specific interventions*

Crèche facilities are provided in association with drug treatment services on a limited basis at present. For example, a pilot study (Moran 1999) that looked at the availability, use and evaluation of the provision of crèche facilities in

drug treatment locations found that when the study was being carried out in late 1998, 20% of the 45 treatment centres in Dublin provided crèche facilities.

(c) Statistics and evaluation results

Project	Statistics	Evaluation Results
<i>Springboard Initiative</i>	<i>No statistics available</i>	<i>No evaluation carried out</i>
<i>Mid Tipperary Drugs Initiative Parenting Programme</i>	<i>No statistics available</i>	<i>No evaluation carried out</i>
<i>Carlow Community Awareness of Drugs</i>	<i>No statistics available</i>	<i>No evaluation carried out</i>
<i>Fas Le Cheile</i>	<i>No statistics available</i>	<ul style="list-style-type: none"> a) <i>improvement in parents communication and listening skills with children</i> b) <i>parents report relevancy of course content</i> c) <i>improvement in overall parental skills and in dialogue between partners/spouse (Evaluation of Medium Term Impact of Fás Le Cheile 1999)</i>
<i>Family Communication and Self Esteem</i>	<i>No statistics available</i>	<ul style="list-style-type: none"> a) <i>positive response to the programme by tutors and parents with parents reporting learning outcomes</i> b) <i>parents reporting relative satisfaction with information provided by programme</i> c) <i>parents reported the usefulness of being in contact with other parents and indicated that they would recommend programme to other parents (Ruddle 1993)</i>

(d) Specific training

Some of the initiatives mentioned above encapsulate specific training programmes which aim to train parents to act as group leaders/facilitators and in some cases parents are trained to become trainers themselves.

9.1.2 School Programmes

The following are an example of prevention programmes operating in schools throughout the country.

(a) Mandatory, recommended or voluntary at different school levels

Category:	<i>Drug education/awareness</i>
Name of project:	<i>The Awareness FC Drugs Prevention Programme</i>
Target group:	<i>5th and 6th class pupils in schools in Finglas and Cabra</i>
Projects aims:	<i>To increase awareness on drug misuse, to encourage participants to make informed decisions about drugs and to increase self-esteem in participants</i>
Activities:	<i>Weekly half-hour drug education/awareness classes in school setting during seven/eight weeks per programme</i>

Category:	<i>Drugs information/awareness programme</i>
Name of project:	<i>The Changeling Project</i>
Target group:	<i>5th and 6th class in primary school</i>
Project aims:	<i>To stimulate awareness of substance misuse within a framework of individual and social responsibility where choices, decisions and consequences are explored</i>
Activities:	<i>Utilising a series of metaphors a drama production performed in schools explores themes such as peer pressure, personal responsibility and the adverse consequences of substance abuse. A pre-show workshop and a post-show workshop accompanied each performance with teachers being encouraged to participate. An information pack is also prepared for teachers and is designed as a support mechanism for them to handle substance misuse related issues as they arise</i>

Category:	<i>Substance misuse prevention project</i>
Name of project:	<i>On My Own Two Feet:</i>
Target group:	<i>Secondary school students</i>
Project aims:	<i>To provide accurate information on drugs and drug misuse, to equip young people with the necessary skills to withstand social pressures to engage in substance misuse and to instill confidence in young people to make informed decisions which benefit them in the long run</i>
Activities:	<i>Special classes are delivered by specially trained teachers/trainers that explore issues such as substance misuse and personal decision-making on a thematic basis</i>

(b) General (health promotion, life skills) or specific (directed to high risk groups) and type of approaches

Category:	Health Promotion
Name of project:	The Healthy Schools Project
Target group:	Second level students in the North Eastern Health Board area
Project aims:	To enable young people to accept responsibility for their own health and behaviour, to facilitate the enhancement of self-confidence, self-esteem, decision making and assertiveness skills. To provide factual information on matters that can impact on their health, including substance misuse.
Activities:	Provides specialised training for all teachers involved in health education. All members of staff who receive special training deliver classes to students in schools. Classes last 35-40 minutes and are held once a week. Classes are presented under a thematic framework and group discussion is encouraged at all times.

Category:	<i>Alternative Lifestyle Approach</i>
Name of project:	<i>The Give Kids A Choice Project</i>
Target group:	<i>Young people 'at risk' of early school leaving and of substance misuse and anti-social behaviour</i>
Project aims:	<i>The overall aim of the project is to involve young people at risk of early school leaving in a positive school based programme that will provide them with opportunities to develop their personal and inter-personal skills. It is hoped that participation in the project may contribute to the young people remaining in formal education for longer and decreasing the chances for engaging with drug misuse and anti-social behaviour.</i>
Activities:	<i>The project incorporates various activities such as a Tuesday/Thursday group, which involve young people participating in developmental, social and recreational activities for approximately 1.5 hours each week. A dance programme that involves young people developing their dance and movement skills. An Amigos programme involving 5th year students befriending 1st year students. In addition the project provides a homework club, one-to-one counselling and a parenting for prevention drugs awareness programme for local parents.</i>

Category:	<i>Drug awareness/education</i>
Name of Project:	<i>Killinarden Drug Primary Prevention Group</i>
Target group:	<i>Primary and secondary school students considered 'at risk' of early school leaving in the area and of becoming involved in drug misuse and anti-social behaviour.</i>
Project aims:	<i>The aims to contribute to the personal development of participants as well as increasing awareness of drug related issues</i>
Activities:	<i>The project is run through eight trained facilitators who deliver a number of programmes and courses to pupils in schools throughout the area</i>

(c) Involvement of teacher, parent and community

NO INFORMATION AVAILABLE

(d) Guidelines for school policy

NO INFORMATION AVAILABLE

(e) Specific research results, statistics and evaluation results

Project	Statistics	Evaluation Results
<i>Awareness FC Drug Prevention Programme</i>	<i>No information available</i>	a) <i>An evaluation of this programme (Morgan 1999) reported a link between improvements in the accuracy of drugs information held by participants and their participation in the programme</i> b) <i>participants less likely to rely on 'myths' about drugs and more likely to make informed decisions</i> c) <i>participants reporting more confidence in making personal decisions about the use of drugs</i>
<i>Killinarden Drug Primary Prevention Group</i>	<i>No statistics available</i>	a) <i>A recent project report (Rourke 1999) has revealed that high participation rates and a generally positive response from young people are indicators that the project is well received.</i> b) <i>An additional development has been that local people such as parents have been trained in facilitation skills for the purpose of delivering the programme, this has enabled them to make a positive contribution to the community and in the process develop their own self-esteem.</i>
<i>The Changeling Project</i>	<i>No statistics available</i>	<i>An evaluation of the project found that the response from teachers and pupils was positive with a lot of voices echoing the message that this was a welcome intervention as relatively little educational work on substance abuse had been done previously in the targeted schools.(Kiely et al 2000)</i>

The Healthy Schools Project	No information available	An evaluation of the programme indicated that there were significant differences between the pilot and the control group on items relating to acceptance of responsibility, self-esteem, and positive outcomes in adulthood and attitudes to substance abuse (Morgan 1997).
The Give Kids A Choice Project	No information available	<i>Main results of the project indicate that a total of 104 people have participated in the various activities which have been organised and delivered through the project. Initial indications would suggest that young people are benefiting from their participation in the activities of the project. Participants have displayed enthusiasm for the activities and have also demonstrated consistently high attendance rates at various activities. In addition improvements in self-esteem among participating young people have been noted, also school attendance among project participants has shown signs of improvement. (Rourke 2000)</i>
On My Own Two Feet	No information available	An outcome evaluation of 'On My Own Two Feet' found that compared to a control group, students who participated in the programme had less positive attitudes to drug/alcohol use, and stronger beliefs in the negative outcomes of such use (Morgan et al. 1996).

9.1.3 Youth Programmes outside schools

(a) Types, settings of activities

Project name:	<i>St Michael's Parish Youth Project</i>
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Type of project: *The project is a community-based intervention designed to provide a number of services for young people in the Inchicore area of Dublin, who are engaged in substance misuse or are at risk of becoming involved.*

Settings of activities: *The project operates in an area of Dublin characterised by high unemployment and an acute drug misuse problem. Main activities/services provided by the project include outreach work, a drop-in centre, a Teenage Health Initiative, a referral service and working with local schools to develop preventative strategies.*

Project name:	<i>Finglas Action Now (FAN)</i>
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Type of project: *The FAN project is a multi-agency initiative funded by the Department of Justice, Equality and Law Reform and run by the Finglas Youth Service with support from the Garda, the Probation and Welfare Service and the local community. The project aims to engage young people in alternative constructive activities in the hope that such pursuits may provide an alternative lifestyle to that of crime and drugs which are endemic in the local community*

Settings of activities: *The project operates in an area with high unemployment, low educational attainment levels, a high crime rate and an acute drug misuse problem. Participants of the project can avail of activities such as camping, fishing, football, rock climbing, canoeing, music, computers, photography, drama and community awareness training.*

Project name:	<i>The Clondalkin Teen Counselling Project</i>
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Type of project:	<i>Provides counselling to young people in the Clondalkin area of Dublin, who are experiencing difficulties with substance misuse, domestic problems, issues at school, and behavioural difficulties.</i>
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Settings of activities: *The Clondalkin area is characterised by high levels of socio-economic disadvantage in particular there is acute inter-generational unemployment attached to the area. The project primarily provides a counselling service that operates four days a week.*

Project name:	<i>The STAY project</i>
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Type of project:	<i>The project is an integrated community response that aims to work with young people at risk of early school leaving and of engagement with drug misuse and anti-social behaviour. The project endeavors to support young people to stay in school and to engage with health and constructive activities.</i>
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Settings of activities: *The project operates within the St. Aengus parish area in Tallaght, Dublin. Participants in the project tend to reside in the most disadvantaged parts of Tallaght. The project's activities include drug awareness courses, swimming, homework support club, art, cooking, computers, canoeing, and a host of other outdoor pursuits.*

Project name:	<i>The Bluebell Youth Initiative</i>
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Type of project:	<i>The initiative seeks to develop the confidence, self esteem and personal skills of young people at risk of early school leaving and engagement with substance misuse through a programme based around recreational and social activities.</i>
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Settings of activities: *The project operates in an area where social disadvantage and problematic drug use is high.*

Activities offered by the project include the summer project, football tournament, a media group for 11-14 year olds, an after schools group and a drop-in facility for young people. The project works with parents of young people and in particular runs a women's group to assist mothers of children at risk of early school leaving and substance abuse.

Project name:	<i>The Carline Project of Learning</i>
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Type of project:	<i>The Carline Project provides day-to-day support and training for young people in the Clondalkin area who are unable to access existing training programmes. The project aims to target young people who are at risk of becoming involved in drug misuse or crime, and who are without training and qualifications.</i>
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Settings of activities: *The project is located in Clondalkin, a large suburb of Dublin. The area is characterised by high levels of unemployment. The project provides training in educational and social skills, computers, mechanics, woodwork/glasswork, horticulture, arts and crafts and various sporting pursuits. The project has developed extensive links with local companies and training agencies.*

Project name:	<i>National Youth Health Programme</i>
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Type of project:	<i>This programme is a partnership between the National Youth Council of Ireland, the Health Promotion Unit of the Department of Health and Children and the Youth Affairs Section of the Department of Education. The aim of the programme is to provide broad based flexible youth health education within the non-formal education sector.</i>
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Settings of activities: *The programme assists youth workers, leaders and volunteers working within youth services and community groups nation-wide in addressing the health needs of young people. The service provides training at an organisational, regional and national level in the health promotion area. The project has developed a Youth Work Support Pack dealing with the drugs issue. The pack covers a number of issues and is divided into four sections; 1) Youth work in a drug using society; 2) Youth work responses to drug use; 3) Policy development and 4) Supporting information*

<i>Project name:</i>	<i>Sound Decisions</i>
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Type of project:	The project is designed to raise awareness of the dangers of drugs among young people and nightclub staff. It was also designed to increase the competence of nightclub staff in dealing with drug related issues
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Settings of activities:	The programme primarily operates in the North Eastern region and consists of training sessions to inform nightclub staff about the legal implications relating to drug use, to enable them to recognise signs of drug use and to respond effectively to drug related emergencies. Promotional materials such as pins, posters, leaflets, stickers and t-shirts are used to highlight for club-goers the dangers associated with drugs
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Project name:	The Staying Alive Campaign – A Dublin Safer Dancing Initiative
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Type of project:	This initiative introduced in 1997 in the Eastern Health Board area is designed to provide training and support to night club staff in order to allow them to respond more effectively to drug related situations in night clubs
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Settings of activities:	This initiative operates primarily in the Eastern region and activities include training programmes for club owners/managers and door supervisors focusing on increasing participants knowledge about drugs, exploring their attitudes towards drugs and examining legal, health and safety issues. Information about drugs in the form of a small credit card sized booklet known as the Vital Information Pack (VIP) are being distributed through a number of venues including third level colleges and clubs for the benefit of young people who frequent nightclubs. A one-day conference was organised to gain support from the music/dance industry for the development of acceptable policies in dance venues across the Eastern region. The project will eventually involve standardising training for door supervisors where different training elements will be provided in modular form.
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<i>Project name:</i>	<i>Health Advice Café</i>
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Type of project:	The main aim of the café is to offer young people direct access to health services and to health information and advice.
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Settings of activities: The café is located in Galway's city centre in the Western region of Ireland. The café incorporates a range of drug prevention and education strategies and provides information about available treatment services. It also places an emphasis on 'fun drug free activities' to illustrate to young people that it is possible to have a good time without using drugs

b) Peer to Peer Approaches

Mid Tipperary Peer Education Programme

The Mid Tipperary Drugs Initiative began to implement A Peer Education Programme in January 2001. The programme intends to cater for teenagers in the 13-18 age group. The programme generally works with groups of ten young people at a time, and participants are recruited through request and referral. The programme operates a flexible approach where the participating young people are encouraged to contribute to the development of the programme. The initial stages of the programme are very much regarded as the pre-induction stages and in general have been focusing on building awareness and confidence levels among young people and encouraging discussion on drug related issues. From September 2001 it is planned to develop the Peer Education Programme to stage two where young people who have completed stage one will be trained to become Peer Educators of other young people on drug related issues. So far the programme has worked with approximately 70 young people.

c) Target groups

Project	Target group
<i>St Michael's Parish Youth Project</i>	<i>Young people in the Inchicore area of Dublin between the age of 8-25, who are at risk of early school leaving and who may be experimenting with illicit drugs</i>
<i>Finglas Action Now (FAN)</i>	<i>Young people aged between 12-18 and living in Finglas, Dublin who are experiencing difficulties in school, at home and in the community resulting from aspects of their behaviour.</i>
<i>The Clondalkin Teen Counselling Project</i>	<i>Young people aged between 12-18 who are resident in Clondalkin, Dublin and are engaged in substance misuse to some extent</i>
<i>The STAY Project</i>	<i>Young people between the age of 10-15 who have been identified as potential early-school leavers, and who reside in Tallaght, Dublin</i>
<i>The Bluebell Youth Initiative</i>	<i>Young people aged between 12-18 resident in the Bluebell area of Dublin who have identified as at risk of engaging in substance misuse and anti-social behaviour</i>
<i>Mid Tipperary Peer Education Programme</i>	<i>Young people in the 13-18 age group from the Tipperary region who could be at risk of engaging in substance misuse and other anti-social pursuits</i>
<i>The Carline Project of Learning</i>	<i>Young people from Clondalkin, Dublin aged between 13-18 who are at risk of becoming involved in drug misuse and crime, and who are without training and qualifications. In particular young people who are unable to access existing training programmes are focused on</i>

National Youth Health Programme	Targets all young people nationwide through individuals at community, voluntary and statutory levels who work with young people in a health enhancement context
<i>The Staying Alive Campaign – A Dublin Safer Dancing Initiative</i>	Young people who frequent disco's and nightclubs in Dublin are targeted through a campaign that trains nightclub staff to deal with the issue of drug misuse in nightclubs and to inform teenagers of the risks involved
Sound Decisions	Both young people who frequent nightclubs in the North Eastern region and nightclub staff who work in this region are targeted with information and awareness training on the risks of substance misuse in nightclubs
Health Advice Café	Young people from Galway in the West of Ireland, who may benefit from advice, advocacy and information on health related matters in particular drug misuse

d) Specific research results, statistics and evaluation results

Project	Research results and statistics	Evaluation results
<i>St. Michael's Parish Youth Project</i>	<i>The project has reported to be catering for the needs of over 200 young people since inception (Quinn 2000, Project Report)</i>	<i>No information available</i>
<i>Finglas Action Now (FAN)</i>	<i>No information available</i>	<i>No information available</i>
<i>Clondalkin Teen Counselling Project</i>	<i>No information available</i>	<i>No information available</i>
<i>The STAY project</i>	<i>No information available</i>	<i>The project reports that all young people who joined the project since March 1998 are still within the mainstream education sector. Attendance levels at various activities in the project are around 90% with a high level of positive feedback from participants (Rourke 2000)</i>
<i>Bluebell Youth Initiative</i>	<i>Since the inception of the project it is estimated that over 250 young people have benefited from contact with the project (Quinn 2000 Project Report)</i>	<i>No information available</i>
<i>Mid-Tipperary Peer Education Programme</i>	<i>So far it is estimated that the programme has worked with over 70 young people (Internal communication)</i>	<i>No information available</i>
<i>The Carline Project of Learning</i>	<i>Many young people on the project have been placed in jobs or further training and some have chosen to return to school full-time (Interim Report)</i>	<i>No information available</i>
National Youth Health Programme	No information available	No information available
Staying Alive Campaign-Dublin Safer Dancing Initiative	No information available	No information available
Sound Decisions	No information available	No information available
The Health Advice Cafe	No information available	No information available

e) Specific Training

NO INFORMATION AVAILABLE

9.1.4 Community Programmes

a) Drug-specific/drug non-specific

The bulk of Community Programmes operating in Ireland can be considered as drug non-specific interventions. Although some programmes emerged in response to an opiate problem, most have developed to include the misuse of all illicit drugs. For example, programmes that prescribe methadone to recovering opiate misusers run a urine analysis to screen for the presence of other drugs. Below is a list of some community programmes that operate as Drug Non-Specific programmes.

<i>Fettercairn Drug Rehabilitation Project</i>
<i>The Community and Prison Link Service</i>
<i>The Candle Community Trust: Training Workshop and Day Centre</i>
<i>Cabra Community Positive Living Year</i>
<i>Kilbarrack Community Coast Programme (KCCP)</i>
<i>Ballyfermot Star Community Support Group.</i>
<i>Edenmore Drugs Intervention Team (EDIT)</i>
<i>Clondalkin Addiction Support Programme (CASP)</i>
<i>Drugs Information Community Education Project (D.I.C.E.)</i>
<i>The Advance Project</i>
<i>Darndale/Belcamp Drugs Awareness Group (DAG)</i>
<i>St. Dominics Community Response Project</i>
<i>The Community Addiction Programme (CAP)</i>
<i>Clonmel Community Based Drugs Initiative (CCBDI)</i>
<i>Co. Waterford Community Based Drugs Initiative (CWCBDI)</i>
<i>Southside Communities Drugs Initiative (Waterford)</i>
<i>Crew Network</i>
<i>DAP – Crosscare</i>
<i>Community Addiction Response Programme (CARP)</i>
<i>Ballymun Youth Action Project</i>
<i>Ballymun Community Action Programme</i>
<i>Adult Substance Misuse Education Programme</i>
<i>Jobstown Assisting Drug Dependency (JADD)</i>
<i>Cabra Resource Centre</i>
<i>The Crinian Project</i>

b) Cities/Rural areas

The vast majority of community programmes operating in Ireland are based in Dublin. (See Table below) There is also a limited amount of community interventions operating outside Dublin. However, when the city/rural divide is referred to in an Irish context, it usually means that includes all areas outside Dublin. Based on this definition a selection of the main Community Programmes operating in Dublin and outside Dublin are presented below.

Community Programmes based in Dublin

Fettercairn Drug Rehabilitation Project
The Community and Prison Link Service
The Candle Community Trust: Training Workshop and Day Centre
Cabra Community Positive Living Year
Kilbarrack Community Coast Programme (KCCP)
Ballyfermot Star Community Support Group.
Edenmore Drugs Intervention Team (EDIT)
Clondalkin Addiction Support Programme (CASP)
Drugs Information Community Education Project (D.I.C.E.)
The Advance Project
Darndale/Belcamp Drugs Awareness Group (DAG)
St. Dominics Community Response Project
Crew Network
DAP – Crosscare
Community Addiction Response Programme (CARP)
Ballymun Youth Action Project
Ballymun Community Action Programme
Community Addiction Programme (CAP)
Jobstown Assisting Drug Dependency (JADD)
Cabra Resource Centre
The Crinian Project

Community Programmes based outside Dublin that can be considered rural interventions

Adult Substance Misuse Education Programme
Clonmel Community Based Drugs Initiative (CCBDI)
Co. Waterford Community Based Drugs Initiative (CWCBDI)
Southside Communities Drugs Initiative (Waterford)

c) Cooperation Structures

NO INFORMATION AVAILABLE

d) Statistics and evaluation results

Project	Statistics	Evaluation results
Fettercairn Drug Rehabilitation project	The project has worked with a total of 70 clients since 1997, in the year 2000 there were 31 active clients involved with the project (Rourke 2000)	A number of clients with the project have progressed onto employment, training and further education. Clients have also set up their own drama group and produced a play, whilst others are competing in a competitive football league. The local community has also noted the benefits from the activities of the project (Rourke 2000)
Community and Prison Link Programme	Over 20 people enrolled for regular meetings with the liaison worker when he visited the prison during the initial phase of the programme(Personal communication)	No information available

The Candle Community Trust Programme	57 young men and 7 young women registered with the workshop in the year 2000. In addition, the project offered 33 programmes throughout that year. In total, the attendance figures for the day centre in the year 2000 were 2,423, however, some of these figures may relate to the attendance of an individual on more than one occasion (Candle Community Trust Annual Project Report)	Subsequent to their participation in the workshop programme, 14 have found employment, 5 went into further education and 20 are still with the project (Candle Community Trust Annual Project Report)
The Cabra Community Positive Living Year Project	No information available	An increase in numbers attending youth club activities in the area with many clubs operating a waiting list. Recent surveys in the area indicate an increase in drug awareness in the community. (Personal Communication)
Kilbarrack Community Coast Programme (KCCP)	The Kilbarrack Community Coast Programme is primarily operated through the FAS Community Employment Scheme. Currently The project caters for 10 recovering drug misusers through a FAS Community Employment Scheme. (Personal Communication)	No information available
Ballyfermot Star Community Support Group.	No information available	No information available
Edenmore Drugs Intervention Team (EDIT)	The project caters for 13 clients through a FAS Community Employment Scheme. In addition to this, the programme offers a short therapeutic service to a further 12 clients, who are unable to engage with the structural requirements of the FAS scheme. In addition the programme currently facilitates eighteen parents or co-dependents on the 10-week drugs education/support course. (Personal Communication)	No information available
Clondalkin Addiction Support Programme (CASP)	At present the treatment phase of the project has 40 clients in full time treatment (Personal Communication)	No information available
Drugs Information Community Education Project (D.I.C.E.)	No information available	No information available
The Advance Project	No information available	The project has created over 20 full-time jobs that have been filled by twenty local people. All of those

		<i>employed are over 35 and have been unemployed for at least five years. Most have a history of drug misuse (Personal Communication)</i>
<i>Darndale/Belcamp Drugs Awareness Group (DAG)</i>	<i>No information available</i>	<i>No information available</i>
<i>St. Dominics Community Response Project</i>	<i>A drop-in centre is provided five days a week. The centre recorded 2,155 visits by clients to the drop-in centre from 1997 to 2000 (Rourke 2000)</i>	<i>No information available</i>
<i>Crew Network</i>	<i>No information available</i>	<i>No information available</i>
<i>DAP – Crosscare</i>	<i>No information available</i>	<i>No information available</i>
<i>Community Addiction Response Programme (CARP)</i>	<i>No information available</i>	<i>An evaluation report (Bowden 1997) showed that participants generally viewed the programme in positive terms and the programme allowed participants to develop the ability to resist heroin.</i>
<i>Ballymun Youth Action Project</i>	<i>No information available</i>	<i>No information available</i>
<i>Ballymun Community Action Programme</i>	<i>No information available</i>	<i>No information available</i>
<i>Adult Substance Misuse Education Programme</i>	<i>The programme is delivered to groups of between 6 and 12 participants at a time and consists of between two and five sessions that are two hours in duration and cover various aspects of substance misuse (Personal Communication)</i>	<i>No information available</i>
<i>Jobstown Assisting Drug Dependency (JADD)</i>	<i>No information available</i>	<i>A recent evaluation (O'Rourke 2000) found that participants generally viewed the programme in positive terms and that JADD had made a significant contribution to the quality of life and provision of opportunities for many people living within the Jobstown area.</i>
<i>Cabra Resource Centre</i>	<i>No information available</i>	<i>No information available</i>
<i>The Crinian Project</i>	<i>No information available</i>	<i>No information available</i>
<i>The Community Addiction Programme (CAP)</i>	<i>The programme caters for 15 clients at a time through a special FAS Community Employment Scheme that runs over a 12-month period (CAP Project report)</i>	
<i>Clonmel Community Based Drugs Initiative (CCBDI)</i>	<i>The maximum number of people in a group is 20 and the minimum is 8. The course runs for eight weeks and the each</i>	<i>Internal assessments of participants' perception of the course indicate the following. All respondents report it to be informative, useful and</i>

	<p>session lasts about two hours. The course is undergoing continuous evaluation and after four courses had been completed for a total of 44 people initial feedback indicates the following.</p>	<p>interesting. 53.28% reported that the most important idea they learned from the course was to get more involved in their child's life. All respondents agreed that the course should be offered again and that they would willingly promote a repeat. 70% of respondents reported that they would be interested in becoming a facilitator on the course and 86.58% of respondents reported that they felt their skills, confidence and ability were enhanced by their participation on the course. (Annual Report 2000)¹⁹</p>
<p>Co. Waterford Community Based Drugs Initiative (CWCBDI)</p>	<p>Included is a 4-week drug awareness programme for parents in the local communities. To date 5 such programmes has been completed. The Parent to Parent programme conducted under the guise of the CWCBDI now has 7 trained facilitators. For the programme, which runs for a period of eight weeks at a time. Extensive work with young people has also been undertaken by the CWCBDI with a total of 5 Drug Awareness and Education Programmes being run with young people from the Co. Waterford area. (Internal Communication)</p>	<p>No information available</p>
<p>Southside Communities Drugs Initiative (Waterford)</p>	<p>No information available</p>	<p>No information available</p>

e) Specific Training

NO INFORMATION AVAILABLE

9.1.5 Telephone Help-lines

a) Interventions at national/regional/local: their characteristics (type of information, costs)

The Northern Area Health Board, the SouthWestern Area Health Board and the East Coast Area Health Board each provide a Freephone Drugs Helpline. The Midland Health Board has recently set up a new 24 hour Helpline service, entitled "Don't Get Down-Get Help". It can be accessed from anywhere in Ireland for the price of a local call regardless of the duration of the call. The service operates 7 days a week, 365 day a year. The helpline was set up to primarily target the 15-24 age group, who may be experiencing emotional

¹⁹ Hayes, M. (2000) Yearly Report of Clonmel Community Based Drugs Initiative(Draft Report)

distress and suicidal thoughts. Although this helpline is not specifically aimed at drug related matters, it is felt that the service can also capture individuals who may be experiencing alcohol and drug related problems.

b) Statistics and evaluation results

NO INFORMATION AVAILABLE

c) Specific training

NO INFORMATION AVAILABLE

9.1.6 Mass Media Campaigns

a) Types and characteristics of mass media campaigns (TV, radio, posters...)

The Health Promotion Unit of the Department of Health and Children disseminates information on drugs and their effects on people on an on-going basis. This information primarily comes in the form of booklets, posters and leaflets and is distributed through local health centres, clinics, schools and hospitals. The South Eastern Health Board has recently produced a number of videos on drugs. The videos are primarily aimed at teenagers and parents and are based on prevention and education.

HYPER

'HYPER' was launched in 1999 by the project promoter – Soilse which is a rehabilitation programme in the Northern Area Health Board area. HYPER which is an acronym for Health, Youth, Promotion, Education and Rehabilitation acts as a voice for young people affected by drugs. HYPER was initially funded through a combination of Eastern Health Board and European funding, however, recently the project has been mainstreamed and is now being funded solely by the Northern Area Health Board. Initially the project targeted 18-20 year olds, however, it has now been decided to increase the age profile of prospective clients to the 18-25 age group. The magazine is produced by former drug users as part of a rehabilitation project and aims to bring young people a magazine which they can relate to and which critically addresses their lifestyles without preaching or scare-mongering. The magazine includes interviews, book and theatre reviews, cartoons and articles that challenge peoples' attitudes towards drugs, young people and health. In July 1999, HYPER won an award in the British based Total Publishing Awards competition for design innovation. The magazine was selected from over 400 entries. The magazine is due to be re-launched in October 2001 under a new editorial team.

b) Cooperation with mass media (cost and cost sharing with media)

NO INFORMATION AVAILABLE

c) Statistics and evaluation results

NO INFORMATION AVAILABLE

d) Specific training

NO INFORMATION AVAILABLE

9.1.7 Internet

- a) **Use of Internet for:** prevention (type of intervention, target, other relevant characteristics) – dissemination of prevention know-how among professionals

<http://dnedrugstaskforce.ie/>

This website has been set up by the Dublin North East Drug Task Force and outlines various activities which have been initiated in response to the problem of drug misuse in the local areas under the task force. It also contains information on treatment centres and rehabilitation initiatives in the local areas.

<http://www.mqi.ie>

Merchant's Quay Ireland is a voluntary organisation which provide treatment, rehabilitation and harm reduction methods to people who misuse drugs. Their website, which was recently launched, contains extensive information on their service provision.

<http://www.kildare.ie/drugsawareness/>

This website covers the areas of Kildare and West Wicklow, which are situated around 20 miles from Dublin. The site offers information on services in the area, as well as seeking to engage visitors to the site to reflect on the issues pertaining to drug misuse.

<http://www.kildare.ie/outreach/index/htm>

This site offers extensive information on outreach services in the areas covered by the Eastern Regional Health Authority, which cover most of the areas which have the most serious problems of drug misuse.

<http://www.drugawareness.ie>

This site offers information on education programmes that teaches local community activists to respond to local drug problems in a measured and informed manner.

<http://www.coolchoices.ie>

This is a government-sponsored website seeking to offer information to young people on the dangers of drug and alcohol abuse.

<http://www.rutlandcentre.org/>

This website introduces the treatment programme that is provided by the Rutland Centre. The centre provides treatment for addiction, to drugs, alcohol

gambling and other recognised conditions. The programme provides residential treatment and extensive aftercare programmes.

<http://www.clubscene.ie/>

Merchants Quay Ireland has launched a unique and innovative new website aimed at clubbers, containing advice and information in relation to dance drug use, harm reduction etc.

b) Statistics and evaluation results

NO INFORMATION AVAILABLE

9.2 Reduction of drug related harm

9.2.1 Outreach work

a) Strategies (*youth work approach, family/community approach, “catching clients”, public health model, self help initiatives, etc*)

Outreach workers employ various strategies in order to make contact with target groups. Essentially the bulk of work carried out by outreach workers in the Dublin/Kildare area consists of the following:

- *Providing support to local communities and individuals who are not in contact with established services*
- *Promoting awareness of HIV/AIDS, drugs and sexual health through the provision of education and information*
- *Advocating on behalf of identified target groups*
- *Attempting to link people into treatment centres for heroin detoxification and maintenance*
- *Providing detoxification options as alternatives to methadone maintenance*

b) Target groups

- *Homeless people engaged in drug misuse*
- *Individuals engaged in male and female prostitution*
- *Individuals engaged in illicit drug misuse who are not in contact with established services*

c) Synthetic description of actors and instrument

The Eastern Regional Health Authority (ERHA) is responsible for providing the bulk of outreach services to drug misusers in the Dublin-Kildare area. The ERHA are instrumental in providing outreach workshops that promote safe sex practices, and which cover hepatitis A/B/C and substitution services in the form of methadone distribution for instance. Workshops are also provided for people working with drug users and precautions are outlined for individual

workers regarding the dangers of needlestick injuries. The ERHA also provide an extensive range of services through street work, these include

- *Reaching out to people who are not presently receiving help or advice.*
Providing information on contaminated heroin.
Monitoring preferred drug use and current price in the area.
Providing HIV information and hepatitis information.

d) Statistics and evaluation results

NO INFORMATION AVAILABLE

e) Specific training

NO INFORMATION AVAILABLE

9.2.2 Low threshold services

a) Organisational framework: structures (public service, NGO, co-operation schemes), **tasks and special services**

The Mobile Clinic was established in the Eastern Regional Health Authority area in 1996. The mobile clinic service is designed for low threshold work and provides initial services to the more chaotic drug users, who are not stabilised on methadone maintenance and who benefit by such intervention. By definition low threshold services place increased emphasis on harm reduction than on abstinence from opiates. Part of the service is the provision of a needle exchange facility and in some cases the administration of low doses of methadone. The clinic also provides a specific service for women engaged in sex work. Currently there are four mobile clinics operating on a seven day a week basis.

b) Target groups

- *Chaotic drug users, who are primarily injecting opiates and are not stabilised on a methadone maintenance programme*
- *Women and men using drugs and engaged in sex work*

c) Statistics and evaluation results

NO INFORMATION AVAILABLE

d) Specific training

NO INFORMATION AVAILABLE

9.2.3 Prevention of infectious diseases

a) Synthetic outline on organisations, strategies and actors

The prevention of the spread of drug-related infectious diseases in Ireland falls under the general auspices of treatment services, in the context of Irish drug policy's emphasis on harm reduction. Under the treatment pillar of the National Drugs Strategy (2001-2008) one of the two main objectives of treatment provision in Ireland is "to minimise the harm to those who continue to engage in drug-taking activities that put them at risk" (Department of Tourism Sport and Recreation 2001, p.6). Each health board is responsible for the provision of services for drug users that will facilitate them in minimising the spread of drug-related infectious diseases. The concentration of injecting drug use in the ERHA has meant that these services have tended to be focused heavily in this region. Both voluntary and statutory agencies are involved in the provision of services and programmes aimed at preventing the spread of drug-related infectious diseases.

b) Principal interventions:

➤ **Needle and syringe exchange**

Approximately 12 needle exchange sites are in operation in Ireland-, all of which are located in the ERHA where the vast majority of known injecting drug users resides (O'Brien et al. 2000). There are three main 'types' programme contexts in which an exchange programme is provided:

- *The Merchant's Quay Project is a voluntary organisation that, among other services, provides a needle exchange programme.*
- *There is a mobile clinic which provides low threshold services to drug users including a needle exchange and a low dosage methadone programme. This clinic services four areas in Dublin City and the surrounding suburbs on a Monday to Friday basis.*
- *The remaining programmes are all statutory services run by the ERHA. These are located in health centres and drug treatment centres around the city.*

➤ **Safer sex/safer education**

In Ireland condoms are distributed free of charge to 'at risk' groups, including drug users, through both voluntary and statutory agencies. However, it should be noted that condoms are not made available to prisoners in Ireland.

➤ **Testing, vaccination**

Drug users who present for treatment at any of the statutory drug treatment services are routinely offered HIV and hepatitis C testing, and a similar service is also available through voluntary agencies. Testing is available free of charge and users are encouraged by service providers to have a test carried out. However, two prison studies on the prevalence of hepatitis C (Allwright et al. 1999; Long et al. 2000) of all prisoners and committal prisoners respectively, found that only 59.3% of all prisoners who had a history of injecting drug use had been tested for hepatitis C (Allwright et al. 1999), and 65.7% of the committal population (Long et al. 2000).

Another form of testing is antenatal testing. A nationwide routine linked antenatal HIV testing programme has been established which can reduce perinatal transmission through the use of antenatal treatment of HIV positive

women with anti-retroviral drugs and careful management at delivery (Department of Health 2000).

Hepatitis B vaccination is available free of charge to drug users from drug treatment clinics, hospitals and general practitioners. In theory all drug users are routinely offered vaccination when in contact with services, but the proportion who are fully vaccinated is not known. A study of clients attending the Merchant's Quay project found that only 19% of clients reported having been vaccinated for hepatitis B (Cox & Lawless 2000). Furthermore, a study of HIV and hepatitis B/C prevalence among committal prisoners (Long et al. 2000) found that of 175 prisoners who reported a history of injecting drug use, only 23% (n=41) reported that they had been fully vaccinated for hepatitis B. This would suggest that to date the services have not been effective in providing a comprehensive vaccination programme.

➤ **Treatment**

Treatment for both HIV and hepatitis C are available free of charge to people infected through drug use.

HIV treatment/HAART is available to IDUs through referral through GUM and Infectious Disease clinics in Ireland. The selection of patients for HAART is based on medical criteria as set out by international recommendations, and the motivation of the individual to undergo the treatment. The first three treatment sites are in Dublin based hospitals, and the fourth in Cork:

- St. James's Hospital
- Beaumont Hospital
- Mater Misericordiae Hospital
- Cork University Hospital

Treatment for hepatitis C is also available. While there are no written selection criteria for acceptance onto a hepatitis C treatment programme, in practice certain criteria need to be met. It is generally agreed among service providers that a potential client should be 'drug stable' (i.e. free from street opiates and injecting drug use) for a minimum of a year prior to starting treatment. It is argued that an individual needs to be drug stable in order to maximise the chances of compliance with the treatment regime. Therefore, while a person with a history of injecting drug use may access treatment for hepatitis C, an active IDU may not. Treatment for hepatitis C is therefore not offered to active IDUs.

c) Providing equipment

As described above injecting drug users are provided with access to clean injecting equipment through a number of needle exchange services.

d) Statistics and evaluation results

Statistics are not routinely collected in the area of programmes for the prevention of the spread of drug-related infectious diseases and evaluations are rare. On a general basis according to the report of the National AIDS Strategy Committee, recent HIV statistics indicate that interventions with

intravenous drug misusers are effective in reducing transmission rates among this 'at risk' group (Department of Health and Children 2000). However, between 1998 and 1999 there was a major increase in the numbers of drug users with HIV which stabilised in 2000 (see Section 3.3 of this report). Smyth et al. (1999) attempted to explore the impact harm reduction programmes in Ireland had on the spread of hepatitis C by carrying out tests for hepatitis C among a cohort of drug users. The cohort included those who had begun their injecting drug use both before and after the expansion of harm reduction programmes in Ireland. Smyth et al. (1999) argue that the findings suggest that those injecting drug users who began their injecting drug use after the introduction of harm reduction strategies, demonstrated a reduced risk of HCV infection. However, Smyth et al. (1999) emphasise that it was not possible to control for other factors that may explain the decline in the HCV infection rate, such as a possible reduction in overall injecting frequency among more recent injectors.

Health Promotion Unit – Merchants Quay Project

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

e) Specific training

Training is made available to midwives and others involved in the routine linked antenatal HIV testing mentioned above. This is provided in all health boards by a team including expert clinicians, a midwife and a social worker.

9.3 Treatments

9.3.1 Treatments and health care at national level

a) Services offered and their characteristics (typology, staffing, monitoring and other relevant aspects)

According to the recent National Drugs Strategy Report (2001)

“...The provision of a comprehensive range of drug treatment options was a crucial component in a number of submissions relating to treatment...”

(p 86)

In recognising the diverse nature of individuals who engage with drug misuse, and in response to concerns raised through community networks, the response has been to implement as far as possible a comprehensive range of treatment options. These can include detoxification, treatment in therapeutic communities, methadone maintenance, counselling and harm reduction methods such as needle exchange. Throughout the 1990s there has been an emphasis on the provision of methadone maintenance for opiate misusers, however, in recent times the role of rehabilitation for drug misusers has been explored. This emphasis on rehabilitation is reflected in the rehabilitation/reintegration blueprint devised by the Eastern Regional Health Authority (ERHA) and the appointment of three rehabilitation co-ordinators by the ERHA. (See section 8.2)

b) Objectives: drug free treatment, not drug free treatments

NO INFORMATION AVAILABLE

c) Criteria of admission

NO INFORMATION AVAILABLE

d) Involvement of public health services and GPs

Drug treatment services are provided through a network of treatment locations with the emphasis on the provision of local based treatment where possible. Within the Eastern Regional Health Authority, 54 treatment locations have been developed over the last number of years and at the end of August 2001 5,605 clients were receiving treatment with methadone. By the end of August 2001 there were 166 general practitioners involved in the prescribing of methadone for opiate addiction and by the end of August 2001 there were 237 community pharmacies dispensing methadone to opiate addicts.

e) Co-ordination between public health services and GPs

NO INFORMATION AVAILABLE

f) Special services

NO INFORMATION AVAILABLE

g) Financing

One of the difficulties in assessing expenditure on treatment in the drug area is that of locating a definition of treatment from which to measure expenditure. This difficulty has been identified for some time, as according to the

Government Strategy to Prevent Drug Misuse (1991) the treatment, care and management of drug misuse does not lend itself to a 'one-solution' approach. Consequently treatment of drug misuse in an Irish context can involve a diverse set of responses which seek to intervene at different stages of the treatment process. These can range from detoxification to the provision of a pre-employment training programme. Therefore it is difficult to arrive at a reliable estimate of costs associated with the treatment of drug misuse. However there is some data available for the year 2000 on Government expenditure on drug misuse initiatives, from which it is accepted that a proportion of this expenditure was directed towards treatment initiatives. The National Drug Strategy Review Group has calculated the following expenditure estimates based on the available data.

Table 9.3a. Government expenditure on drug misuse initiatives, 2000

Department/Agency	Expenditure €Millions
Dept. of Health and Children	€31997400
Dept. of Enterprise, Trade and Employment	€5967770
Dept. of Education and Science	€7491455
Dept. of Tourism, Sport and Recreation	€11554617

Source: Department of Tourism, Sport and Recreation 2001-2008: 63

The expenditure for the Department of Education and Science includes the Young Person's Facilities and Services Fund. This fund was set up to provide sport and recreational facilities in disadvantaged areas where a significant drug problem exists. The expenditure for the Department of Enterprise, Trade and Employment represents funding for the Special Drugs Community Employment Programme run by FAS for recovering drug misusers. This is an integral component of the rehabilitation/reintegration approach being implemented through the local projects funded through the Local Drugs Task Forces. The Department of Health and Children and the Department of Tourism, Sport and Recreation are primarily responsible for the funding of recognised treatment centres through the area Health Boards and the Local Drug Task Forces respectively.

One of the areas identified as in need of immediate expenditure was the provision of funding for adequate premises from where to run treatment programmes. A specific sum of €4444083 million was provided by the Department of Tourism, Sport and Recreation through the National Drugs Strategy for the Capital funding of 16 separate premises. This was the first allocation of funding under the new community based Premises Initiative, whereby €12697380 million is being provided over 3 years to assist community based drug projects to meet their accommodation needs.

The Eastern Regional Health Authority (ERHA) in their Service Development Plan for 2001 has drawn up the following proposals as part of their Opiate Addiction Services. An allocation of €2841673 has been received for the development of new drug demand reduction initiatives. It is planned to provide for the following new developments with this allocation:

- to develop three pilot projects in A&E Departments in acute hospitals to liaise with the drug services - €76185*

- to develop a pilot project in each Area Health Board to utilise community pharmacists in the area of health promotion for persons with an addiction and who are still using needles - €50790
- to appoint a Hepatitis C Co-ordinator for each Area Health Board to ensure that the links are maximised with the acute hospitals to ensure that persons who are drug using and have hepatitis C access services and attend treatment and follow up - €95230
- to provide three additional Consultant Psychiatrists with a particular expertise in youth and adolescent addiction problems - €190460.
- to establish a dedicated 12 bed unit for adolescents who require treatment in Cherry Orchard Hospital - €317435
- to provide 2 specialist day programmes for young people who wish to access treatment - €380920
- to continue the provision of treatment services in areas of greatest need and in particular those areas which have waiting lists for treatment - €733910
- to open a new 20-bed rehabilitation unit in St. Mary's Hospital (Phoenix Park) early in 2001. This will have the benefit of providing greater access to rehabilitation services and will also allow for a greater number of clients to be detoxed in the Cuan Dara unit as the overall length of the programme in Cuan Dara will be changed to allow clients to move to the residential unit - €380920
- to establish a drop-in centre for drug free clients who are in recovery in the inner city - €63486
- to establish a further clinic for women involved in prostitution who have a drug addiction problem - €95230
- to provide dedicated counselling services for general practitioners who are involved in treating clients in the community - €126973
- to commission a number of research projects particularly in relation to outreach services and counselling services - €63486
- to address the capacity problems that has emerged from the number of additional patients in treatment and the need for more detailed reporting of urinalysis and screening programmes
- to provide additional laboratory staff to ensure that specimens are reported on in a timely manner - €126973
- to appoint a Co-ordinator for the development of drug services to the prison population. A separate development plan is being prepared which will be the subject of a separate funding application to the Department of Health & Children and the Department of Justice, Equality & Law Reform – cost in 2001 €50789
- to appoint a Senior Administrative person in each Area Health Board to ensure that the projects are mainstreamed, funded and evaluated on an on-going basis - €88880

The decision of the National Drugs Strategy Team to mainstream a large number of projects, which were being funded by the Drug Task Forces, has resulted in significant additional responsibility for the Area Health Boards in the funding and management of projects. The total additional cost of providing these developments in 2002 is €321245

h) Statistics and evaluation results

National Drug Treatment Reporting System Statistics

The National Drug Treatment Reporting System (NDTRS) data for 1999 (the latest year for which published data are available) indicate that there was an increase in the numbers reporting for treatment for drug related problems, compared to the 1998 figures. Similarly there has been a corresponding increase in the numbers recorded as first time treatment contacts. (Table 9.3b)

Table 9.3b: Ireland 1998-1999. Number of all recorded and first time treatment contacts.

	1998	1999
Number of all recorded treatment contacts	6043	6443
Number of first time treatment contacts	1652	1852

Source: NDTRS Data, 1998-99

75.2% of all recorded treatment contacts in 1999 indicated that their main drug of misuse was heroin, and 57.9% of first time treatment contacts in 1999 also gave heroin as their main drug of misuse. 83.5% of all recorded treatment contacts for 1999 were treated in the then Eastern Health Board area. This Health Board area caters for the Greater Dublin area, which has been identified as having the most severe cases of drug misuse in Ireland. The fact that this area contains 13 of the 14 established Local Drug Task Forces is testament to the response that was required to address the drug misuse issue.

According to the data collected in 1999, there was a slight increase in those reporting to having injected drugs at some point in their lives. (Table 9.3c)

Table 9.3c: Ireland 1998-1999 All recorded treatment contacts reporting to have injected drugs at some point in their drug use. Percentages.

	1998	1999
All recorded treatment contacts reporting to have injected drugs at some point in their drug use	66%	68.9%

Source: NDTRS Data, 1998-99

A gender breakdown of all recorded treatment contacts for 1999 show that 69% were male which shows little variation on the 70.2% recorded as male contacts in 1998. It would appear that there has been a decrease in the numbers reporting for treatment in 1999 who report living with either parents/family, in contrast to the 1998 figures. (Table 9.3d). A decrease in the numbers reporting for treatment that is under age 25 has also been recorded. (Table 9.3e)

Table 9.3d: Ireland 1998-1999. All recorded treatment contacts living with either parents/family. Percentages.

	1998	1999
All recorded treatment contacts living with either parents/family	65%	62.7%

Source: NDTRS Data, 1998-99

Table 9.3e: Ireland 1998-1999. All recorded treatment contacts under 25 years of age. Percentages.

	1998	1999
All recorded treatment contacts under 25 years of age	58%	52.6%

Source: NDTRS Data, 1998-99

A number of questions arise as a result of the data collected, on the employment/unemployment status of clients reporting for treatment. An emerging trend is apparent in the increase in the numbers reporting for treatment that are in gainful employment (Table 9.3f)-gainful employment meaning paid employment. Some of the questions that can be posed are to what extent does Ireland experience this increase due to the positive economic climate in recent times, which has seen a steady growth in employment figures? What role has the use of prescribed methadone played in increasing the employment opportunities of individuals attending for treatment? Or can this increase be partly explained by a greater and more visible availability of treatment?

Table 9.3f: Ireland 1997-1998-1999. All recorded drug treatment contacts reporting to be in gainful employment. Percentages

	1997	1998	1999
All recorded drug treatment contacts reporting to be in gainful employment	14%	20%	26%

Source: NDTRS Data, 1998-99

i) Specific training

General practitioners – GPs who are the primary substitution service providers in Ireland, are required to undergo specific training before they are permitted to prescribe methadone. This requirement has been in place since the introduction of the Methadone Prescribing Protocol in 1998. The Irish College of General Practitioners provides this training in conjunction with the local health boards. There are two training levels that GPs can complete. The level attained will dictate the nature of the contract the GPs will have with the health boards in terms of the substitution services he/she can provide within their general practice.

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

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

The number of GPs providing this service has increased over the year. In 1996 there were 58 GPs registered as prescribing methadone in the setting of

their practice. This number increased to 97 in 1998, 143 in 1999, and 158 in 2000 and to 166 by the end of August 2001.

The Irish Council of General Practitioners (ICGP) collaborates with the Drug Misuse Research Division (DMRD) in encouraging GPs to participate in the National Drug Treatment Reporting System (NDTRS), by providing a slot in GP training sessions for briefing on the NDTRS. Training in NDTRS data collection is subsequently provided to GPs on an individual level by the DMRD.

j) Other national specifications

NO INFORMATION AVAILABLE

9.3.2 Substitution and maintenance programmes

a) Organisation and delivery of substitution drugs:

NO INFORMATION AVAILABLE

b) Criteria of admission

During the early 1990's substitution services in Ireland were expanded and became more widely available to the opiate using population. In accessing maintenance programmes preference has always been given to pregnant women and those who have AIDS or is HIV positive. However, in 1998 the Eastern Health Board produced an 'Inventory of Policies' which lays down criteria for admission to substitution programmes.

Methadone Maintenance

The following are the criteria for inclusion of a person on a methadone maintenance programme.

- They must meet physical emotional and behavioural criteria for addiction as set down by the 10th edition of the International Classification of Diseases.
- They must be aged over 18, but those between the ages of 18 and 20 will require a more extensive investigation before being commenced on methadone. This would require an extensive drug history going back more than two to three years, which will need careful clarification.
- They must have an extensive one-year history of intravenous drug use.

Special cases that need not meet the above criteria for admission will include the following:

- patients who are HIV positive;
- partners; and
- patients who are pregnant.

These patients will be offered detoxification, maintenance or inpatient services as appropriate.

Young people, 18 years or younger

Young persons under the age of 18 will need their parents to attend and give parental consent. There should be a history of at least one failed detoxification, usually two or three preferably at inpatient level. However, where patients have a very long history that can be verified, this condition may be waived.

Young persons 18 years or younger will require very careful assessment and consideration at team meetings and will need the formal decision of a consultant psychiatrist before commencing methadone maintenance.

Dosages above 80mg can only be offered after consultation with the consultant psychiatrist.

Source: Barry (2000)

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

c) Mode of prescription

Legal Basis for Substitution

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

The guidelines aim to create a more controlled environment for the prescribing and dispensing of methadone. Under the Regulations the prescribing medical practitioner must register each client in receipt of a methadone prescription on the Central Methadone Treatment List. The guidelines aim to restrict the number of clients for whom individual GPs can prescribe methadone. While there is no specific licence required by GPs in Ireland to provide substitution programmes, they are required to undergo training and must be approved by the relevant health board. Approval is only forthcoming after the GP has undergone the training programme organised by the Irish College of General Practitioners. Methadone itself is a licensed prescription drug controlled under Schedule 2 of the Misuse of Drugs Regulations, 1988. Methadone is currently prescribed in a number of service

settings: drug clinic setting and GP setting. Furthermore, it is also dispensed from community pharmacies.

Clinic Setting

Clinics have been developed specifically to meet the needs of drug users. Expansion in the clinic services has been overwhelmingly in the area of substitution programmes, including methadone detoxification, stabilisation and maintenance. The number of clinic locations where methadone is prescribed has grown from two in 1991 to 45 in 1999 and 62 in August 2001. Fifty-six of the sixty-two clinics are based in the Eastern Regional Health Authority Area where the large majority of opiate users reside.

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

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

General Practice Setting

As mentioned above, in 1993 a protocol was published for the prescribing of methadone in the GP setting. The basic premise outlined in the 1993 Protocol is that GPs should take on responsibility for the care of opiate dependent people once they have been stabilised in either an addiction centre or a satellite clinic. GPs and clients should then have the continued support of that centre. A protocol review committee was established which produced a report in 1997, the recommendations of which were implemented through legislation in October 1998. The main changes this had on the organisation and delivery of methadone services in the GP context were:

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

As with the number of clinics providing substitution services, the number of GPs offering the service has increased dramatically over recent years. In 1996 there were 58 GPs registered as prescribing methadone in their practice setting, this grew to 143 in 1999 and in August 2001 was 166.

Community Pharmacists

As substitution programmes have become more decentralised the role of the community pharmacist has become increasingly important. Pharmacies are responsible for dispensing methadone to clients attending a GP based substitution programme and those attending satellite clinics. Each client is assigned to a particular pharmacy in the local community, from which his or her methadone will be dispensed. Pharmacists are involved in dispensing take home doses and also provide a supervised administration service. The Pharmaceutical Association of Ireland recommends that pharmacists agree a written contract with clients upon initiating these services. Contracts detail the pharmacy service and the expected standards of behaviour of clients. The number of pharmacies involved in dispensing methadone has increased significantly over recent years. As of August 2001 there were 237 pharmacists involved in dispensing methadone, 167 of these were based in the Eastern Regional Health Authority area.

Specialised Prescription Forms

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

d) Objective (gradual detoxification, maintenance)

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

e) Substitution drug/s, mode of application

The only substitution drug currently prescribed in Ireland is oral methadone. The average dose of methadone prescribed is 55mg (Barry 2000). Prior to 1996 the only form of methadone available in Ireland was Physeptone Linctus (2mg methadone per 5mls of syrup). As part of a move in the reorganisation of the methadone treatment services, the health board decided to transfer patients on to methadone mixture (5mg methadone per 5mls syrup). This change was first implemented in treatment clinics and then in GP surgeries. This methadone mixture is the only form currently available from treatment services.

The Pharmaceutical Society of Ireland has proposed that the use of non-opioid alternatives to methadone for the management of addiction, such as Lofexidine, be considered in the future.

f) Psycho-social counselling (requirements and practice)

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

g) Drug testing

Both clinic and GP based programmes require clients to give regular supervised urine samples that are tested for the presence of prohibited substances. In the clinic settings, urine samples are taken on a twice-weekly basis during stabilisation, and on at least a weekly basis once clients are stabilised. These samples are all screened for opiates and methadone. On a monthly basis all clients are screened for other substances such as benzodiazepines and cocaine. Where clients are identified as having a specific 'problem' with such substances they are screened for them on at least a weekly basis. Where clients are transferred to a GP based programme, urine screening is organised between the Eastern Regional Health Authority and the GP, and carried out on a weekly basis. All samples are currently sent to the Trinity Court Drug Treatment Centre for analysis.

h) Diversion of substitution drugs

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

i) Statistics (measure point)

At the end of August 2001 there were 5,605 clients registered as receiving substitution treatment in Ireland. Clients of both GP and clinic based programmes are all registered on a Central Methadone Treatment List. As mentioned in previous sections, opiate use in Ireland is overwhelmingly based

in the Eastern Regional Health Authority Area, therefore most substitution programme clients are resident there. In August 2001 163 of a total of 5,605 clients registered on the Central Methadone Treatment List were receiving substitution services outside the Eastern Regional Health Authority area. Data gathered through the Central Methadone Treatment List is confidential and is not available for analysis.

j) Specific research results

Most research carried out in Ireland with clients of substitution programmes has focused on their identity as injecting drug users rather than their experiences of substitution programmes. In addition this has been limited to sample populations from one particular clinic (Smyth et al. 1998; Smyth et al. 1995; Dorman et al. 1997; Williams et al. 1997). Little research has been done looking at substitution programmes per se. However, this gap is due to be addressed by the National Advisory Committee on Drug (NACD), which has called for tenders to evaluate opiate addiction treatment services.

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

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

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

k) Evaluation results

The following evaluative studies have been reported to be underway at the time of writing, most are nearing completion (Barry 2000):

- an evaluation of the first 150 inpatients in the detoxification unit;*
- a five year follow-up of the first 350 patients in outpatient methadone maintenance;*
- a four-year follow-up of the first 150 patients in inpatient detoxification and stabilisation;*
- an assessment of the care process for 700 patients referred to health board services as a result of regulatory changes in 1998;*
- an analysis of the first decade of first-time needle-exchange patients;*
- a review of the level of care of female users at a city centre clinic;*
- an evaluation of outpatient satellite clinics; and*
- a study of seroprevalence of blood-borne viral infections in methadone patients.*

9.4 After-care and re-integration

a) Organisation

NO INFORMATION AVAILABLE

b) Accessibility for different target groups (after treatment, after prison, for long term substitution clients)

Project	Target Group
<i>The Fusion Project</i>	<i>After Treatment: Stabilised methadone users</i>
<i>The Turas Project</i>	<i>After Treatment: Stabilised methadone users</i>
<i>The Millennium Carving Project</i>	<i>Recovering drug misusers</i>
<i>Aislinn Addiction Treatment Centre</i>	<i>For individuals aged 15-21 requiring treatment for addiction</i>
<i>The Cavan Centre</i>	<i>Young people aged 16-19 who are at risk of early school leaving and of engaging in substance misuse</i>
<i>Tallaght Rehabilitation Project</i>	<i>Recovering/stable drug misusers from the Tallaght area who specialist intervention in pursuit of mainstream social integration</i>
<i>Rehabilitation and Support Programme (RASP)</i>	<i>After Treatment: Stabilised methadone users</i>
<i>The Pathways Post-Release Centre</i>	<i>Ex-prisoners: including those recovering from drug misuse</i>
<i>The Merchant's Quay Re-integration Programme</i>	<i>Former drug misusers who have been through residential treatment and are seeking to access mainstream employment and educational options</i>
<i>Arbour House Treatment Centre</i>	<i>Individuals seeking to recover from addiction plus the families of individuals using the service</i>
<i>Hesed House: Counselling and Family Therapy</i>	<i>Individuals engaged in drug misuse and their families, where the need for counselling and therapy has been identified</i>
<i>Soilse/Rutland Centre Partnership for Treatment</i>	<i>Individuals from the North Inner City of Dublin who are recovering from drug misuse</i>

9.4.1 C) Education and training

Project	Medium through which education/training is delivered
<i>The Fusion Project</i>	<i>FAS Community Employment training programme</i>
<i>The Turas Project</i>	<i>Training programme</i>
<i>The Millennium Carving Project</i>	<i>FAS Community Employment training programme</i>
<i>The Cavan Centre</i>	<i>Training programme</i>
<i>Tallaght Rehabilitation Project</i>	<i>FAS Community Employment training programme</i>
<i>Rehabilitation and Support Programme (RASP)</i>	<i>FAS Community Employment training programme</i>

<i>The Pathways Post-Release Centre</i>	<i>Education centre</i>
<i>The Merchant's Quay Re-integration Programme</i>	<i>Training centre</i>
<i>Soilse/Rutland Centre Partnership for Treatment</i>	<i>Partly-an education/training programme</i>

9.4.2 D) Employment

The Merchant's Quay Re-integration Programme:

The Merchant's Quay Project (MQP) in its capacity as a drug service provider identified the need for a programme that would assist former drug users who had completed residential treatment to gain entry to the mainstream employment market. The needs of this client group were given priority because the lack of employment opportunities had been identified as a factor, which contributed to the relapse of former drug users. In response to this gap in service provision, the MQP with initial funding from the EU Integra project established the reintegration programme called 'From Residential Drug Treatment to Employment' in September, 1997. The operational phase of the programme began in January 1998 with the first client admitted in February of the same year. The overall objective of the programme was to 'develop, evaluate and disseminate a model of good practice in relapse prevention, using a locally based, holistic programme which facilitates the integration of former drug users into mainstream training, educational and employment opportunities'. The MQP identified three main target groups to work with. These were former drug users who had completed residential treatment, local employers and state training agencies. Former drug users were the primary target group and therefore the intervention was primarily aimed at enhancing their chances of social integration. It was also felt that employers could be encouraged to facilitate former drug users by offering them employment or job training. Whilst it was thought that training agencies could benefit by receiving some drug awareness training to equip them to understand the needs of the client group. The work with former drug users comprised two six-week phases. Phase one the residential phase, focuses on enabling clients to 'let go' of the therapeutic environment that many had just left and to facilitate movement back into the community. The second phase of the programme concentrates on obtaining employment/job placements or educational opportunities for clients. During this phase clients are also encouraged to give at least one day per week to the attention of personal matters such as housing and social welfare issues and to maintain links already forged. The programme is underpinned by the belief that clients needs are best approached in a holistic manner. An evaluation of the programme found that there has been a good deal of success in reaching the target group with 49 client admissions over a two year period of 1998-99. In particular, the programme has attracted female clients with 31% of clients being female. 65% of admissions have completed the programme. For the year 1999 94% of those who embarked on job placement completed the task. While 83% secured full-time employment and 13% went on to pursue full-time educational opportunities. Of those participants surveyed in 1999, 94%

reported that they had acquired important new skills while 65% indicated that existing skills had been improved. A majority of participants during 1999 reported that relationships with family and friends had improved. 89% of clients agreed that the programme provided the necessary skills to avoid relapsing into drug use. The programme also ran a Drug Education course for state training agencies. All participants who attended reported positive changes with many reporting less anxiety at the prospect of dealing with former drug users in the future. Also they reported that they now had a greater understanding of the reasons why some people turn to drugs and the consequences that ensue. A majority of employers who accepted clients on work placement reported that they rated the work by former drug users as either good or very good. All employers noted that clients were very energetic and highly motivated.

9.4.3 E) Housing

There are no specific interventions that directly address the housing needs of former drug users. However, The Merchant's Quay Re-Integration Programme (referred to above) highlighted the extreme difficulty former drug users experienced in accessing accommodation, specifically in Dublin. The project found that former drug users who had been through residential treatment, and had also been through the social and educational re-integration programme were particularly affected by accommodation problems. Two key factors tend to predominate against former drug users seeking to avail of accommodation.

- 1) Many former drug users have been evicted from the family home during the active stages of their drug-using career. Under legislation prohibiting anti-social behaviour (Housing Miscellaneous Provisions Act 1997), they remain barred from residing in the family home and their local community, even when they enter treatment programmes. In some cases, some former drug users are allowed back into the family home but only when local community activists and the local corporation have vetted their re-entry.
- 2) Due to escalating property prices and a general shortage of accommodation in Dublin, property owners charge exhorbitant rents that cannot be afforded by former drug users as most of them are not in gainful employment and are usually reliant on subsidisation to meet their rent.

f) Other national specifications

NO INFORMATION AVAILABLE

g) Statistics and evaluation results

Project	Statistics	Evaluation results
The Fusion Project	In the initial year of the project, 39 people in drug treatment developed links with the Fusion project. 24 were placed in Community Employment or training, 8 were	The following outcomes have occurred for participants on the Fusion project. <ul style="list-style-type: none"> • 2 individuals are now in full-time employment

	placed in preparation for employment or training and 7 opted not to accept a place. (Internal communication)	<ul style="list-style-type: none"> • 10 participants have acquired NCVA level 2 in Media and Radio Production • 7 participants have completed a course in pre-enterprise training • 3 participants have completed a full drug detoxification process • 10 have been referred to other services in Ballyfermot <p>Of the 7 individuals who did not accept a place the latest information indicated that 1 had gone abroad, 2 are in full-time employment, 1 is drug free and attending NA, 1 is in touch with Fusion and 1 has returned to active drug use. (Personal Communication)</p>
The Turas Project	The project accommodates 20 trainees, 10 men and 10 women per year. (Personal Communication)	No information available
The Millennium Carving Project	When the project started a total of 78 applications were submitted, from which a total of 24 places allotted to recovering drug misusers through a FAS Community Employment Scheme. (Project report)	No information available
Aislinn Addiction Treatment Centre	Since it opened in October 1998, the centre has worked with over 200 individuals who reported with addiction problems. (Personal Communication)	The South Eastern Health Board is currently evaluating the centre (Personal Communication)
The Cavan Centre	The number of people using the centre each year since 1990 has been approximately between 2 and 3 thousand each year. Figures for 2000 show that 2,832 people used the centre and this was made up of 182 groups. However, it must be noted that an individual's attendance may be counted more than once in these figures. (Project report)	No information available
Tallaght Rehabilitation Project	The project involves the participation of 15 clients (at any one time) on a Special Community Employment Project. Clients attend the project for four hours each day. The project offers numerous education/training activities and seeks to build social skills and self-esteem among clients. During the year 2000, the age of participants ranged from 22 years to 35 years. 69% of participants were women, with 31% men. Initial reports	

	<i>suggest that clients are responding positively to the challenges of the project. (Rourke 2000 Project Report)²⁰ The Tallaght Drugs Task Force, FAS and the Eastern Health Board provide funding of the project. An extensive evaluation is currently being carried out on the project.</i>	
<i>Rehabilitation and Support Programme (RASP)</i>	<i>No information available</i>	<i>No information available</i>
<i>The Pathways Post-Release Centre</i>		<i>However, an evaluation of the centre found that when participants begin to attend the centre they are either on a maintenance programme or drug free. The centre offers the services of professional drug counsellors and the evaluation noted that in over a two-year period there were 167 appointments between clients and counsellor, the number of sessions completed with one client ranging from one session to twenty-five (25) sessions. The Department of Education, FAS and the City of Dublin Vocational Educational Committee (CDVEC) provide funding for the centre.</i>
<i>The Merchant's Quay Re-integration Programme</i>		<i>An evaluation of the project's outcomes found that 65% of clients managed to complete the programme, 94% of clients who undertook job placements completed these placements and 83% of clients secured full-time employment on completing the programme. 13% of clients secured full-time educational opportunities, while a high proportion of clients reported improved family relations, and an improvement in skills and education. The programme was also attributed with providing the necessary relapse prevention skills for 89% of clients. This data relates to the years 1998 and 1999, when a total of 49 clients were admitted to the re-integration programme over the two year period.</i>
<i>Arbour House Treatment Centre</i>		

²⁰ Rourke, S. (2000) Tallaght Rehabilitation Project, Project Report,

<p><i>Hesed House: Counselling and Family Therapy</i></p>	<p><i>Since receiving Task Force funding the Counselling and Family Therapy services of Hesed House have worked with 208 clients and all of these have been touched in some way through drug misuse.</i></p>	
<p><i>Soilse/Rutland Centre Partnership for Treatment</i></p>		<p><i>An evaluation of the programme carried out in 1999 revealed that 7 out of 10 participants reported successful outcomes through engagement with the programme. The evaluation identified three core components of the programme, which influenced successful outcomes as reported by participants. These were 1) the experience of living in a safe environment and feeling part of a therapeutic community 2) building peer networks and having opinions validated and 3) the existence of a continuum of care from detox to treatment to rehabilitation. In addition 12 participants were interviewed for the evaluation. 11 reported that they felt they had been prepared for independent living and work through their participation with the project. Of these, three were in jobs, one on a Community Employment Scheme, two involved in a Community Drama Group and two had applied for an Access Group. (Morgan 2000)²¹</i></p>

h) Specific training

NO INFORMATION AVAILABLE

9.5 Interventions in the Criminal Justice System

(a) Interventions

➤ **Medical (detoxification, drug substitution)**

In Ireland any individual held in custody has the right to request to see a general practitioner (Criminal Justice Act). Where a drug user wishes, he/she may request to see a general practitioner who will tend to them while they are being held in custody and assess whether to provide the individual with medication, e.g. methadone, to alleviate withdrawal symptoms. However, data are not currently collected on either the number of people held in custody who avail of this service or the proportion who do so as a consequence of their drug use.

²¹ Morgan, M. (2000) Soilse/Rutland Centre: Partnership for Treatment, Process Evaluation.

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

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

Day 1-2 35mls methadone mixture

Day 3-5 30mls methadone mixture

Day 6-8 25mls methadone mixture

Day 9-11 20mls methadone mixture

Day 12-14 15mls methadone mixture

Day 15-17 10mls methadone mixture

Day 18-20 5mls methadone mixture

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

The provision of methadone maintenance within the Irish prison system remains limited. Methadone maintenance is available to prisoners who are HIV positive or who have AIDS and to those who were on a maintenance programme prior to imprisonment. Currently, methadone maintenance is only commenced in Irish prisons in the case where a prisoner is HIV+. However, it is currently being planned to expand the provision of methadone maintenance to include initiation for those who at some stage in the past have participated on a methadone maintenance programme in the community.

➤ Drug-free programmes

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

A seven-week ‘Drug Detoxification and Rehabilitation Programme’ is run by probation and welfare officers, and is based in the Medical Unit of Mountjoy prison. The programme caters for nine male prisoners at a time. There is no equivalent service available to female prisoners. To access the programme prisoners are interviewed by probation and welfare officers and assessed for suitability. Only prisoners with less than 26 months to serve or with a court

sentence review date less than 26 months away can apply for the programme. Participation entails an initial methadone detoxification followed by an intensive rehabilitation programme. A multi-disciplinary team that includes both medical staff and counsellors from outside agencies delivers this programme. Participants who remain drug free during the seven-week period are then transferred to a designated drug free unit (the Training Unit). While workers from a therapeutic community are involved in service provision for this particular programme, there is no therapeutic community type programme available to drug users in the Irish prison system. A similar programme with more of a focus on factors associated with imminent release into the community is run over an eleven-week period. This is also based in Mountjoy Prison Dublin and will be discussed in the section on 'Release' below.

➤ **Self-help groups**

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

➤ **HIV/Hepatitis prevention (needles and syringe exchange)**

Needle and syringe exchanges are not provided to drug users in the Irish prison system. Furthermore, there is no structured access to cleaning materials for injecting equipment. However, a recent report of the Group to Review the Structure and Organisation of Prison Health Care Services, established by the Minister for Justice, Equality and Law Reform (2001) has recommended that disinfectant tablets should be introduced into the Irish prison system "without further delay" (p.11) as a method of limiting the spread of communicable diseases- this continues to be problematic due to on-going objections of prison officers. The group did not go so far as to recommend the introduction of a syringe exchange programme in Irish prisons, arguing that "the risk of attacks on staff and prisoners with syringes supplied by the state would appear to be unacceptable" (p.46).

As mentioned above the Probation and Welfare Service in Mountjoy prison Dublin have developed a Drug Awareness Programme which is also run to some extent in other prisons. This is a four-week programme consisting of one session per week. The principal aim is to educate participants about their drug use and the associated risks. It is aimed at all prisoners with a history of drug use, including those who have ceased their drug use and those who are continuing to use within the prison setting. Included in this programme is a session on HIV and Hepatitis.

(b) Drug testing

In the community, probation and welfare officers as a condition of an offender's Supervision Order sometimes use drug testing (urinalysis). Routine randomised drug testing is only carried out within the prison system in the designated drug free area of the Training Unit in Mountjoy Prison. A drug free environment is ensured by the requirement for all prisoners, irrespective of whether they have a drug using history or not, to undergo random urinalysis.

Where a prisoner tests positive for a prohibited substance, he is moved either to another prison or another area of Mountjoy. Drug testing is also used to monitor those prisoners who are receiving methadone on a maintenance basis in the prison setting.

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

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

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

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

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

The CONNECT project was established in Mountjoy under the European DESMOS project which is supported by the European Social Fund under the Integra Employment Initiative. The main objective of its work is 'to encourage the (re) integration of offenders in society through employment as a support.' Each country has developed its own national programme which has as its

base the guidelines on employment recommended by the Council of Europe, which have at its core four aims:

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

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

(d) Statistics and evaluation results

There has been little evaluation carried out of programmes aimed at drug users in the Irish criminal justice system. Crowley (1999) provided a medical review of the seven-week Drug Detoxification and Rehabilitation Programme in Mountjoy prison, Dublin. Up to February 1999, 187 prisoners had entered the programme, 173 completed the detox and 14 failed to complete the detox. While this implies a 93% success rate, Crowley (1999) highlights the need for the success of this intervention to be determined by the 6 and 12 month relapse figures. Overall it was found that there was a twelve monthly relapse rate of 78%. Crowley argues that while this may appear high, it compares favourably to outcome rates of other inpatient detoxification programmes.

(e) Specific training

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

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

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

As part of its proposals for the staff development the Steering Group on Prison Based Drug Treatment Services (Irish Prisons Service 2000), it is proposed that a special Prisons Service Training Officer be appointed. It is proposed that this Assistant Training Officer would work in tandem with the Area Health Authority's training department of the Drugs/AIDS services. The Officer would have responsibility for implementing a full training package for

all staff within the prison who are working with drug users. The proposed training would consist of two levels. The first level would cover general education, basic skills training and awareness training of drug problems for all prison staff in relevant institutions. The second level would be more specific training for a core group of staff who would be working directly with drug users, within prison treatment units.

Interventions outside the prison system but remaining within the remit of the Criminal Justice System.

Project Name: *Harristown House*

Target Group: *Male offenders with drug and alcohol problems*

Aims of project: *To serve as an alternative to prison for offenders with drug and alcohol problems that have been identified by the courts as people who would benefit from an intervention of this kind*

Activities of project: *A self sufficient residential drug free unit offering a treatment programme that includes a blend of cognitive and behavioral therapy underpinned by the principles of the Minnesota Model of addiction treatment.*

Project Name: *Copping On: National Crime Awareness Initiative*

Target Group: *Early school leavers and young people 'at risk'*

Aims of Project: *To reduce the risk and incidence of offending behaviour among young people and to decrease harmful and damaging behaviour such as bullying, alcohol and drug misuse*

Activities of Project: *Training for professionals who work with young people 'at risk' and training and instruction for young 'at risk'*

Project Name: *The Tower Programme*

Target Group: *Young offenders aged 18-30*

Aims of Project: *To serve as an alternative to custody for young offenders who are deemed suitable to for inclusion on the project*

Activities of Project: *A FAS sponsored vocational training programme plus evening classes for those waiting to join the full-time programme and sports and leisure activities are organised for participants on weekends.*

Project Name: *The Garda Youth Diversion Project*

Target Group: *Young people between 10-18 who are deemed 'at risk' of becoming involved in drug misuse and crime.*

Aims of Project: To prevent crime and drug misuse among the target group

through community and multi-agency cooperation and to improve the quality of life within a community.

Activities of Project: Training and educational upgrading including literacy and numeracy, training in job skills, work experience and job placement.

b) Drug Testing

NO INFORMATION AVAILABLE

c) Release: referral to treatment, aftercare, probation

NO INFORMATION AVAILABLE

d) Statistics and evaluation results

Project	Statistics	Evaluation results
<i>Harristown House</i>	<i>Since the inception of the project in November 1998, 102 young men have been placed on the project</i>	<i>No information available</i>
<i>Copping On: National Crime Awareness Initiative</i>	<i>Over a 1,000 people have been trained to implement the programme.</i>	<i>An evaluation by Bowden 1998 recorded a positive reaction from trainers and participants.</i>
<i>The Tower Programme</i>	<i>No information available</i>	<i>Evaluation in progress</i>
<i>The Garda Youth Diversion Project</i>	<i>No information available</i>	<i>A recent evaluation revealed that the programme is beginning to have an impact on offending and anti-social behaviour among the target groups.</i>

e) Specific Training

NO INFORMATION AVAILABLE

9.6 Specific targets and settings

a) Description of new trends and developments

The National Advisory Committee on Drug (NACD) has tendered for research to be carried out with a number of marginalised groups. For instance, homeless drug users, drug users working in the sex industry and drug use among travellers. The nature of the research will predominantly be explorative in order to shed some light on 'hidden' aspects of social life. However, it is hoped that the research and the conclusions that is anticipated from the research will provide a background from where policy interventions in the areas outlined can be influenced.

b) Specific services and interventions (prevention, treatment programmes, etc.)

The Renewal Project/ A Gender Specific Programme

The Renewal Project was set up by Tabor Lodge in response to a need for a residential supportive environment for women who are in the early stages of recovery from addiction. The project offers accommodation for 10 women aged 18 years and over. The project demands that entrants are free of alcohol and drugs for 72 hours prior to admission. The project offers a three-month programme based on the Hazledon model of total abstinence. Services provided include group therapy, one to one counselling and parenting skills and training in relapse prevention. Residents are encouraged to work outside on a part-time basis and some attend training courses and FAS schemes. At weekends residents return home when appropriate and those who remain at the project are encouraged develop their drug free lifestyle by socialising in social settings where the use of alcohol and drugs is minimal. The South Eastern Health Board primarily funds the project, and clients are encouraged to pay a small sum towards their keep. As well the Southern Corporation under section 10 give funding to cater for homeless recovering drug users. The centre caters for women only who are over 18 of age.

The Lorien Project/ Targeting the Children of drug users

The Lorien Project is a family support project that aims specifically to work with the families of drug using parents. The project also works with parents who are using drugs and in this context operates a holistic and integrated approach. The project is located in Tallaght, a large suburb of Dublin. So far the project has worked with over 63 families since it was established in 1997. On the basis of 2-3 per family it is estimated that the project has impacted on approximately 150 people (drug users, their children and siblings).

Ethnic Minorities/The Traveller Specific Drugs Initiative

Pavee Point received funding through the National Drug Strategy in 2000 to establish the Traveller Specific Drugs Initiative. Pavee Point is a national non-governmental organisation, which is committed to the attainment of human rights for Irish Travellers. The organisation is a partnership of Travellers and settled people working together to address the needs of Travellers as a minority ethnic group who experience exclusion and marginalisation. From the outset, representatives from the Travelling community made clear that this initiative was not about the development of a separate segregated service for Travellers but rather about the promotion of Traveller inclusion in existing mainstream services and other services that are being developed. The Traveller Specific Drugs Initiative is run by a co-ordinator. To date the work of the co-ordinator within the initiative has concentrated on:

- *Developing and disseminating information to Travellers and Traveller organisations on a variety of issues specific to Travellers and drug use. This includes information on the Traveller Specific Initiative itself, The National Drugs Strategy, The Local Drugs Task Forces and basic information on drug misuse.*

- *Support to Traveller organisations in assisting them to explore the drugs issue within their area and examine responses that may be developed.*
- *Raising the issues of Travellers and drug use and the distinct needs of the travelling community with the Local Drugs Task Forces. This work has centered on raising awareness of the issues of Travellers and drugs use and working with the structures to promote Traveller inclusion.*
- *The need for more research into drug use and the traveller community has been a central concern of the initiative to date. In order to forward this aim the initiative has made contact with the National Drugs Strategy Team and the National Advisory Committee on Drugs regarding the funding and development of research into Travellers and drug use.*

To date there has been little research conducted into drug use in the travelling community. However, a recent exploratory study (Hurley 1999) has confirmed that:

- *There is a growing drug problem among the Traveller community throughout the country.*
- *There are no specific services targeted to meet the needs of Travellers who misuse drugs.*
- *Service providers identified the need to develop an outreach/targeted dimension to their work in order to facilitate Traveller access to and uptake of existing services.*
- *Owing to on-going discrimination of Travellers in society, it is easier for Travellers to access cannabis and other illegal drugs than to gain access to a public house to purchase alcohol legally.*

Alternatives to prison and prosecution

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

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

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

The 'Order of Recognisance' would appear to be an important non-custodial option for drug users who offend in Ireland. However, in practice the courts do not generally use this order. The necessary rules and regulations have not

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

been made. Furthermore, the provision of a statutory place of treatment has always been problematic. The Expert Group on the Probation and Welfare Services has recommended that the necessary Courts Rules and Regulations be updated by the various Court Rules Committees to facilitate wider use of the 'Order of Recognisance' (Expert Group on the Probation and Welfare Services 1999).

A Drug Court was established in Ireland in January 2001 on a pilot basis in one area of Dublin City. The Court has as its primary aim "the reduction of crime through rehabilitation of the offender but not excluding punishment should the circumstances so warrant. The purpose of the proposed Drug Court is to provide a scheme for rehabilitation, under the auspices and control of the court, of persons who are convicted of, or who have pleaded guilty to, drugs offences, relating to possession for own use or for supply to others on a minor scale, and crimes triable in the District Court²² which are related to the drug misuse of the offender" (Drug Court Planning Committee 1999, p.15). In order to access the court the person must be seventeen years of age or older, and either have pleaded guilty or been convicted in the District Court of a drug or drug-related offence which would warrant a prison sentence. The offender must express a wish to be admitted to the Drug Court and at the recommendation of either the police, the Probation Service, a drug treatment professional or the defending solicitor the individual will be assessed as to their suitability for engagement in the Drug Court process (Drug Court Planning Committee 1999). To date 44 offenders have been referred to the Drug Court, of those 15 were deemed either to be unsuitable or their involvement was terminated due to non-compliance with the Court's requirements- the remainder are currently "in front of the Court" (personal communication, Drug Court Planning Committee). The pilot phase is being evaluated over its initial twelve-month period, with a focus on 'success' in terms of changes in offending behaviour; cost; and feasibility of expansion to cover the remaining areas of the city. The evaluation is due for completion in May 2002 (personal communication, Drug Court Planning Committee).

c) Statistics and evaluation results

NO INFORMATION AVAILABLE

d) Specific training

NO INFORMATION AVAILABLE

²² "The jurisdiction of the District Court extends to offences which are triable summarily or indictable offences where the judge accepts jurisdiction to hear the case summarily after election by the accused or at the direction by the Director of Public prosecutions (DPP). The maximum sentence the District Court may impose on any one charge cannot exceed 12 months imprisonment and an overall total of 24 months on a combination of more than one offence" (Drug Court Planning Committee 1999, p.13).

10. Quality Assurance

10.1 Quality assurance procedures

NO INFORMATION AVAILABLE

a) Formal requirements for quality assurance

NO INFORMATION AVAILABLE

b) Criteria and instruments applied in quality assurance

Evaluation of Local Drug Task Force Funded Projects

A recent evaluation of Local Drug Task Force Projects (Ruddle et al 2000)²³ revealed that according to the perceptions of project managers, the emergence of local drug projects had contributed to improvements in the lives of participants and in the local community. In the main, project managers reported perceptions of positive outcomes emanating from the various projects. These observations were primarily due to the dedication and commitment shown by clients/participants towards the projects, plus the self-development of clients/participants and the positive recognition of the project at community level.

The overall aim of the evaluation was to examine the manner in which each project has managed to handle the first two stages of project development, i.e. the planning and implementation stages. This satisfies the criteria for process evaluation. At the time of evaluation approximately 220 projects had received funding. Of these 142 projects were covered for the evaluation, a profile breakdown of projects reveals that:

- *51 % are educational/prevention projects*
- *36 % treatment/rehabilitation*
- *7 % combination of both of above*
- *3 % supply control*
- *3 % research and information*

The fieldwork was done over a three-month period by a panel of 13 evaluators, primarily consisting of an in-depth interview with project managers. The evaluation served two main purposes, on the one hand it enable successful projects to be identified for “mainstream funding”. This meant that responsibility for funding such projects could be transferred on a permanent basis to the state agency from through which funding for the project was initially channeled. The evaluation revealed a number of key insights into the operation of projects under the Local Drug Task Forces, such as:

- *The majority of project managers (82%) admit that pitfalls were experienced or narrowly avoided. Main pitfalls being a lack of suitable premises, community hostility and staffing issues.*
- *The main factors identified as enabling project delivery include the commitment and qualities of the project staff and support and networking opportunities with other bodies.*
- *Main factors identified in constraining project delivery include unsuitable premises, lack or loss of trained staff and funding issues.*
- *Over two thirds of project managers 68% believed that the original objectives of their projects had been reached. This was based on their perceptions.*
- *The key indicators which project managers use to assess achievement are the numbers of clients availing of or staying with the project. Or the client's personal progress. Main method used to gather information on this is the client's participation records.*
- *Main factors identified in enabling attainment of projects include the quality and commitment of staff and support from other agencies and bodies.*
- *Main factors identified in constraining attainment of objectives include lack or loss of staff and inadequate premises.*

10.2 Treatment and prevention evaluation

a) Evaluation policy

NO INFORMATION AVAILABLE

b) Requirements for evaluation

To date in Ireland the bulk of evaluation that has been carried out on interventions in the field of demand reduction has been process evaluations. These tended to concentrate on the planning and implementation stages of projects/initiatives. In preparation for the next stage of evaluation, the outcome and impact assessment, and a number of requirements have been outlined.²⁴ For example, it is recommended that:

- *At project level, the project manager has the responsibility of ensuring that, from the outset, evaluation of outcomes and impact is built into the projects information systems and is taken into account when determining the funding and resources required*
- *Support in the form of resources, funding, expertise, guidance and training must be provided to the projects by the National Drug Strategy Team and the Local Drug Task Forces*
- *A means to explore ways of obtaining consumer feedback from the project's clients be explored*
- *The need for research into the many dimensions of local drug issues be explored to assist in the contextualisation of impact and outcome assessments from local projects*

²⁴ For further information see Evaluation of Local Drug Task Forces, Ruddle et al 2000

- *And, that each Local Drug Task Force have a trained research worker dedicated to the research function*

c) Use of evaluation results

Review of Eastern Health Board (EHB) Drugs and AIDS services

A review of the EHB's Drugs and AIDS services was conducted during 1999 (Farrell et al. 2000)²⁵. The review was designed to examine the service development over the 5 years since the last review was undertaken, to assess the current service provision and service mix and to make recommendations about policy development and the evolution of policies in the context of services and practices elsewhere. The report concluded that the EHB has achieved a major expansion in drug services over the last five years and has developed innovative services. A number of recommendations were made in the report. It was suggested that an audit of benzodiazepine use be conducted and that the current needle exchange facilities be expanded.

Review of Current Alcohol and Drug Problem Service Provision in Kilkenny

A review of the Current Alcohol and Drug Problem Service Provision in Kilkenny was conducted during 2001 (Farrell and Marsden 2001)²⁶. The review was designed to assess the current levels of service provision and to make recommendations about future development of service organisation and service delivery. The report concluded that the current service, which primarily operated from a single floor in an outpatient building of St. Luke's Hospital in Kilkenny, gave the impression of being underfunded. There was a distinct lack of administrative support that meant the workload of counsellors overburdened. The overall level of activity over the previous three years was 120 to 130 new cases per year. The report concludes that perhaps there is pockets of the community that would benefit from contact with the services. However, given the demands of the current workload on the service, the limited amount of counsellors and private rooms and the lack of administrative support, perhaps the wider community is unable to access treatment options. The authors make some key recommendations, which state that:

- *The development of an integrated community based service is the best way to harness new resources and develop and innovate on the basis of current funding opportunities.*
- *Service delivery can be improved if people with alcohol and drug problems in the area can access services appropriate to their needs, that the service can deliver access to a range of primary, secondary and tertiary health*

²⁵ Farrell, M. Gerada, C. and Marsden, J. (2000) External Review of Drug Services for The Eastern Health Board. London; National Addiction Centre, Institute of Psychiatry, London.

²⁶ Farrell, M and Marsden, J. (2001) External Review of Current Alcohol and Drug Problem Service Provision in Kilkenny. Commissioned by the Drug Co-ordination Unit of the South Eastern Health Board.

and social care options and the delivery of care is based on a continuing assessment of presenting and evolving treatment and support need.

- *That a working group is established to oversee the development and implementation of enhanced arrangements for monitoring the delivery and impact of treatment.*

d) Evaluation training

NO INFORMATION AVAILABLE

10.3 Research

a) Demand Reduction research projects: objectives, structure and organisation

A National Advisory Committee on Drugs (NACD) comprising of experts from the research, voluntary, community and statutory sectors was established in 1999 to co-ordinate and commission research on drug problems in Ireland. The primary objective of the NACD is to advise the Government, in relation to the prevalence, prevention, treatment and consequences of problem drug use in Ireland. The Committee has set out a detailed three-year plan of research, which includes an examination of the areas of prevention, treatment and rehabilitation. These are three key areas in the field of demand reduction and it is anticipated that a valuable insight into the strengths, weaknesses and gaps in these areas will materialise upon completion of this research programme. In particular the programme will endeavour to do the following:

Prevention

- *To examine the effectiveness in terms of impact and outcomes of existing prevention models and programmes, with particular regard to evaluation instruments developed at European level*
- *To undertake comparative studies of different models with particular reference to those in operation in task force areas*

Treatment/Rehabilitation

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

b) Relations between research and drug services

The following are some examples of relatively recent research that has been carried out with individuals attending drug treatment services in Dublin.

A document outlining a blueprint for rehabilitation services for opiate addicts in the Eastern Health Board area (Dorman et al 1999) drew on the findings of a research project commissioned by the Drug Rehabilitation Committee of the

Eastern Health Board. The research was carried out in order to facilitate the informed planning of rehabilitation services in the future. The research was qualitative in design and looked at three distinct perspectives, those of the clients, the staff in drugs services in the health board areas and the local community. 94 opiate addicts, attending rehabilitation services funded and/or operated by the Eastern Health Board were interviewed. Focus groups were held for staff and for those representing the community. The report made the following recommendations. Rehabilitation should be; comprehensive, client centred, delivered through an integrated multi-disciplinary service and offering a range of responses. In addition, it should be well resourced with fast access and every opportunity given for addicts to contribute to the design and delivery of programmes.

Smith et al (1999) claimed that while there was evidence of a reduction in the rates of unsafe injecting practices among opiate users while injecting, there had not been much published evidence to show that harm reduction programmes helped to reduce the occurrence of the hepatitis C virus. The study aimed to explore whether or not, among intravenous drug users with short injecting histories, the prevalence of hepatitis C was lower in those who started injecting after an expansion in harm reduction services in Dublin. The study was set in Trinity Court addiction treatment centre.

In the context of the relatively high prevalence rate of hepatitis C among injecting drug users (IDUs), (Smyth et al, 1999) sought to explore and assess the understanding of hepatitis C among IDUs attending an addiction clinic. In total 105 IDUs were interviewed. It was found that respondents were better at identifying activities that carried a risk of hepatitis C transmission than at identifying activities that posed no threat. Understanding of the long-term nature of hepatitis C was found to be poor, and respondents in recent contact with a GP performed less well than those without contact. The authors concluded that understanding of hepatitis C among IDUs in contact with health professionals was poor and in need of major improvements.

c) Funding of demand reduction research

The bulk of funding being provided for research in this field comes from the Department of Tourism, Sport and Recreation the Department of Health and Children, the National Advisory Committee on Drugs, the National Drug Strategy Team through the Local Drugs Task Forces and the regional health boards. Representatives from the community sector who identify a gap in research can also apply for funding through the Local Drugs Task Forces. While a limited amount of research is carried out in the voluntary sector and is usually funded by a mixture of statutory and private subsidies.

d) Training in demand reduction research

Trinity College, Dublin, incorporates a research component into both the Diploma in Addiction Studies and the M.Sc. in Drug and Alcohol Policy.

10.4 Training for professionals

a) Training in quality assurance and evaluation: type and structures

NO INFORMATION AVAILABLE

b) University training, Non-University Vocational training, in-service training

UNIVERSITY TRAINING	NON-UNIVERSITY TRAINING	IN-SERVICE TRAINING
Diploma In Addiction Studies	Alcohol and Drug Abuse Awareness	Teen Community Addiction Studies Course
M.Sc in Drug and Alcohol Policy	Drugs and Addiction	Peer Support Training Programme
National Diploma/Degree in Community Drug Prevention Studies	Peer Education Drug Awareness Programme	Probation and Welfare Service Training
	Peer Leadership Training	Garda Training
	Substance Abuse Prevention Programme	Drug Education and Awareness for Pharmacists
	Social, Personal and Health Education	Substance Abuse Training Course
	Training for Community Drug Workers	Certificate in Drug Counselling and Intervention Skills
	Certificate Course in Community Leadership and Substance Misuse Awareness	Drug Response and the Traveller Community
	Community Addiction Studies Course	Learning Together, Working Together
	Drug Information and Community Education (DICE)	Drug Awareness for Voluntary Leaders
	Further Training in Community Drug Work	Drug Questions, Local Answers
	Leadership Training for Prevention of Drug Problems	Foundation Level Training in Drugs and Addiction Education
	Parenting for Prevention	Working with clients: Motivational Interviewing and Brief Counselling Skills
	Certificate in Addiction Studies	
	Addiction Studies Certificate	
	Social and Health Education Facilitation Training	

c) Statistics and evaluation results

NO INFORMATION AVAILABLE

Conclusion:

Plans for the future development of the demand reduction field in Irish drug policy is embedded in the National Drugs Strategy 2001-2008. In particular, the fields of prevention, treatment and rehabilitation are well covered in this

regard. However, there are a number of issues across the three areas that warrant special attention. The strategy recognises the tackling of poverty, poor housing conditions and inadequate educational opportunities all have a role to play in the prevention and management of drug misuse and drug related harm. The point can also be made that prevention strategies like school based drug programmes need to take account of the probability that those most 'at risk' may not be benefitting from the provision of mainstream drug education programmes. For instance, the school prevention programmes may be missing early school leavers, while the content and delivery of drug programmes in schools may be too difficult for some children with learning difficulties to understand.

In terms of treatment, the strategy aims to increase the number of treatment places to a minimum of 6,500 by the end of 2002. A noble aspiration one might say, however, an issue that needs constant attention is the use of prescription drugs by those in treatment, primarily benzodiazepines. The efficacy of the treatment process runs the risk of being seriously undermined both in medicinal and cultural terms. In particular, the cultural element requires attention as if local community members witness people in treatment being 'stoned' on a regular basis, this can have implications for the status of treatment among the community.

Finally, perhaps the biggest challenge facing the drug strategy and the key players in the drug field is the area of rehabilitation. The development of effective models of rehabilitation is crucial to the future of the drug strategy and the overall Irish drug policy in general. Programmes delivering personal development, training and educational services for former drug users need to be developed around the needs of individuals. These programmes need to combine preparation for mainstream activities like the job market, while recognising the special needs of recovering drug users.

PART 4
KEY ISSUES

11. Polydrug Use: Drug Set and Setting – Martin Keane

Despite an increased research focus on drug misuse related issues in Ireland over recent years, an area that has received little attention has been that of polydrug use. However, a review of the literature on drug misuse in Ireland has revealed ‘pockets’ of evidence indicating some levels of polydrug use among individuals engaging in drug misuse. In the majority of these studies which will be referred to throughout this chapter, polydrug use is reported as a part of the drug-using career of individuals with little focus on the nature, effects, extent or rationale behind the polydrug using behaviour.

The purpose of this chapter is to explore the issue of polydrug use in an Irish context by looking at different combinations of drugs used and effects sought, historical and new patterns of polydrug use, user groups, and the health and social consequences of polydrug use. Differences in routes of administration, gender, age, rural/urban and sexual orientation among polydrug users will be discussed.

Three different approaches were taken to examine the issue of polydrug use in Ireland, namely:

- A comprehensive search of the Irish literature on drug use and misuse;
- An analysis on data collected by the National Drug Treatment Reporting System (NDTRS) for 1999 (last year of complete national data);
- A survey of small convenient sample of ‘confirmed’ polydrug users using a self-completed questionnaire. This data was collected at three separate locations in Dublin using a self-completed questionnaire. Two of the locations were Health Promotion Clinics, the other a Post-Release Centre for ex-prisoners. Individuals were asked to respond to a filter question, which inquired “Have you ever used two or more of the following drugs during the same 24-hour period”. A list of 14 different drugs and a separate category for ‘other drugs’ were presented. In the event of responding in the affirmative, individuals were asked to complete the remainder of the questionnaire. In total 41 respondents completed the questionnaire, 3 additional questionnaires that were partially completed were dismissed. This study will be referred to throughout the remainder of this chapter as the “exploratory survey on polydrug use”.

Defining polydrug use

Polydrug use can prove an elusive term to define. Broadly speaking, the phenomenon of polydrug use primarily involves the use of different substances and different combinations at different times (Keup 1990, Bergmark 1998). Some of the issues that render polydrug use a difficult term to define are deciding on whether to include the use of legal and prescribed

drugs in addition to the use of illicit drugs. Also deciding on the timeframe within which polydrug use can be examined. For instance, is it the use of a number of drugs (usually two or more) during an individual users lifetime, or within the last year/month/week? An additional point to consider is deciding on whether to look at how often does the usage of a number of drugs occur, is it daily/weekly/monthly? Also do users take particular combinations of drugs in order to achieve specific effects?

For the purpose of preparing this chapter a number of different definitions of polydrug use were employed in the process of data collection and data analysis. A literature search of material on aspects of drug misuse in an Irish context revealed that most of the studies that touched on polydrug use referred to it in broad terms. For instance, in the majority of studies where polydrug use was indicated, respondents reported the 'use of two or more drugs during their lifetime'. The second source of data referred to in this chapter comes from the National Drug Treatment Reporting System (NDTRS), specifically the year 1999. In this instance, polydrug use is defined as the 'use of two or more drugs on a daily basis in the month prior to treatment'. Finally, the exploratory survey on polydrug use utilised the definition of polydrug use as the 'use of two or more drugs during the same twenty-four hour period'.

11.1 Patterns and Users Groups

a) Combinations and effects sought

In recent times in Ireland an emerging tendency has been noted for drug users to combine ecstasy and heroin (Table 11.1a). In most cases the indications are that individuals aimed for a desired effect in using this combination. It appears that smoking heroin or 'chasing the dragon' as it's often referred to is seen as effective in helping to 'come down' from the high of ecstasy (Gervin et al. 1998). What is not made clear is why individuals required the intervention of another drug in 'coming down' from ecstasy. For instance, does this mean that individuals are smoking heroin to conceal the high of ecstasy from parents, or is heroin smoked to alleviate the short term 'negative effects' that withdrawing from ecstasy is reported to bring on (Bissett 1997). The studies referred to (Table 11.1a) looked at ecstasy use over lifetime usage of drugs by individuals, but the studies do not reveal the number of times that individuals may have used this combination of heroin and ecstasy. The limitations of this lifetime usage definition are discussed in (Section 11.5). However if individuals report to using to counteract the effects of ecstasy then it can be inferred that this form of usage is more likely to take place within the same 24-hour period, thereby indicating a more intense form of polydrug use.

Table 11.1a: The combination of heroin and ecstasy among some drug using individuals in Ireland

Author	Sample source	Data collection	Definition of Polydrug use	Combinations and effects sought
Gervin et al (1998)	Treatment Centre (n=46)	Interviews	Lifetime usage	Almost 50% reported smoking heroin to "come down" off ecstasy
Dorman and Jones (1999)	Treatment Centre (n=94)	Interviews	Lifetime usage	Smoking heroin to counter ecstasy use
Crowley (1999)	Prison Detox Programme (n=187)	Self Completed Questionnaire	Lifetime usage	100 heroin 60% ecstasy (effects sought not known)

Another combination of drugs that has been picked up by some studies is the link between heroin and benzodiazepines and in some cases the use of methadone (Table 11.1b). The word 'combination' is being used loosely here as it must be noted that it is not clear from the studies referred to (Table 11.1b) whether the use of these drugs were combined during the same 24 hour period. Neither is it clear what effect individuals were seeking to induce by using these types of drugs. It could be argued that the combining of heroin and benzodiazepines has implications for the efficacy or otherwise of opiate treatment programmes. Clearly, if individuals opiate use is being addressed while their co-existing benzodiazepine use is being neglected then there is potential for the undermining of drug specific treatment programmes such as methadone maintenance and methadone substitution.

Table 11.1b: The combination of heroin and benzodiazepines among some drug using individuals in Ireland

Author	Sample Source	Data Collection	Definition of polydrug use	Combinations and effects sought
Rooney et al (1998)	Treatment Centre (n=63)	Interviews and urine/analysis	Lifetime usage	Over two thirds of sample tested positive for opiate and benzodiazepine use (effects sought not known)
Hutchinson et al (1995)	A&E Departments (n=141)	Self completed questionnaire	Lifetime usage	Reported use of opiates, prescribed methaone and benzodiazepines (effects sought not known)
Browne et al (1997)	Treatment Centre (n=107)	Urine/analysis	Drug use in 30 day prior to test	45% tested positive for using benzodiazepins while using methadone (effects sought not known)
Farrell (2000)	Treatment Centres	Urine/analysis	Drug use in 30 days prior to test	65% tested positive for benzodiazepine use while taking methadone (effects sought not known)

Polydrug use among those treated for problem drug use was examined using data from the National Drug Treatment Reporting System (NTRS) for the year 1999 (last year of complete national data). A total of 6443 treatment contacts were made in 1999 of which 956 (14.8%) reported using two or more drugs, on a daily basis, in the month prior to treatment. Where polydrug use was reported on a daily basis by all treatment contacts 740 (77.4%) reported taking two drugs only, 188 (19.7%) reported taking three drugs only, and 28 (2.9%) reported taking four drugs only. No information was available on a fifth (or subsequent) drug.

Where two drugs only were reported as being used on a daily basis Heroin and Cannabis, and Heroin and Benzodiazepines were the most common combinations, accounting for 45 per cent of all two drug combinations (Table 11.1c). A daily Methadone and Benzodiazepine combination was used by a further 15 per cent.

Table 11.1c. The combinations of drugs used by all treatment contacts reporting daily use of two drugs only in the month prior to treatment

Drug Combination (2 drugs only)	N (%)
Heroin + Cannabis	174 (23.5)
Heroin + Benzodiazepines	159 (21.5)
Methadone + Benzodiazepines	108 (14.6)
Heroin + Methadone	85 (11.5)
Heroin + Cocaine	34 (4.6)
Other Combinations	180 (24.3)
Total	740 (100)

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

Where three drugs only were reported as being used on a daily basis Heroin, Methadone and Benzodiazepines was the most common combination, accounting for over 31 per cent of all three drug combinations (Table 11.1d). A daily Heroin, Benzodiazepine and Cannabis combination was used by a further 16.5 per cent.

Table 11.1d. The combinations of drugs used by all treatment contacts reporting daily use of three drugs only in the month prior to treatment

Drug Combination (3 drugs only)	N (%)
Heroin + Methadone + Benzodiazepines	59 (31.4)
Heroin + Benzodiazepines + Cannabis	31 (16.5)
Heroin + Methadone + Cannabis	13 (6.9)
Methadone + Benzodiazepines + Cocaine	9 (4.8)
Methadone + Benzodiazepines + Cannabis	6 (3.2)
Other Combinations	70 (37.2)
Total	188 (100)

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

Where four drugs only were being taken on a daily basis the most common combination of drugs used was Heroin, Methadone, Benzodiazepine and Cannabis. A total of 7 (25.0%) of the 28 treatment contacts reported taking this combination of drugs.

A total of 1852 first treatment contacts (i.e. clients who had never been previously treated for drug misuse) were made in 1999 of which 207 (11.2%) reported using two or more drugs, on a daily basis, in the month prior to treatment. Where polydrug use was reported on a daily basis by first treatment contacts 168 (81.2%) reported taking two drugs only, 33 (15.9%) reported taking three drugs only, and 6 (2.9%) reported taking four drugs only. No information was available on a fifth (or subsequent) drug.

Where two drugs only were reported as being used on a daily basis Heroin and Cannabis was the commonest combination, accounting for 34 per cent of all two drug combinations (Table 11.1e). A daily Heroin and Benzodiazepine combination was used by a further 21 per cent.

Table 11.1e. The combinations of drugs used by first treatment contacts reporting daily use of two drugs only in the month prior to treatment

Drug Combination (2 drugs only)	N (%)
Heroin + Cannabis	57 (33.9)
Heroin + Benzodiazepines	35 (20.8)
Heroin + Methadone	16 (9.5)
Cannabis + Alcohol	10 (6.0)
Cannabis + MDMA	7 (4.2)
Other Combinations	43 (25.6)
Total	168 (100)

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

Where three drugs only were reported as being used on a daily basis Heroin, Methadone and Benzodiazepines was the commonest combination accounting for 15 per cent of all threedrug combinations (Table 11.1f). A daily Heroin, Benzodiazepine and Cannabis combination was used by a further 12 per cent.

Table 11.1f. The combinations of drugs used by first treatment contacts reporting daily use of three drugs only in the month prior to treatment

Drug Combination (3 drugs only)	N (%)
Heroin + Methadone + Benzodiazepines	5 (15.2)
Heroin + Benzodiazepines + Cannabis	4 (12.1)
Heroin + Benzodiazepines + Benzodiazepines	2 (6.9)
Heroin + Methadone + Cannabis	2 (6.1)
MDMA + Cannabis + Alcohol	2 (6.1)
Other Combinations	18 (54.5)
Total	33 (100)

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

In the six cases where first treatment contacts reporting taking four drugs only on a daily basis during the month prior to treatment no discernible pattern or drug combinations could be established.

Findings from the exploratory survey on polydrug use show that 41 individuals reported to engaging in polydrug use where this meant using two or more drugs during the same 24-hour period. In terms of looking at the combinations used and effects sought on the FIRST occasion individuals used two or more drugs in the same 24-hour period, the following emerged from the survey.

Alcohol and cannabis was the most likely combination to be used, and was reported by 36.5% of respondents.

The survey utilised two open-ended qualitatively focused questions in order to ascertain why people engaged in polydrug use on the FIRST occasion and what effects they were seeking on this occasion. The following is a breakdown of the findings:

- Around 25% of the sample indicated that their desired effect was to *forget their worries*.
- Around 20% reported that they first engaged in polydrug use in order to *intensify their high and get “really out of it”*.
- Most of the remainder submitted mixed responses primarily indicating that *they wanted to “feel good”* and that *the drugs were available and they used their opportunity to experiment*.
- Around 60% of respondents indicated that *“peer pressure”* played some part in their first engagement with polydrug use.

The open-ended questions that elicited these responses were part of a self-completed questionnaire and therefore it was not feasible for the researcher to explore the meanings of terms such as “really out of it” and “peer pressure”.

b) Patterns and user groups: historical perspective and new patterns

A review of the literature on drug related activities in Ireland shows that as far back as 1983, when the first prevalence study of opiate use in Ireland was carried out (Bradshaw 1983) polydrug use was evident in the drug using activities being reported by individuals engaged in drug misuse. Table 11.1g shows that polydrug use, utilising different definitions, can be detected in a range of studies on drug related issues in Ireland throughout the 1980s and 1990s. When lifetime usage is referred to, this means the use of more than one drug during the lifetime of an individual, however it cannot be inferred from this that more than one drug was used at the same time during lifetime usage. It must be noted that there is no evidence on patterns of polydrug use available through the literature.

Table 11.1g: Some instances of polydrug use among drug using individuals in Ireland in the 1980s and 1990s

Author	Sample Source	Data Collection	Definition of polydrug use	Evidence of polydrug use
Carr et al (1980)	Treatment Centre (n=100)	Interviews	Use of 2 or more drugs in past month excluding opiates	25% reported polydrug use in previous month
Bradshaw (1983)	Opiate Users in the community (n=82)	Interviews	Lifetime Usage	Almost 75% use heroin + other drugs
Dean et al (1984)	Opiate Users in the community (n=36)	Interviews	Drug usage in 12 months prior to interview	92% using heroin and cannabis + other drugs
Lavelle (1985)	Opiate Users in the community (n=74)	Interviews	Lifetime Usage	Almost third using heroin and other drugs
McCarthy et al (1997)	Opiate Users in the community (n=26)	Interviews	Lifetime Usage	32% report daily use of heroin and physeptone
Keogh (1997)	Garda Records (n=352)	Garda Interviews	Lifetime Usage	96% report heroin use, of this group 35% report use of methadone, 33% cannabis, 20% ecstasy and 13% cocaine
O'Mahony (1997)	Men's Prison (n=108)	Interviews	Lifetime Usage	76% report usage of drugs other than cannabis and heroin
Cassin et al (1998)	Health Promotion Unit (n=770)	Self Report Questionnaire	Drug Use in previous month	67.4% under 25s and 63.5% over 25s reported polydrug use in previous month
Coveney et al (1999)	Treatment Centre (n=16)	Interviews	Lifetime Usage	40% reported using nine drugs, 35% reported use of five drugs
Crowley (1999)	Prison Detoxification Programme (n=187)	Self Report Questionnaire	Lifetime Usage	100% heroin 98% cannabis 90% benzodiazepines 85% cocaine 60% ecstasy
Centre of Health Promotion (2000)	Irish Prisons (n=777)	Self Report Questionnaire	Drug Use in previous 3 months = Drug Use in previous 12 months	63% male and 83% female report using other drugs in addition to cannabis In addition to heroin, 47% male and 52% female used amphetamines. Usage of cocaine and LSD also reported

Gender and rural/urban differences

Gender and rural/urban differences in polydrug use among those treated for problem drug use were examined using data from the National Drug Treatment Reporting System (NTRS) for the year 1999 (last year of complete national data). A total of 6443 treatment contacts were made in 1999 of which 956 (14.8%) reported using two or more drugs, on a daily basis, in the month prior to treatment. Of these the majority were male (67.5%) and living in urban areas (88.0%). A total of 1852 first treatment contacts (i.e. clients who had never been previously treated for drug misuse) were made in 1999 of which 207 (11.2%) reported using two or more drugs, on a daily basis, in the month prior to treatment. Of these the majority were again male (76.6%) and living in urban areas (79.4%).

11.2 Health and Social Consequences

A review of the files of drug and alcohol related deaths investigated by the Dublin City coroner for the year 1998 reveals that 520 inquests were held in 1998, 108 or 20.76% were identified as having drugs or alcohol implicated in the death.²⁷ The majority was male and under 44. (Byrne 1999)

Of the 108, 28 cases, which were deemed to be primarily alcohol related, were eliminated plus a further 10 that were deemed to be suicides or possible suicides. This left a cohort of 70 that were deemed to be primarily drug related deaths and this revealed that only 7 of these deaths had a singular drug implicated in their death. One person tested positive for five separate drugs, 13 were positive for four, 25 were positive for three, and 24 people for two. Benzodiazepines were implicated in 69% of cases, methadone in 53%, heroin in 51.4% of cases and alcohol in 42.8%.

Between 1st January 1998 and the 31st of December 2000 the Dublin City and County Coroners conducted 2063 inquests into deaths due to unnatural causes within their jurisdictions. A recent study by (Byrne 2000) examined these files and identified 254 (12.3%) as being related to the use of opiates. These were extracted for the purpose of conducting further analysis. The research shows that a singular drug was implicated in only 6.7% of drug related deaths.

²⁷ A drug is deemed implicated when it has proven positive at toxicology or when evidence was presented that the drug had been consumed prior to death. This is not to infer that the drug is the cause of death, although it may have been. However, it may imply that the drug/drugs was a contributory factor in the death.

Table 11.2: Number of drugs implicated in deaths due to unnatural causes. Frequency and Percentages

Number of Drugs	Frequency	Percentage %
0	5	2.0
1	17	6.7
2	53	20.9
3	70	27.6
4	60	23.6
5	36	14.2
6	9	3.5
7	3	1.2
10	1	0.4
Total	254	100

(Source: Byrne, 2000)

Benzodiazepines were implicated in the highest number of fatalities 70.5%, with Diazepam the drug most cited (68%) in this regard. Heroin was implicated in 61.8% of fatalities and methadone was implicated in 56.7% of fatalities. There were six ecstasy-related deaths during the three-year period.

Note: A drug is deemed implicated when it has been proven positive at toxicology or when evidence was presented that the drug had been consumed prior to death. This is not to infer that the drug is the cause of death, although it may have been. It may imply that the drug/drugs was a contributory factor in the death.

11.3 Risk assessment and local market

a) Products and physical description

NO INFORMATION AVAILABLE

b) Combination of different substances on the local market

NO INFORMATION AVAILABLE

11.4 Specific approaches to the intervention

a) Approaches to polydrug use

NO INFORMATION AVAILABLE

b) Evaluation results

NO INFORMATION AVAILABLE

11.5 Methodological issues

a) Limitations in data availability

The data referred to in this chapter comes from three main sources, a literature search, an exploratory survey on polydrug use and an analysis of the data collected by the National Drug Treatment Reporting System. All three sources contain their limitations regarding the exploration of polydrug use. For instance, the literature search of Irish drug related literature revealed a gap in research on the issue of polydrug use. In essence this meant that the phenomenon of polydrug use had not been investigated in an Irish context. However, some studies picked up 'pockets' of polydrug use among drug using individuals. In most cases polydrug use in these studies referred to lifetime usage of two or more different drugs. It could be argued that this definition has severe limitations for describing or explaining polydrug use as there is often little indication of the time gap between the use of one drug and another and how often these drugs are consumed.

The main limitations of the exploratory study were a) it was confined to a small sample (n=41) and by virtue of this its findings cannot be attributed to any individual or group outside the sample. And b) the definition employed was the use of two or more drugs during the same 24-hour period, and this failed to capture whether drugs were combined concurrently or whether there was a time gap and if so how long and for what reasons?

In terms of the National Drug Treatment Reporting System (NDTRS) the main limitation in this data is that it is confined to people who report for treatment. Therefore, it's not often useful to attribute findings to the wider population. The NDTRS data does reveal some useful information on polydrug use among individuals reporting for treatment, it may be the case that this is merely a snapshot of the real extent of polydrug use among drug using individuals in Ireland.

b) Future needs/ Methodological proposal

Exploration of the polydrug using habits, social settings, influences and aspirations of recreational/problematic polydrug using groups

It would appear from the data available that at least two different categories of polydrug users are to the fore in an Irish context. These can be broadly referred to as 'recreational polydrug users' and 'problematic polydrug users', however, it must be noted that these categories are not always clearly demarcated in terms of their use and often there are overlaps between the different drugs used. For instance, some of the issues that confound the definitional boundaries are, heroin use, which is primarily referred to in 'problematic' terms, can be said to have crossed the boundary into 'recreational' use when combined with ecstasy. In addition, is it feasible to refer to drug users in treatment as 'problematic' given that their drug use is being treated?

It could be argued that a key distinguishing feature dividing both categories is the use of heroin by intravenous injecting by 'problematic polydrug users'. There does not appear to be any evidence to suggest that 'recreational polydrug users' engage in injecting behaviour. What seems to be the case in

an Irish context is that 'recreational polydrug users' in the main tend to reject the use of heroin by intravenous injecting. For example, individuals attending the Gay Men's Health Clinic whom were surveyed as part of the exploratory survey on polydrug use, all identified themselves as 'recreational polydrug users' and all expressed a clear anti-heroin mentality. This mentality appeared to be part of their individual belief system and also part of their social settings in pubs, clubs and house parties. Nevertheless, there are some 'recreational polydrug users' who may smoke heroin as part of their ecstasy use (O'Gorman 1998, Gervin, et.al 1998, Dorman and Jones 1999).

It would be useful to carry out further exploratory research into the some of the comparisons and contrasts between problematic and recreational polydrug users. Such research could go a long way to profiling both sets of polydrug users in a more refined definitional sense. In addition, some key questions that need to be addressed are;

- Why do recreational polydrug users in the main reject heroin use by intravenous injection and why do problematic polydrug users embrace this method
- What regulations govern the social settings of both groups when it come to polydrug use and what is the social origins of these regulations
- What are the primary expectations underpinning each groups polydrug use, for example, do recreational polydrug users aspire to liberation and sexual freedom and do problematic polydrug users seek to enhance their coping mechanisms by the use of narcotics
- What are the socio-economic aspirations of each group and to what extent does their polydrug use and the culture surrounding same manage to satisfy or defer these aspirations
- What are the economic incentives for both groups to engage in different forms of polydrug use

Knowledge of the Health risks of polydrug use among recreational/problematic groups

There can also be a misconception that recreational polydrug users are better equipped to handle their drug use. For example, there may be a perception that the 'recreational' category is more responsible and better informed and aware of the risks involved in their polydrug use. Whereas, those in the 'problematic category' can be viewed as ignorant, irresponsible and requiring more intense intervention. However, when it comes to polydrug use so little is known about the health risks and psychological effects of combining different drugs that it is implausible to suggest that one group has a monopoly on information.

In this regard it would be useful to carry out a comparative study between both groups to ascertain the level of awareness and information on the effects and health of engaging in polydrug use. To put this research gap in perspective a comparison of two recent studies into cocaine use highlights the potential misconception of health risks among recreational drug users.

(Mayock 2001) reported that the recreational drug users whom she interviewed described how

“ Their cocaine use was strongly linked with alcohol consumption. [with emphasis on] the compatibility of alcohol and cocaine...” p, 124

Furthermore, the respondents did not appear to have any reservations about mixing cocaine and alcohol and also reported combining cannabis and ecstasy on occasions. However, according to Andrews (1997) there are acute health risks associated with the combination of cocaine and alcohol.

“Use of cocaine and alcohol at the same time the effects are experienced together results in another psychoactive substance being made in the body. ‘Cocaethylene’ ...is associated with seizures, liver damage and compromised functioning of the immune system. It has also been argued to have an 18-25 fold increase over cocaine alone in risk of immediate death”.

Survey into the polydrug using habits of young clubbers under 18

A survey needs to be carried out on young people under the age of 18 attending clubs/discos to ascertain what the polydrug using habits of young people are. A survey such as this would go some way to capturing information on people not attending treatment or needle exchanges and not in regular contact with hospitals. The survey could be carried out using a short questionnaire containing closed text questions. The location for the survey could be inside the entrance of clubs/discos with some incentive being offered for participating in the survey.

Data collection on polydrug using habits of sections of the drug using population

It would be useful if the current Eastern Regional Health Authority (ERHA) needle exchange programmes included a section in their data collection system for the purpose of recording polydrug use among clients. This could be done in a similar way to the National Drug Treatment Reporting System (NDTRS) where primary and secondary drug use on a daily/weekly/monthly basis during the last month is recorded. It may be useful for the needle exchange to record information for the previous 24/48/72 hour's period prior to attending the needle exchange. In addition the Hospital In-Patient Enquiry System (HIPE) could include a similar method for capturing information on polydrug use among individuals reporting for treatment (not drug related) in general hospitals.

12. Successful Treatment: The effectiveness of the interventions – Lucy Dillon

Defining what constitutes ‘drug treatment’ can prove problematic. For the purpose of data collection for this section the definition of treatment used in the National Drug Treatment Reporting System [NDTRS]²⁸ has been adopted. As defined in the NDTRS, treatment is:

“any activity which is targeted at people who have problems with their drug use, and which aims to ameliorate the psychological, medical or social state of individuals who seek help for their drug problems. The activity will often take place at specialised centres for drug users, but may also take place in general services offering medical/ psychological help to people with drug problems.

Treatment is broadly defined and includes:

- Interventions aimed at reducing drug-related harm amongst active users, as well as those whose primary goal is detoxification and abstinence
- Non-medical as well as medical interventions
- Short-term crisis interventions, counselling or support, as well as more structured longer-term programmes.

However treatment excludes:

- Contacts with services which involve requests for social assistance only
- Contacts where drug use is not the reason for seeking help
- Imprisonment per se (although admissions to drug treatment programmes in prison or to treatment as an alternative to prison are included)
- Interventions solely concerned with the physical complications of drug misuse (e.g. overdoses or infections treated at hospital)
- Contacts by telephone or letter only
- Requests for practical information only
- Contact with family only”

(National Drug Treatment Reporting System 2001).

12.1 The approaches to treatments and the related concepts of success

a) The concept and criteria for success considering: Intervention approaches, target groups, drugs used

Underlying Approach to Treatment

In the absence of an agreed definition of ‘successful treatment’ in the Irish service context, this section will describe the approach underlying treatment provision in Ireland and the implications of this for defining the ‘success’ of the various programmes. Prior to the early 1990s, drug treatment services in Ireland were based on a centralised-specialist model, with abstinence considered to be the only acceptable aim of treatment programmes (Butler 1991). However, as happened elsewhere in Europe, the advent of HIV/AIDS in Ireland in the early 1990s, and its connection with injecting drug use, signaled a change in the structure and focus of treatment services. In addition, there was public pressure on the government to address the drugs issue because of a perceived escalation of drug-related crime. The 1991

²⁸ The NDTRS is a national database of all those receiving treatment for illicit drug use in Ireland- the database is held in the Drug Misuse Research Division of the Health Research Board.

Government Strategy to Prevent Drug Misuse reflected the central role that the advent of HIV, and its prevalence among injecting drug users, had in the development of government policy in relation to drug treatment services.

“Insofar as HIV infection is concerned, of the 1049 cases identified, 582 (or 57%) are drug misuse related..... It is clear from the foregoing that the prevention of transmission of HIV virus in this country must include strategies developed to deal with the drug misuse problem.” (Department of Health 1991, p.17)

The report called for a heavier focus on a “multiplicity” of treatments in order to ensure services were appropriate to the individual user’s needs. A two-pronged service programme aimed at both harm minimisation and abstinence was identified as the ideal. This called for changes in treatment programmes both in terms of the services they provided, and the manner in which they were delivered.

“These strategies must be community-based, client orientated and, given the serious nature of the problem, of necessity, innovative. They must include emphasis on outreach programmes involving counselling, methadone maintenance and needle exchange. Advice on risk reduction services generally must form an essential part of any such strategies to minimise the spread of the disease.” (Department of Health 1991, p.17)

In addition to abstinence based programme, services were to include treatment modalities based on an ethos of harm minimisation. Furthermore, treatment was to be provided on a more decentralised, community-based model.

A ‘Ministerial Task Force to Reduce the Demands for Drugs’ was established that subsequently produced two reports (Ministerial Task Force on Measures to Reduce the Demand for Drugs 1996 & 1997). Both dealt with treatment and, in particular, the development of the community-based model. The first report highlighted methadone maintenance services as having a “crucial role in stabilising injecting addicts, whose behaviour threatens families and whole communities” (Ministerial Task Force on Measures to Reduce the Demand for Drugs 1996, p.41). The second report saw the Task Force as having developed “a strong philosophy of harm reduction and treatment of the consequences of drug abuse-stabilisation, methadone maintenance, detoxification, rehabilitation and re-integration” (Ministerial Task Force on Measures to Reduce the Demand for Drugs 1997, p.7). Despite this emphasis on harm reduction, the report reiterated that the ultimate aim of all treatment programmes, including substitution programmes, was abstinence.

More recently the National Drugs Strategy 2001-2008 has highlighted the two-pronged approach to the provision of drug treatment services in Ireland. Treatment forms one of the four pillars (supply reduction, prevention, treatment and research) of the government’s drugs strategy- the objectives of which are:

- “To encourage and enable those dependent on drugs to avail of treatment with the aim of reducing dependency and improving overall health and social well-being, with the ultimate aim of leading a drug-free lifestyle; and
- To minimise the harm to those who continue to engage in drug-taking activities that put them at risk.”

(Department of Tourism, Sport and Recreation 2001, p.6)

Target Groups and Drugs Used

A range of treatment services has developed to meet the needs of drug users in Ireland and a variety of treatment modalities constitute Irish drug treatment service provision. These include substitution services, counselling, and therapeutic communities. The types of treatment services available to drug users in Ireland are categorised in the NDTRS under the following headings according to the treatment centre type:

“Specialised Residential

Hospital inpatient unit
Therapeutic community
Other specialised residential treatment

Specialised Non-Residential

Hospital outpatient treatment centre
Day centre/day hospital
Local health care/ social service centre
Low threshold/drop-in/street agency/mobile clinic
Other specialised non-residential

Based in general services

Inpatient psychiatric hospital/unit
Outpatient mental health care centre
General Practitioner
Residential social care facility
Non-residential social care facility
Other non-specialised non-residential
Primary care”

(NDTRS, 2001)

It is important to note that there are distinct geographical variations in the nature of drug use in Ireland, reflected in the profile of those attending treatment for their drug misuse. This also means that there are geographical variations in the treatment services available. As can be seen from Table 12.1a the vast majority of those reported to be receiving treatment were resident in what was called the Eastern Health Board²⁹ (EHB) area in 1998, incorporating counties Dublin, Kildare and Wicklow. Furthermore, there is significant variation in the profile of those receiving treatment depending on geographic location (see Table 12.1b). The variation is particularly acute between the EHB and the rest of the country- opiate use being based predominantly in the EHB.

²⁹ Now the Eastern Regional Health Authority (ERHA).

Table 12.1a Clients (by residence) receiving treatment for drug misuse by Health Board Area in 1998

Residence	Number	%
Eastern Health Board	5,076	85%
Southern Health Board	303	5.1%
North Western Health Board	48	0.8%
Midland Health Board	96	1.6%
Western Health Board	14	0.2%
Mid Western Health Board	96	1.6%
North Eastern Health Board	128	2.1%
South Eastern Health Board	201	3.4%
Total (includes residence not known)	6,043	100%

Source: National Drug Treatment reporting System

Table 12.1b Treatment by main drug of misuse in Regional Health Boards areas in 1998

Area	Total No.	Heroin		Cannabis		Ecstasy		Cocaine		LSD		Other	
National	6,043	4,297	71.1	642	10.6	196	3.3	88	1.5	14	0.2	806	13.3
EHB	5,076	4,121	81	211	4.2	45	0.9	58	1.1	4	0.1	637	12.7
SHB	303	14	4.6	120	39.6	89	29.4	12	4	4	1.3	64	21.1
NWHB	48	10	20.8	21	43.8	10	20.8	0	0	1	2.1	6	12.5
MHB	96	23	24	51	53.1	5	5.2	0	0	2	2.1	15	15.6
WHB	14	6	42.9	2	14.3	1	7.1	1	7.1	0	0	4	28.6
MWHB	96	7	7.3	57	59.4	11	11.5	3	3.1	1	1.0	17	17.7
NEHB	128	32	25	52	40.6	15	11.7	2	1.6	2	1.6	26	19.5
SEHB	201	22	10.9	119	59.2	19	9.5	9	4.5	0	0	32	15.9

Source: National Drug Treatment reporting System

Attempts have been made to meet the needs of all those requiring treatment for their drug use. However, the needs of two specific target groups have been highlighted in particular within the Irish context- young drug users and prisoners. The age profile of Irish drug users presenting for treatment has received some attention. Data on clients presenting for treatment for the first time in the period in 1995-1999 show that over 70% of those presenting for treatment for the first time were under the age of 25. This is younger than in other EU countries and reflects the demographic situation of Ireland, where the median age of the Irish population is much younger than the EU average- 48% of the Irish population is under 30, whereas the median age in other EU countries is between 35 and 40 years (Moran et al. 2001). The relatively young age at which Irish drug users present for treatment has meant the identification of young drug users as a specific target group for treatment. A number of programmes have been established specifically for younger users and the development of a specific protocol for their care within established programmes is to be undertaken (National Drugs Strategy 2001-2008).

The provision of treatment services for prisoners in Ireland is particularly complex. While the care of drug users in the community falls under the remit of the Department of Health and Children, that of prisoners is the responsibility of the Department of Justice, Equality and Law Reform. Unlike in the community where there is a focus on harm reduction in the treatment services through the provision of treatment services such as substitution and needle exchanges- harm reduction programmes are confined to restricted substitution services and there is no provision of access to clean injecting

equipment of cleaning materials³⁰. Recently, efforts have been made to improve treatment provision for Irish inmates through increased co-operation between the Health Boards and the prisons. Within the context of 'successful' treatment the National Drugs Strategy, 2001-2008 has called for an independent evaluation to be carried out of the overall effectiveness of the Prison Strategy by mid 2004- including a focus on treatment services- although it is not clear what will be considered an appropriate definition of 'success'.

A number of other specific groups considered to be 'at risk' and in need of specially targeted services have been identified, these include: the homeless population, members of the travelling community and persons involved in prostitution (National Drugs Strategy, 2001-2008). As with other treatment programmes in Ireland, none of the programmes developed for these groups have been evaluated for 'successful treatment'.

In conclusion, Irish drug treatment services have evolved in response to the developing drug problem in Ireland. They have progressed from being based on a principal of abstinence as the only acceptable outcome of treatment, to considering the reduction of drug-related harm as a crucial aim of treatment provision. However, while the provision of services has progressed this has not accompanied by the development of either concepts or measures of 'successful treatment'.

b) Political and professional choices and principles behind the approaches

As discussed above, while the objectives of the government policy on drug treatment have been laid out (Department of Tourism, Sport and Recreation 2001), measures of success for the services have yet to be defined on both a political and professional level. However, it would appear that the two-pronged approach taken to treatment (i.e. a joint focus on harm reduction and abstinence) in the government's policy would encompass the principles guiding individual treatment services if used as the basis for developing a definition of 'successful treatment'.

Consistency, or lack thereof, between the political strategy and professional choices in terms of definitions of successful treatment in Ireland should become more apparent in the context of a major piece of research on treatment outcomes currently being commissioned by the National Advisory Committee on Drugs³¹ (NACD). The National Drugs Strategy 2001-2008 recommended that the NACD should commission outcome studies to establish the impact of methadone programmes on individual client's health and offending behaviour. Furthermore, the remit of the NACD includes that they look at how best to determine the effectiveness of existing models and programmes in the area of drug treatment. A call has been made by the

³⁰ For a full discussion on the situation in Irish prisons see section 13 of this report.

³¹ The National Advisory Committee on Drugs (NACD) was established in July 2000 to advise the government in relation to prevalence, prevention, treatment/rehabilitation and consequences of problem drug use in Ireland, based on analysis of research findings and information available to it.

NACD for proposals to carry out a national longitudinal study (to be carried out over a period of 3 years) that would evaluate the effectiveness of treatment and other intervention strategies used in the care of adult (i.e. over 18 years) opiate users. Substitution programmes form the basis of treatment provision for opiate users in Ireland. In August 2001 there were 5,605 people registered as receiving methadone in Ireland (Central Methadone Treatment List, personal contact). It is expected that the methods used will be similar to those of the National Treatment Outcomes Research Study (NTORS) in the UK. This piece of research should go some way to filling the gap in information on 'successful treatment' in the Irish context and also open up the debate on what constitutes 'success' in the treatment of drug use.

12.2 Evaluation of the treatments

a) Research findings and used methodologies

As mentioned above, the number of Irish treatment programmes to examine their success is extremely limited. To date, no success criteria have been defined on a national basis, nor have any national level evaluations been carried out that allow for comparisons between either individual programmes or different treatment modalities. However, there have been a number of small-scale studies that have aimed to ascertain the 'success' of particular programmes. These will be described in the following sections.

Substitution programmes:

While substitution programmes (i.e. methadone programmes) form the basis of drug treatment services for opiate users in Ireland, no formal evaluations have been carried out of the service. In their review of drug services in the then Eastern Health Board region, Farrell *et al.* (2000) reported that within 5 treatment clinics the results of urinalysis, carried out as a routine part of the treatment programme, showed a 70% reduction in heroin consumption among clients once on the programme. While this finding may indicate that the programmes are 'successful' in reducing clients' intake of street opiates, data are not collected as a formal measure of 'success' and other outcomes were not measured.

'Drug Detoxification and Rehabilitation Programme' in Mountjoy Prison, Dublin:

Treatment services within Irish prisons have tended to be very limited, although they are currently under expansion. Other than limited substitution prescribing the Drug Detoxification and Rehabilitation Programme provided in Mountjoy Prison Dublin has been the only dedicated drug treatment programme available to prisoners. Crowley (1999) provided a medical review of the seven-week programme. Up to February 1999, 187 prisoners had entered the programme, 173 completed the detoxification and 14 failed to complete the detox. While this implies a 93% 'success' rate (i.e. where success is taken to be abstinence), Crowley (1999) highlights the need for the success of this intervention to be determined by the 6 and 12 month relapse figures. Overall it was found that there was a twelve-month relapse rate of 78%. Crowley argues that while this may appear high, it compares favourably

to outcome rates of other inpatient detoxification programmes, although these are not presented.

In-patient detoxification unit:

An audit was carried out between July 1995 and July 1996 of the performance of the in-patient detoxification unit at Cuan Dara (Smyth and Lane 1997). The programme consists of a detoxification with methadone over approximately 10-12 days and intensive counselling and rehabilitation for an additional 4 weeks. 'Success' of the unit was explored by looking at (i) the proportion of patients completing methadone detoxification, (ii) the proportion completing the full six-week inpatient programme and (iii) the proportion of patients remaining drug free after discharge.

Data were collected on all clients admitted to the programme between July 4th 1995 and 30th June 1996. One hundred and five admissions were included in the data analysis. Details on demographics and drug using history were collected from patient notes and/or referral forms. Attempts were made to contact clients who had been discharged for more than two weeks, to collect data on the outcome variables (i-iii above) on three occasions during the year (Dec 1st 1995, Mar 1st 1996 & Aug 1st 1996). Three sub-groups were formed depending on clients' date of discharge.

Twenty-nine per cent of patients (n=30) left hospital on or prior to day fourteen of the programme, i.e. before detoxification was complete. In terms of status on follow-up (average time gap over 10 weeks): 18% drug free, 5% undergoing another methadone detoxification, 12% on methadone maintenance, 33% had relapsed, 3% were in prison and contact could not be made with 29%. Therefore, of those for whom data were available, 26% were drug free and 49% had relapsed. The authors conclude that "the success rates from the point of view of detox completion and program completion approximate to those reported in similar centres around the world" (Smyth and Lane 1997, p. 11).

Harm minimisation strategies:

As discussed above, harm minimisation programmes constitute one of the two prongs of drug treatment in Ireland. A number of harm reduction strategies have been developed which specifically aim to prevent the spread of HIV and other drug-related infectious diseases among injecting drug users in Ireland. However, the impact of these programmes on infection rates among injecting drug users is unclear. A number of research papers have explored the 'success' of these programmes according to certain criteria. Smyth et al. (1999a) attempted to explore the impact these programmes had on the spread of hepatitis C by carrying out tests for hepatitis C among a cohort of drug users. The cohort included those who had begun their injecting drug use both before and after the expansion of harm reduction programmes in Ireland. Data were collected on the results of HCV tests as recorded in clients' medical files in one treatment centre, categorising them according to the date when they initiated injecting drug use. Smyth et al. (1999a) argue that the findings suggest that those injecting drug users who began their injecting drug use after the introduction of harm reduction strategies (post 1993),

demonstrated a reduced risk of HCV infection. However, they emphasise that it was not possible to control for other factors that may explain the decline in the HCV infection rate, such as a possible reduction in overall injecting frequency among more recent injectors.

Smyth et al. (1999b) also carried out a study of knowledge regarding hepatitis C among a sample of injecting drug users (n=84) in a treatment setting in Dublin. Included in the sample were individuals who were on a methadone maintenance programme and those who were on a short-term detoxification programme. The study aimed to explore the 'success' of the programme by assessing clients' understanding of hepatitis C and the associated risks. Data were gathered by a researcher, who was independent of treatment services, through a structured interview with clients. The authors developed a series of questions and scoring system designed to assess clients' knowledge regarding hepatitis C. Smyth et al.'s basic hypothesis was that those injecting drug users with increased contact with medical services would demonstrate better understanding of hepatitis C and associated risk behaviours, i.e. a 'dose-response' type effect. The hypothesis was not confirmed. Seventy-three of the sample recognised the four main infection routes, i.e. injecting drug use, sex, transfusion and vertical. However, only 44% recognised activities with no recognised risk, i.e. injecting without sharing, smoking heroin and kissing. Smyth et al. (1999b) expressed concern about the finding that substantial minorities believe that there is a risk of exposure even when not sharing injecting paraphernalia. They argued that perceived personal vulnerability to infections such as hepatitis C is likely to be a factor in leading individuals to avoid practising unsafe injecting behaviour. Where this vulnerability is diminished by false beliefs about already having been exposed to infection when actually engaging in 'safe' practices, then the preparedness to share injecting equipment may well increase.

Local Evaluations

Evaluations of specific programmes in Ireland have tended to focus on process evaluation rather than evaluations based on defined success criteria. However, a small number of programmes have also explored changes in clients' behaviour and circumstances since starting on the programme- these will be explored in this section. Evaluations of the largest needle-exchange programme in Ireland and two community-based initiatives that aim to address the needs of drug users within their local communities will be discussed. Methadone prescribing is provided as part of the treatment service offered within the two latter programmes. Each programme has been evaluated and certain success criteria measured. None of the evaluations identified a specific definition of 'successful treatment', rather they tended to look at a variety of aspects when considering the impact of participation on the programme on the individual client. Furthermore, they are evaluations of individual programmes rather than a treatment modality *per se*. Aspects considered, included a reduction in illicit drug use, changes in criminal behaviour and general physical and social well-being. Each evaluation will be considered individually.

Merchant's Quay Health Promotion Unit: Merchant's Quay provides the biggest needle-exchange service in Ireland. The syringe exchange programme is located within the agency's Health Promotion Unit which "provides a model for working with people who engage in both injecting and sexual risk behaviour. This model concentrates on reducing or eliminating these risks in so far as is possible" (Cox and Lawless 2000, p. vii). Five specific aims of the Unit were identified:

- To enable clients to gain access to sterile injecting equipment and condoms;
- To reduce the risk of contracting HIV, hepatitis B and C and other STDs;
- To increase knowledge of safer injecting and sexual practices;
- To improve health care and;
- To evaluate changes and trends in drug use.

(Cox and Lawless 2000, p. 4)

While the provision of clean syringes is the central activity of this service, the unit also provides harm reduction orientated information and education for drug users. An evaluation of the service was carried out between 1997 and 1998 (Cox and Lawless, 2000). Self-report data were collected on the following outcome domains: drug use, injecting risk behaviour, sexual risk behaviour, contact with services and health and well-being. Data were gathered during clients' first visit and then at a three-month follow up visit.

The evaluation found the Health Promotion Unit to be effective in meeting its aims on a number of levels. Specific findings included:

- An 11% reduction in IV drug use among those who reported doing so at first visit (n=341).
- Sixty-seven per cent of respondents who reported injecting in excess of 4 times a day (n=104) reported less frequent IV use at their three month follow-up visit.
- Fifteen per cent (n=56) of clients reported lending their used injecting equipment at first visit compared with only 9% (n=33) of clients at follow-up.
- Twenty three per cent (n=85) of first visit clients reported borrowing injecting equipment compared with 15% of follow-up clients (n=55).
- At follow-up there was a 44% increase in the number of clients who reported cleaning their injecting site before administration.

Jobstown Assisting Drug Dependency (JADD): The objective of the programme is stated to be "to provide realistic care and support for persons with an established opiate addiction resident in the Jobstown electoral district" (Bourke, unknown, p. 1). The main services offered by JADD are methadone maintenance and a gradual detoxification programme. The evaluation of the programme was carried out a year after the programme started. At the time the evaluation was carried out 28 people had approached the programme, 26 of whom had started treatment. The evaluation focused on a process evaluation but it was found that the programme was 'successful' in effecting change under a number of criteria. In summary it was found that after a period of time on the programme employment rates increased, involvement in criminal behaviour was reduced and there was a significant reduction in the intake of illicit drugs.

Addiction Response Crumlin (ARC): The evaluation of ARC included a more detailed assessment of the impact of participation on ARC on its clients than the previous evaluation discussed. A survey was carried out in October 1998 of 91 out of a total caseload of 100 clients who used ARC in December 1997 (McKeown and Fitzgerald 1999). Once on the programme, all of the clients had been prescribed methadone and had access to further rehabilitative services including counselling, a drop in service and various forms of group work. The following are some of the measures of success that were found in the evaluation:

- At the time of interview, approximately 73% of clients were still receiving methadone and 27% were drug-free.
- Significant improvements in clients' self-assessed state of health were reported. In total, 86% of clients reported that their health had improved since starting on the programme.
- Eighty-nine per cent of respondents reported an improvement in their quality of life since starting on the programme. They also reported improvements in the quality of their relationships with various significant others including their mothers (76%), fathers (59%), children (73%) and partners (69%).
- Sixty-nine per cent of clients were unemployed when they first began on the programme, this fell to 44% at the time of the evaluation.
- Prior to starting on the programme, 68% of the sample admitted to being involved in theft to finance their drug use and 66% that they had been 'in trouble with the law' before starting on the programme. Since starting on the programme only 23% reported being involved in criminal activity.

In conclusion, while the number of Irish treatment programmes that have undergone evaluation remain limited, there appears to be a focus on similar outcomes of success i.e. reduced illicit drug use, reduced criminal behaviour etc. However, these evaluations highlight the need for 'successful treatment' to be properly defined and the concepts to be discussed in order that outcomes can be measured effectively.

b) Comparison between treatments and related approaches

Due to the lack of evaluations carried out in the Irish context and the absence of a definition of 'successful treatment', there is currently no information available that would allow for comparisons to be made between treatments and related approaches.

12.3 Methodological issues

a) Limitations in data availability

Irish data on 'successful treatment' remain extremely limited. The gaps in data are apparent on an individual programme basis, across treatment modalities and across the Irish treatment service programme as a whole.

b) Future needs

Extensive work needs to be carried out in the area of exploring 'successful treatment' in Ireland. It is important that a definition of 'successful treatment' be developed that could be adapted to the objective of particular programmes and/or treatment modalities, i.e. harm reduction or abstinence. It is important that a definition of 'successful treatment' incorporates the interests of all stakeholders (i.e. policy makers, service providers and service users). On the basis of a suitable definition of 'success' outcome variables may then be established that can be used to measure the 'success' of particular treatment programmes and/or modalities.

c) Methodological proposal

As mentioned above (12.3 (b)) there is a need for a definition of what constitutes 'successful treatment' in the Irish context to be established. It is proposed that initial research in this area should include an exploration of the views of all the stakeholders in drug treatment services (policy makers, service providers and service users) to establish their perceptions of success. Once established it would then be necessary to develop measures that would reflect the definition of success that could be used in longitudinal analysis of 'successful treatment' in the Irish context.

12. Annex

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13. Drug Users in Prison – Lucy Dillon

Introduction

This paper aims to provide an overview of the issues related to drug use among prisoners in Ireland. A number of sources have been used to access the relevant information, and an attempt made to draw together these disparate sources of information in as comprehensive a manner as possible. In accordance with the EMCDDA guidelines, the main areas covered in this paper are:

- 13.1 Epidemiological situation
- 13.2 Availability and supply
- 13.3 Contextual information
- 13.5 Demand reduction policy in prison
- 13.6 Evaluation of drug users treatments in prison
- 13.7 Methodological issues

13.1 Epidemiological Situation

a) Drug use before and within prison

Ireland has a daily prison population of approximately 3,000, located in sixteen prisons (www.irishprisons.ie). It has been found that within the Irish prison population a significant proportion of these individuals have a history of illicit drug use (Allwright *et al.* 1999; Long *et al.* 2000; Hannon *et al.* 2000). However, studies carried out have tended to look at prison populations as a whole, rather than the experiences of specific groups such as ethnic minorities or juvenile offenders. This section will explore the data available on the prevalence of drug use among prisoners, noting the experiences of specific groups where available.

Prevalence of prisoners with a history of drug use

In estimating the prevalence of drug use among Irish prisoners it has been argued that an analysis of drug-related convictions and committals largely underestimates the extent of the problem (O'Mahony 1997a). Research has shown that when comparing the number of Irish prisoners reporting a history of drug use with the number imprisoned because of a drug-related crime, the former significantly outnumbers the latter (O'Mahony and Gilmore 1983; Carmody and McEvoy 1996; O'Mahony 1997b).

National: In their study Allwright *et al.* (1999) found that 52% of a national sample of prisoners (n=1,205) reported a history of opiate use, and 43% reported a history of injecting drug use. In what were designated 'medium-risk' prisons the rate of 'ever injected' was 21%, compared to 58% in the 'high-risk' prisons.³² A subsequent study that used the same methodology (Long *et al.*

³² Prisons in the study (Allwright *et al.*, 1999) were categorised as high, medium or low risk according to expected prevalence rates for infection with drug related infectious diseases (hepatitis B, C and HIV), this was mainly based on estimates of the proportion of injecting drug users within each prison's population.

2000) found that 35% of a sample of committal prisoners (n=607) had a history of opiate use and 29% reported a history of injecting drug use.

Local- Mountjoy Prison, Dublin: Drug use has been identified as an issue of concern among populations in various prisons around the country- particularly those based in the Dublin area. Other research carried out in the Irish prison context has been limited to Mountjoy Prison in Dublin, which cannot be considered representative of the overall prison population in relation to drug use. At the time the research below (see Table 13.1) was carried out Mountjoy was the main committal prison in the country. It had an average population of 650 prisoners on any one-day, approximately a quarter of the total Irish prison population. Owing to the concentration of Ireland's problematic drug use in the Dublin area (O'Brien *et al.* 2000), and estimates that approximately 66% of indictable crimes in the Dublin metropolitan area were attributable to 'known hard drug users' (Keogh 1997), Mountjoy was likely to have a higher proportion of drug users in its population than other prisons.

Gender: Hannon *et al.* (2000) explored the drug-using history of a sample of prisoners (n=777)- reporting results separately for male and female respondents. They found that 68% of the sample of female prisoners (n=59) reported using heroin in the last twelve months, compared to 38% of male prisoners. Overall, 72% of male prisoners and 83% of female prisoners reported some lifetime drug use. Sixty-three per cent of the male sample and 83% of the female sample had used drugs other than cannabis. Allwright *et al.* (1999) found a less distinct gender difference. They found that approximately 60% of the female prisoners in the sample (n=57) and 45% of the male sample (n=1,130) had smoked heroin in the last year. Only approximately 3% of the Irish prison population are female (ww.irishprisons.ie), but these findings suggest that drug use may be particularly acute among this portion of the prison population.

While the data collected through the available research are not directly comparable, owing to variations in methodology, they give a clear picture of illicit drug use as prevalent among Irish prisoners (see Table 13.1a).

Table 13.1a: Summary of Irish Research Findings on Prisoners with a History of Illicit Drug Use

Sample Location	Authors (Publication Date)	Year of Fieldwork	Sample Size (n)	Ever Used Opiates (%)
Mountjoy: Male Section	O'Mahony & Gilmore (1983)	1981	22*	73
	O'Mahony (1993)	1986	95	32
	O'Mahony (1997)	1996	108	66
Mountjoy: Female Section	Monaghan (unpublished)	1989	34	31
	Carmody & McEvoy (1996)	1994	100	57
National Surveys	Allwright <i>et al.</i> (1999)	1998	1,205	52
	Male	1998	1130	45*
	Female	1998	57	59*
	Long <i>et al.</i> (2000)	1999	607 ^a	35
	Hannon <i>et al.</i> (2000)	2000	777	32*
Male		718	38*	
Female		59	68*	

- Sample made up solely of prisoners who described themselves as 'drug abusers'.
- 8 Sample made up solely of committal prisoners.
- 9 Used heroin in last twelve months.

Drug use within the environment of Irish prisons

Studies have shown that a significant proportion of Irish prisoners have a history of drug use (see Table 13.1a). However, most of these studies have not considered the extent and nature of drug use engaged in by these prisoners *while* incarcerated. Four studies have looked at the extent to which prisoners use drugs while incarcerated and the risk behaviours in which they engage; two studies were carried out on a national basis (Allwright *et al.* 1999; Long *et al.* 2000) and two in Mountjoy Prison, Dublin (O'Mahony 1997b; Dillon 2001).

Imprisonment has been found to impact on an individual's pattern of drug use. Both O'Mahony (1997b) and Dillon (2001) found that prisoners continue to use drugs while in the prison environment. O'Mahony (1997b) found that 42% (n=45) of a sample of 108 prisoners had used heroin while in prison serving their current sentence. This was 63% of those who had ever used heroin. Dillon (2001) reported that of a sample of 29 respondents selected through network sampling, 24 had a history of illicit drug use, all had used drugs at some stage while in prison and 17 reported that they were using drugs in the prison at the time of interview. However, both studies found that respondents reduced the quantity of drugs they used once imprisoned and the frequency with which they used them. Based on the qualitative data gathered in both studies a lack of access to drugs appeared to be the main reason for the lower frequency of use.

On a national basis Allwright *et al.* (1999) found that 45% of the 334 respondents who reported a history of injecting drug use and had been in prison for longer than three months, stated that they had injected drugs in the month prior to interview.

Another issue addressed in these studies was initiation into drug use while in prison. Initiation into first ever use of an illicit drug in the prison was found to be very rare, slightly less rare was initiation into the use of 'new' drugs. Six prisoners in O'Mahony's (1997b) sample (n=108) reported that their first-ever experience of heroin had been in prison. Dillon (2001) also found evidence that a small number of prisoners are initiated into heroin use while in prison.

It would appear, therefore, that entering prison in Ireland does not necessarily mean a cessation of drug use.

Injecting Drug Use and Risk Behaviours

Studies have found that Irish prisoners engage in injecting drug use while incarcerated and that they tend to share injecting equipment (O'Mahony 1997b; Allwright *et al.* 1999; Long *et al.* 2000; Dillon 2001). Research has highlighted two main issues- initiation into injecting drug use while in prison and sharing injecting equipment while in prison. Furthermore, qualitative work has explored people's motivations for engaging in these behaviours.

A study carried out by Allwright *et al.* (1999) focused on the risk behaviours engaged in by prisoners in relation to the spread of hepatitis B, hepatitis C and HIV. One-fifth (104/506) of those reporting a history of injecting drug use said they had first begun injecting drugs while in prison. In considering the risk behaviours engaged in by these prisoners, it was found that injecting drug users were more likely to share injecting equipment while in prison than when they were in the community. Fifty-eight per cent of injecting drug users said they had shared all injecting equipment (needles, syringes, filters, spoons) while in prison, compared to 37% who reported sharing in the month prior to being incarcerated.

Qualitative evidence offers an insight into the motivations behind these practices. Dillon (2001) found that injecting was the dominant route of heroin administration among a sample of prisoners based in Mountjoy Prison, Dublin. Relatively small quantities of the drug were available within the prison setting and prisoners reported a culture in which the drug needed to be used in what was perceived to be the most 'economical' way possible- this meant using the smallest amount of heroin to the largest effect for the most people. In this context, respondents reported that smoking heroin was perceived to be wasteful, whereas injecting was seen as an 'efficient' use of heroin. However, it was also reported that injecting drug use within the prison was synonymous with the sharing of injecting equipment. All of those who had injected heroin within the prison setting had shared injecting equipment.

From these studies it is clear that prisoners continue to use drugs while in prison in Ireland. It appears that the quantity of drugs used and the frequency with which they use them is greatly reduced, when compared to drug using behaviour while in the community. However, the evidence also suggests that an injecting culture exists within at least one Irish prison (Dillon 2001). Prisoners appear to adapt their drug-using behaviour to suit their environment- in the absence of access to clean injecting equipment and the small quantity of drugs available to them prisoners engage in risky injecting

practices. This raises issues of particular concern for public health in relation to the spread of drug-related infectious diseases (HIV, hepatitis B and C). However, it has also been noted (Dillon 2001) that the reduction in the quantity and frequency of use suggests that imprisonment may provide an important opportunity for prisoners to address their drug use and that there is a need for the appropriate services to be developed to capitalise on this opportunity.

b) Health status in prison, social and legal consequences among drug users in prison

This section will explore the consequences of drug use in prison for inmates in two areas: the health-related consequences and legal consequences.

Health-related consequences

Three aspects of the health-related consequences of drug use among prisoners will be considered: drug-related infectious diseases, mortality and morbidity.

Drug-related infectious diseases: Prevalence of HIV, hepatitis B and C

In a context where drug-related infectious diseases have been found to be prevalent among injecting drug users in the community³³, a number of studies have explored the prevalence of these diseases within cohorts of the prison population.

Two national studies (Allwright *et al.* 1999; Long *et al.* 2000) have been carried out on drug-related infectious diseases among prisoners. Both studies found that the needle-sharing practices engaged in by prisoners appeared to have serious implications for their health status. In Allwright *et al.*'s study, of those who had shared equipment inside the prison, 89.1% had tested positive for hepatitis C, compared to 62.2% of those who had not shared injecting equipment while in prison. While Long *et al.* (2000) found that a smaller proportion of committal prisoners had a history of drug use, they found similar risk behaviours occurring and similarly high rates of infection, particularly of hepatitis C (see Table 13.1b).

Table 13.1b Number and percentage of injectors testing positive for HIV, hepatitis B and hepatitis C.

Study	Injectors in sample (n)	% of injectors tested positive for HIV	% of injectors tested positive for hepatitis B	% of injectors tested positive for hepatitis C
Allwright <i>et al.</i> 1999	509	3.5	18.5	81.3
Long <i>et al.</i> 2000	173	5.8	17.9	71.7

Smaller scale qualitative studies have found evidence that even where prisoners were aware that they were infected with a drug-related infectious disease, some continued to engage in needle sharing practices while in the prison (Dillon 2001; O'Mahony 1997b). Unlike in the community, Irish prisoners do not have access to clean injecting equipment through structured

³³ See Dillon & O'Brien (2001) for an overview of the data available on drug-related infectious diseases among Irish injecting drug users.

programmes. This contributes to an environment in which injectors are at risk of contracting drug-related infectious diseases.

Mortality

The number of deaths recorded in prisons in Ireland is shown in Table 13.1c below. Between 1990 and 1997 17% of the deaths that occurred in custody were due to natural causes; 27% due to overdose or the prisoner choking on his/her own vomit; and, 56% due to hanging. The number of prisoners dying of natural causes has increased in recent years, this is in part attributed to an increase in the number of older people being committed to prison (particularly for sex offences) (National Steering Group on Deaths in Prisons 1999). It is not clear how many deaths were directly related to drug use. However, between 1991 and 1997 at least one death a year was attributed to overdose.

Table 13.1c Number of deaths in Irish Prisons. 1990-2000.

Year	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00
Deaths	4	5	5	3	5	3	9	7		7	9

Source: National Steering Group on Deaths in Prisons 1999; Irish Prisons Service, personal communication.

Suicide among prisoners has become a major issue of concern within the prison service. However, as with deaths in the prison in general, it is not clear how many of these are related to drug use. In 1999, six people committed suicide while in custody (see Table 13.1d). As a response to growing concern about suicides in prisons, local Suicide Awareness Groups were established in each institution in the early 1990s that are chaired by the prison Governor and include members from the relevant prison services (National Steering Group on Deaths in Prisons 1999). Further measures have also been introduced in an attempt to minimise the risk of suicide among prisoners, e.g. the development of a suicide prevention policy in each prison and increased awareness among prison staff of the risk of suicide among prisoners. However, despite these measures the numbers of suicides recorded have not reduced. Furthermore, it should be noted that where death is caused by an overdose this is not recorded as a suicide and therefore the actual number of prison suicides may be greater.

Table 13.1d: Number of suicides in Irish Prisons. 1985-1999.

Yr	'85	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99
S*	2	1	1	4	5	3	4	3	1	3	1	5	3	3	6

*Number of suicides

Source: National Steering Group on Deaths in Prisons 1999; Irish Prisons Service, personal communication

Morbidity

Studies carried out on the health of prisoners have found that they suffer from a relatively high level of morbidity, both in terms of their physical and psychological health. In their study of female prisoners in Mountjoy, Carmody *et al.* (1996) found that almost half (n=49) of the women in their sample (n=100) had received psychiatric treatment at some time- 26 of whom had spent time as an in-patient in a psychiatric hospital. Furthermore, 37 reported that they suffered from a specific physical illness, these were mainly respiratory complaints.

Hannon *et al.* (2000) carried out a study of the general health care of prisoners in Ireland. They found that compared to a sample of the general Irish population, prisoners tended to suffer from a higher level of morbidity. Twenty-two percent of male prisoners (compared to 7% of males in the general population survey) and 29% of female prisoners reported that they had a long-standing illness or disability that limited their activity. They also reported experiencing a number of other medical conditions, a sample of which can be seen in table 13.1e below.

Table 13.1e: Self-reporting of male and female prisoners and of males from general population survey on the frequency of occurrence of having (A) any of 14 medical conditions in the previous twelve months and (B) ever having been told by a doctor that they had any of the same 14 conditions.

Condition	<i>In the last twelve months</i>		<i>Ever been told</i>		
	Male prisoners	Female prisoners	Male prisoners	Female prisoners	Males general pop.
Depression	22	42	14	44	4
Asthma	10	36	11	33	na
Anxiety	14	11	8	16	3
High blood pressure	5	11	11	12	4
Skin diseases	12	15	8	11	na

Source: Hannon et al. 2000, p. 25

Legal consequences

It is prohibited for prisoners to have in their possession drugs or the paraphernalia required to use them. Prisoners caught in possession of drugs within the prison are normally dealt with and punished under the Rules for the Government of Prisons, 1947- possession of drugs or paraphernalia are dealt with under the rules related to possession of an unauthorised article. Other offences such as sharing a toilet cubicle to use drugs (see Table 13.2) are dealt with as an offence against good order and discipline. The punishments include:

13.2 Availability and supply

a) Availability of illicit drugs in prison

Due to the illicit status of drug use within the prison setting and the covert nature of that use which continues within this environment, little is known about the actual availability of drugs and their routes of supply into Irish prisons. However, the measures invoked by prison authorities to prevent drugs being smuggled into prisons suggest that prison visits may provide the main access route and that drugs sometimes are thrown to inmates over the prison walls (Cork Prison Visiting Committee Report, St. Patrick's Prison Visiting Committee).

The findings from an exploratory study of drug use among prisoners in Mountjoy Prison Dublin (Dillon 2001) offer some insight into aspects related to the availability of illicit drugs in prison. The findings of the study suggest that the types of drugs used in prison reflect those used by the prison population while in the community. Therefore, the Dublin based prison population

focused on accessing heroin and cannabis, whereas in a prison elsewhere cannabis and stimulants were reported to be the main drugs accessed and used. This reflected the main drugs of use reported by clients attending for treatment in the respective community (O'Brien et al. 2000).

Prisoners in Dillon's study (2001) argued that the quantity of drugs available within the prison was greatly exaggerated by media reports, and that they were significantly more difficult to access than was generally perceived by those outside the prison.

Dillon's (2001) study focused on the distribution networks established to distribute drugs once they had been smuggled into the prison. It was found that the sale of drugs within the prison was not reported to be a common practice at the time the study was carried out. Rather a 'favour' network was reported to be the main distribution tool. The distribution process invoked by inmates was seen to impact on the quantity of drugs used, the frequency of use and the risk behaviours engaged in by those using drugs in the prison setting.

The principal means of drug distribution in Mountjoy Prison was found to be through networks set up between prisoners. Networks were generally established between prisoners who had known each other in the community. Fellow prisoners were often people with whom respondents had mixed outside prison, either through their drug use, their criminal activity or simply because they came from the same community. Distribution was based on a reciprocal arrangement between those who had access to drugs from the community. One person would access drugs by smuggling them into the prison, and then he/she would distribute them within his/her network. Another member of this network would then access drugs in a similar way and distribute them to the members of this network. As such, members of this group were assured that they would continue to receive drugs from other people's visits, as long as they continued to receive drugs that they could then distribute.

No information is available on the means through which drugs are distributed in prisons other than Mountjoy. Anecdotal evidence suggests that drugs may be sold for cash elsewhere, although there is no information on prices available.

b) Smuggling into prison

The prison authorities invoke a number of measures to prevent prisoners from smuggling drugs and the relevant paraphernalia into prisons. These include:

- monitoring all visits (both by prison officers in the visiting hall and a closed circuit television system);
- prohibiting physical contact between visitors and prisoners during visits;
- internal and external body searches of prisoners suspected of smuggling drugs or paraphernalia into the prison; and

- carrying out searches of cells where it was suspected that drugs or paraphernalia were being kept.

Other measures are taken in some of the prisons. For example, in some prisons netting has been installed over the exercise yards- this is to prevent drugs from being thrown over the prison walls to inmates.

In the period from April 1998 to April 2000 there were 622 seizures of drugs in Irish prisons. Furthermore, a number of visitors were successfully prosecuted for attempting to supply drugs to inmates (Irish Prisons Service, personal communication). Some more detailed data are included in the Visiting Committee reports for each prison. In their 1999 annual report, Mountjoy Prison's Visiting Committee reported a number of incidents in which prisoners were found to be contravening prison regulations in relation to drugs and their use (see table13.2).

Table 13.2: Cases of informal offences reported in Mountjoy Prison, Dublin. 1998-1999.

Informal Offence	1998	1999
Receiving drugs on visits	152	112
Possession of drugs in cells	78	88
Possession of syringe	191	161
Using drugs in prison	7	35
Sharing a toilet cubicle to use drugs	82	91
Giving a false name to receive medication	9	35

Source: Mountjoy Prison Visiting Committee Report, 1999.

13.3 Contextual information

This section will describe the general structure of the Irish prison system, including the organisational structure, the relevant legislation and a general profile of the prison population and places of detention. Furthermore, an overview of data available on the culture within Irish prisons and the relationships that exist within this setting will be presented.

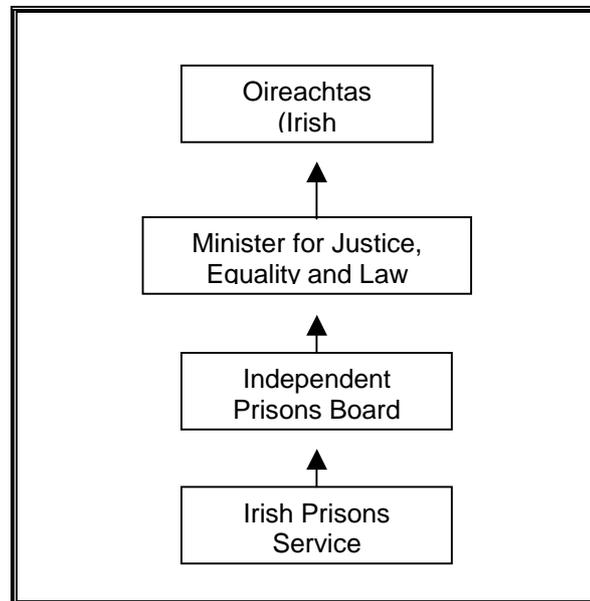
Structure of the Irish prison system

The structure of the Irish prison system is currently undergoing significant changes- the Irish prison service is undergoing a transition from being a functional area of the Department of Justice, Equality and Law Reform, to an independent executive agency status (www.irishprisons.ie). In November 1996, on foot of recommendations from various reports (Commission of Inquiry into the Penal System 1985; Department of Justice 1994), the Irish Government approved the establishment of an independent prisons agency to take on responsibility for the day-to-day running of the prison service. The agency will be overseen by an independent Prison Board to ensure that it is operationally independent in performing its day-to-day functions and activities. The Minister for Justice, Equality and Law Reform however, will continue to be politically accountable for the prison system.

A Prisons Authority Interim Board was appointed by the Minister for Justice, Equality and Law Reform in April 1999 and the first Director General of the Irish Prisons Service was appointed in July 1999. The Service is to be

established on a statutory basis, requiring the preparation of the necessary legislation in the form of a Prison Service Bill. This Bill has yet to be enacted despite plans to do so during 2000. The structure of the new system can be seen in diagram 13.3 below.

Diagram 13.3: Reporting Structure of Irish Prison System



On a day-to-day basis each institution is managed by a prison governor. Governors are appointed by the Minister for Justice, Equality and Law Reform, and come from a variety of backgrounds. Within the new structure it is planned that greater authority, responsibility and accountability will be given to Governors in the management of their own prisons.

Prison Visiting Committees: An important structure within the Irish prison system, and a valuable source of information on prisoners' experiences of this system, are the annual reports of the Prison Visiting Committees. Prison Visiting Committees were established under the Visiting Committee Act, 1925, and a statutory instrument of 1972 (S.I. No. 217/1972: Prisons (Visiting Committees) Order, 1972). They are independent statutory bodies that act on behalf of the public to oversee the treatment of prisoners and to ensure that the prison system operates humanely (Vaughan 2001). Prisoners are able to access the committees and make complaints to them about any aspect of their treatment by the prison authorities. The Visiting Committees of the various institutions carry out a statutory role under the Prisons (Visiting Committees) Act, 1925 to:

- (a) from time to time and at frequent intervals to visit the prison.... To hear any complaints which may be made to them by any prisoner.....; and
- (b) to report to the Minister any abuses observed or found by them in such prison; and
- (c) to report to the Minister any repairs to such prison which may appear to them to be urgently needed; and

(d) to report to the Minister on any matter relating to such prison on which the committee shall think it expedient or shall have been requested by the Minister so to report.

The Visiting Committee for each prison is required to make a report to the Minister on an annual basis to which the public may have access. The Committees however have been subject to some criticism for not being wholly impartial (Commission of Inquiry into the Penal System 1985; Vaughan 2001).

Legislative Framework

The legislation governing the operation of the prison system is made up of a variety of Prison Acts dating from the 19th century, with the principal Acts being: the Prisons (Ireland) Act, 1826; the Prisons (Ireland) Act, 1856; the General Prisons (Ireland) Act, 1877; the Visiting Committee Act, 1925; the Criminal Justice Act, 1960; the Criminal Justice (Miscellaneous Provisions) Act, 1997; and the various statutory Rules and Regulations- the most important of which are the Rules for Government of Prisons, 1847 (S.I. number 320 of 1947). The Rules of Government for Prisons, which were last updated in 1947, are to be replaced with a new set of Prison Rules drawn up in line with EU-formulated prison rules- the new rules have been signed off by the Irish Prisons Service and the Department of Justice, Equality and Law Reform, and are currently being studied by the Office of the Attorney General.

Profile of Prisoners and Places of Detention

As mentioned above Ireland has a daily prison population of approximately 3,000 housed in 16 prisons around the country. Box 13.3a provides a brief profile of the Irish prison population on June 1st 2000.

Box 13.3a: Profile of Prisoner Population on 1st June 2000

97% of prisoners are male 90% of prisoners are under sentence 44% of sentenced prisoners are aged between 17 and 25 65% are aged under 30 years of age 8 out of 10 (80.5%) are serving sentences of more than one year 64% of sentenced prisoners are serving sentences of two or more years 25% are serving sentences of between 5 and 10 years and 10% more than 10 years.
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Source: www.irishprisons.ie

The Irish prison system is made up of what are termed 'open', 'semi-open' and 'closed' prisons. The type of institution reflects the level of security considered necessary for the cohort of prisoners housed there. The variation between the different institutions is best reflected in the daily regime of each type of institution (see Box 13.3b).

Box 13.3b: Structure of Daily Routine in Irish Prisons.

Daily Timetable “closed” Institutions.

The timetable in closed institutions is generally as follows; 8.15am unlock, breakfast, return to cell. 9.15am unlock, tidy cell, go to place of employment/training, course/school. 12.15pm collect dinner, return to cell. 2.15pm unlock, tidy cell, return to employment/training/education activities. 4.15pm collect tea, return to cell. 5.30pm unlock go to recreation. 7.30pm collect supper, return to cell. 8.00pm final lock up. It should be noted however that not all prisoners in these institutions have access to the employment/training/education activities. Therefore, the hours when they are ‘unlocked’ prisoners engage in the limited recreational activities available to prisoners.

Daily Timetable Semi-open Institution (Training Unit)

The Training Unit located in the Mountjoy Prison Complex is the only institution within the Irish prison service to have the status of a semi-open institution. Here the traditional lock-unlock regime does not apply. A prisoner rises at about 8am and is not obliged to return to his cell until he goes to bed at about 10pm. Most of the day (9am to 5pm) is spent in one of the workshops or at education classes, with meal breaks in the course of the day. From 5-10pm approximately, there is recreation time during which prisoners may engage in a full range of activities including watching television or playing snooker, squash, volleyball etc.

Daily Timetable Open Institutions

The daily regime in an “open” centre is more relaxed, reflecting the lower security rating. From the time the prisoner rises until he/she goes to bed, prisoners have practically full-time association with other prisoners. Furthermore, they have access to a wide range of activities- both indoor and outdoor. The traditional lock up system associated with closed prisons does not apply in “open” institutions.

Source: www.irishprisons.ie

Prison Culture

Little is known about the culture that exists within different Irish prisons. Prisons tend to house inmates resident in the locale of that prison wherever possible, i.e. offenders normally resident in Cork tend to be imprisoned in Cork Prison. However, some prisons deal with specific categories of prisoners. For example, the population of the Curragh prison consists mainly of sex offenders, while the Portlaoise Prison population includes offenders convicted by the Special Criminal Court of “subversive-type offences” (www.irishprisons.ie), mainly members of various paramilitary organisations (e.g. IRA, UVF) who are considered by the prison service to pose a high security risk. Therefore, each prison will probably have a different culture depending on the profile of prisoners it houses. As mentioned above, little research has been carried out to explore these different cultures. However, in the context of drug use among prisoners some work has been carried out on the culture that exists within at least one prison in which drug use has been found to occur.

Mountjoy Prison in Dublin is an institution in which studies have shown that a large proportion of the population has a history of opiate use (O’Mahony 1997b; Allwright *et al.* 1999), most having engaged in daily use right up to the time they entered the prison. The Department of Justice, Equality and Law Reform has estimated that Mountjoy has to cope with detoxifying 1,200 –

1,500 opiate users each year (Department of Justice, Equality and Law Reform 1999). In his commentary on the prison system, O'Mahony has argued that Mountjoy is 'totally dominated by a drugs culture embodied in prisoners' attitudes, values and behaviours' (1997a, p.42). Mountjoy is the only prison in which effort has been made to explore the culture that exists in the prison. For the purpose of this Special Topic the findings of Dillon's (2001) exploratory study in relation to the culture that existed within Mountjoy Prison will be overviewed. While this study in no way purported to provide a comprehensive profile of prison culture in Ireland, it offers an overview of a prison culture where drug use was a central feature of daily life.

Overall, respondents in Dillon's (2001) study (n=29) reported that life in prison was characterised by tension, monotony and that being in prison was a depressing experience. Where respondents with a history of illicit drug use were not engaged in structured activities, the boredom experienced was seen to reinforce the perceived positive aspects of illicit drug use. Furthermore, other than in the designated drug-free wing of the Training Unit, respondents perceived Mountjoy Prison to be characterised by a drugs culture, manifest in the attitudes and behaviour of prisoners. Irrespective of the drug-using history of prisoners, or their current drug-using status, there was an overall consensus that drug use was an issue they faced on a daily basis. Respondents reported that they saw significant variation between different areas of the prison in terms of the visibility of the activities involved in illicit drug use, i.e. distribution, administration and being under the influence of drugs. While it was reported that drug use was not seen in one area of the prison (the designated drug free wing- Training Unit), it was reported to be particularly acute in others (main Male Prison, Female Prison). Prisoners currently using drugs, and those who were not, reported that drugs were one of the main topics of conversation among prisoners. Accessing them, using them and past experiences of them were talked about on a frequent basis. Respondents identified drug use as visible, depending on which area of the prison they were housed in, rather than whether they were engaged in illicit drug use in the prison or had a history of illicit drug use. They reported that the overall atmosphere of the prison was affected by drug use. In an environment where the availability of drugs fluctuated, tensions among those depending on drugs also fluctuated. This resulted in a volatile atmosphere in most areas of the prison. Respondents argued that drugs impacted on all of those in the prison setting, including prisoners with a history of drug use, prisoners with no history of drug use, and prison staff. Prisoners with a history of drug use argued that the perceived benefits of drug use were reinforced in the prison environment. Drugs were seen to alleviate some of the problems associated with prison, such as boredom and depression. To stay or become drug-free in an environment characterised by a drugs culture was not perceived as feasible by those with a history of drug use. The prisoners with no history of drug use, who were housed outside the designated drug free area of the Training Unit, reported that, at least initially, the presence of drugs made the prison environment more threatening for them. Respondents felt that the presence of drugs in the prison made for a more threatening working environment for prison officers.

While this study provides a valuable insight into the culture within one of Ireland's prisons, it is likely that prison cultures will vary across the country. Furthermore, where different types of drugs are used by different populations this is likely to impact on the nature of the drug culture in each institution. Further research needs to be carried out in this area.

Prison Relationships

As with prison culture, little research has been carried out on the relationships that exist between those in the Irish prison system. Dillon's (2001) qualitative study again provides the main source of information on this subject from one of Ireland's prisons. Relationships developed within the prison both between prisoners and between prisoners and staff. Prisoners' perceptions of these relationships were explored in the interviews carried out by Dillon (2001).

Another study had established that prisoners in Mountjoy tend to be from a limited number of areas in Dublin that are characterised by relative deprivation (O'Mahony 1997b). Dillon (2001) found that prisoners who had been living in Dublin prior to imprisonment tended to come from these same areas. Furthermore, they tended to know each other not only through being members of the same community but also through their drug use. Where relationships had already been established in the community, they were maintained in the prison. Relationships were also based on an individual's drug-using status. In general, prisoners tended to select those whom they spent time with based on their drug-using status. For those currently engaged in drug use, social affiliations tended to be with other prisoners who were part of the drug distribution network in which they were involved. On the other hand, prisoners who were not engaged in drug use tended to spend their time with other non-users. Overall, as in the community, individuals selected a peer group of 'like-minded' individuals. The divisions in terms of drug-using status were highlighted by the experience of those housed in the Training Unit, which was a designated drug-free area. Respondents generally felt that, owing to the lack of a drug-using culture in this area, there was less differentiation between those prisoners with a history of drug use and those with no history of drug use. In this environment the tensions around drug use were removed. This was seen to encourage mutual respect between prisoners, and removed divisions based on drug-using status. There was a much higher level of interaction between prisoners, irrespective of drug-using history.

This study (Dillon 2001) did not aim to examine prisoner–staff relationships in depth and data on this aspect of prison life are limited. Staff were not interviewed and therefore data were restricted to the perceptions of prisoners. While there was a range of different staff in the prison, respondents focused almost exclusively on their relationships with prison officers. Prisoners had daily contact with prison officers, who were perceived to play a key role in their day-to-day experience of prison life. Respondents had mixed attitudes towards prison officers. A small number held particularly negative attitudes about them and categorised them all as 'being the same', emphasising a 'them' and 'us' relationship between officers and inmates. Overall, however, while the majority of prison officers were viewed in a generally negative way

by interviewees, a significant minority were viewed more positively. As with other aspects of prison life there appeared to be variations in the relationship between prison officers and inmates in different areas of the prison. Overall, prison officers tended to be seen as more of a source of support by female respondents than by male respondents. In summary, prisoners had mixed views of prison officers and this was reflected in their relationships with them. While a significant minority were seen in a positive light, prisoners generally maintained a distance between themselves and the prison officers.

None of the respondents in Dillon's (2001) study made allegations of ill-treatment against prison officers. However, on a more general level, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (ECPT, 1999), reported that a number of Irish prisoners interviewed alleged that they had been mistreated by prison staff. Where a prisoner feels he/she has been mistreated while in prison, he/she can make a complaint to the prison's Governor, the Visiting Committee, the Department of Justice, Equality and Law Reform, a solicitor or a member of the police force (An Garda Síochána) (Vaughan 2001). In response to the ECPT's report, the Department of Justice, Equality and Law Reform published the following table 13.3a outlining the number of complaints made by prisoners, the number referred on to the Gardaí and those that were not pursued. In none of the cases there was sufficient evidence to sustain a charge of ill-treatment. However, there is currently one case pending against a prison officer for the ill-treatment of a prisoner (personal communication, Irish Prisons Service).

Table 13.3a No. of complaints by prisoners 1996-1998

Year	Ill-treatment complaints	Referrals to Gardai	Withdrawals/ not pursued
1996	27	6	2
1997	18	6	6
1998	44	14	13

Source: Department of Justice, Equality and Law Reform

In exploring the quality of life of prisoners Hannon et al. (2000) asked prisoners about their perceptions of their environment and the threat they felt it presented them with. They found that inmates tended to perceive the prison to be threatening environment, but the experiences varied depending on what type of an institution they were based (see Table 13.3b). Table 13.3b below indicates the extent to which male prisoners felt they had been subjected to one of a number of threatening experiences within the prison setting.

Table 13.3b Aspects of prison life among male prisoners

	Closed (%)	Semi-open (%)	Open (%)
Physical harm from prison officers	31	25	15
Verbal abuse from prison officers	59	44	28
Feeling very/extremely safe in daily life	32	69	70
Physical harm from other prisoners	14	15	10
Verbal abuse from other prisoners	26	35	13

Source: Hannon et al. (2000)

13.5 Demand reduction policy in prison

a) Drug user needs assessment in prison

Although limited, research carried out to date has consistently found drug use to be an issue of concern among prisoners (Allwright *et al.* 1999; Long *et al.* 2000; Hannon 2000; O'Mahony 1997; Dillon 2001). Furthermore, the needs of drug users within prison have been noted both by the Department of Justice, Equality and Law Reform and the Irish Prisons Service. Despite evidence that a significant number of Irish prisoners engage in problematic drug use, and recognition on the part of the relevant authorities of the necessity of providing the appropriate services to meet their needs, no research has formally been carried out that has aimed to assess drug users' needs within the prison environment.

b) Organisation of the drug services in prison

In 1994 the Department of Justice clearly stated that equivalence of care and continuity of care of prisoners were among the objectives of the prison medical services in Ireland:

To provide primary health care (prevention, treatment and health rehabilitation) to offenders of at least an equivalent standard to that available to citizens in the general community; this involves as a minimum an adequate reception, medical assessment and examination, through-care while in prison and making appropriate arrangements for the continuation of health care following release. (Department of Justice 1994, p. 51)

This stance was reiterated in a 1999 document concerned with developing drug treatment provision in the prison setting (Department of Justice, Equality and Law Reform, 1999), the Report of the Group to Review the Structure and Organisation of Prison Health Care Services (2001), and in a recent speech by the Minister for Justice, Equality and Law Reform (speech given on July 4th 2001).

The care of drug users in the community falls under the remit of the Department of Health and Children, whereas in the prison setting, it is the responsibility of the Department of Justice, Equality and Law Reform. This situation creates inherent problems for the continuity of care of drug users. A draft action plan drawn up in 1999 (Department of Justice, Equality and Law Reform) sought to reflect a medical policy agreed between the Department of Justice, Equality and Law Reform, the Department of Health and Children and the Eastern Health Board.³⁴ It proposed the development of a range of treatment services within the prison setting including methadone maintenance programmes, detoxification programmes and addiction counselling. In addition, it was proposed that drug-free wings be introduced.

³⁴ Now the Eastern Regional Health Authority.

There was also a recommendation that by 1 July 1999 prisoners be provided with access to bleach for sterilising injecting equipment, in an attempt to prevent the spread of communicable disease. The provision of bleaching tablets has also been recommended in a more recent report of the Group to Review the Structure and Organisation of Prison Health Care Services – at the time of writing these have yet to be provided in Irish prisons.

The provision of a needle exchange programme is not currently being considered by the Irish Prisons Service and has not been identified specifically as a point of action within current drug policy. However, an action point within the National Drugs Strategy 2001-2008 states that the health boards should “review the existing network of needle-exchange facilities with a view to ensuring access for all injecting drug misusers to sterile injecting equipment” (Department of Tourism, Sport and Recreation 2001, p.118). While not specifically targeted at the prison context, this may have implications where there continues to be evidence of injecting drug use occurring within the prison setting. However, in the more recent Report of the Group to Review the Structure and Organisation of Prison Health Care Services it is stated that the Group is not recommending the introduction of syringe exchange programmes into the Irish prison system because “the risk of attacks on staff and prisoners with syringes supplied by the state would appear to be unacceptable” (p.46).

Following on from the draft action plan (Department of Justice, Equality and Law Reform 1999), a Steering Group on Prison-Based Drug Treatment Services was established at the end of 1999, under the chairmanship of the Director General of the Prisons Service. The group consists of senior prison staff, representatives of the Department of Justice, Equality and Law Reform, the Prisons Psychology Service, the Probation and Welfare Service, the Prisons Education Service, the Director of Prison Medical Services and several nominees from the Eastern Regional Health Authority. In a report by the group, a further commitment to the provision of drug treatment services based on the principle of equivalence of care was given (Irish Prisons Service, 2000). Furthermore, the report proposed a ‘new treatment ethos’ (Irish Prisons Service 2000, p.3) for a number of prisons in which prisoners with a history of drug use were concentrated. In October 2000 the government approved the implementation of recommendations contained in this report (Irish Prisons Service 2001). Furthermore, the implementation of the report’s recommendations has been identified as a priority within the new National Drugs Strategy 2001-2008 (2001).

On foot of the Steering Group’s report, methadone maintenance service provision was expanded within the prison setting. All prisoners entering the remand prison Cloverhill, all new committals to Mountjoy, and prisoners transferring from Cloverhill Prison who are on approved methadone maintenance treatment programmes, were to continue to receive methadone maintenance while in prison (Irish Prisons Service, 2001).

Furthermore, the Minister for Justice, Equality and Law Reform announced a directive to the Irish Prisons Service to develop drug free regimes, wings and

facilities across the prison system, and build up detoxification and counselling services for prisoners with a history of drug use, within a three-year time frame from July 2001 (Department of Justice, Equality and Law Reform press release July 4th 2001). While a range of drug treatment services are available in Irish prisons (see Table 13.5), and the recent developments suggest a more innovative approach on the part of the Irish prison system to drug treatment, the principle of equivalence does not currently prevail in the Irish prison system in its care of drug users.

Table 13.5 : List of dedicated drug treatment services available in Irish prisons³⁵

Prison	Dedicated Drug Treatment Services
St. Patrick's Institution	Short-term methadone detoxification Methadone maintenance Monitored drug-free wing
Mountjoy female prison	Short-term methadone detoxification Methadone maintenance
Mountjoy Training Unit	Monitored drug-free wing
Mountjoy Main Prison	Short-term methadone detoxification Methadone maintenance Drug detoxification and rehabilitation programme
Wheatfield	Short-term methadone detoxification Methadone maintenance
Cork Prison	No dedicated drug service
Limerick Prison	Short-term methadone detoxification*
Portlaoise Prison	Short-term methadone detoxification*
Arbour Hill	Short-term methadone detoxification*
Castlerea	No dedicated drug service
Cloverhill	Short-term methadone detoxification Methadone maintenance
Fort Mitchel	No dedicated drug service
Loughan House	No dedicated drug service
Shanganagh Castle	No dedicated drug service
Shelton Abbey	No dedicated drug service
Curragh	No dedicated drug service

**No dedicated detox programme but will continue detox for those transferred in who need it.*

Source: Personal communication, Irish Prisons Service.

c) Link with the community services outside the prison

The care of drug users while in the community falls under the remit of the Department of Health and Children, while that of drug users in prison is the responsibility of the Department of Justice, Equality and Law Reform. This has meant that there have been persistent problems with providing continuity of care for drug users moving between the community and prison. Recently however, there has been a concerted effort on the part of those involved to form stronger links between services provided within the prison and the community- the importance of establishing links between prison and community based services has been highlighted by the Irish Prisons Service:

“The Service acknowledges that it has an essential role and duty to perform in tackling drug misuse and that this role must be undertaken in

³⁵ It should be noted that within Ireland there are variations between Health Boards in terms of what they will provide in the area of drug treatment, therefore it is to be expected that these variations will impact on what services are provided within each prison.

a co-operative and co-ordinated way with other government departments, statutory agencies, prisoners and their families and the wider community.”
(Irish Prisons Service 2000, p.1)

Strengthening links with community services has been identified as a priority in the National Drugs Strategy 2001-2008. It is recommended that the involvement of community and voluntary sectors in prison drug policy be expanded. It is proposed that this be done through the development of Local Prison Liaison Groups and formal meetings held between the relevant sectors and the Steering Group on Prison Based Drug Treatment Services.

In Ireland there is no formal referral scheme for drug using prisoners to treatment upon release. The need to develop a structured through-care programme from the prison system to the community has been identified within the Irish criminal justice system (Irish Prisons Service 2000; Mountjoy Complex Redevelopment Group 2001; Group to Review the Structure and Organisation of Prison Health Care Services 2001). In the absence of formal links between the community and the Irish prison service, a number of programmes aimed at preparing prisoners for release or meeting their needs upon release have been developed on an ad hoc basis. The Probation and Welfare Service of the Department of Justice, Equality and Law Reform carry out group work programmes in the prison setting. These aim to promote desired behavioural changes in terms of risk behaviour and drug misuse, and to help prisoners cope with imprisonment and to prepare them for life demands following release from prison.

There are also a couple of specific projects underway which are targeted specifically at dealing with the issues surrounding release including: a programme that facilitates prisoners in developing a Community Release Plan; a programme aimed directly at ex-prisoners to facilitate their reintegration back into society; and, training and education based programmes aimed at providing ex-prisoners with an alternative to crime upon release.

13.6 Evaluation of drug users' treatments in prison

a) State of the art evaluation in prison

To date there has not been a tradition of evaluation within the context of service provision for drug users in the Irish criminal justice system. However, evaluation has been identified as an important aspect of future service development within the prison context (Irish Prisons Service 2000). In their report, the Steering Group on Prison Based Drug Treatment Services said “the Steering Group strongly recommends that review and evaluation systems for the new prison based drug treatment services be established from the outset” (Irish Prisons Service 2000: 4). Furthermore, within its Action Plan, the National Drugs Strategy 2001-2008 (2001) proposes to have carried out an independent evaluation of the overall effectiveness of the Prison Strategy by mid-2004.

b) Main findings and evaluation results

As mentioned above, generally evaluation has not been carried out on drug treatment services within the prison. Crowley (1999) provided a medical review of the seven-week Drug Detoxification and Rehabilitation Programme in Mountjoy prison, Dublin. Up to February 1999, 187 prisoners had entered the programme, 173 completed the detoxification and 14 failed to complete the detox. While this implies a 93% success rate, Crowley (1999) highlights the need for the success of this intervention to be determined by the 6 and 12 month relapse figures. Overall it was found that there was a twelve monthly relapse rate of 78%. Crowley argues that while this may appear high, it compares favourably to outcome rates of other inpatient detoxification programmes.

Despite the potential for the spread of HIV and hepatitis among intravenous drug users in prison, a report evaluating services in this field found that at the time there were no harm reduction strategies in place in the Irish prison system (O'Brien and Stevens 1997). An award-winning booklet and video, containing information for prisoners on HIV discrimination, infection and prevention, had been produced and were supposedly available to all prisoners. However, focus group interviews with prisoners and former prisoners found that HIV-positive individuals in the focus groups had seen neither of these materials (O'Brien and Stevens 1997).

It is hoped that the emphasis on evaluation in recent policy development will result in a tradition of evaluation within the context of prison based drug treatment services.

13.7 Methodological issues

a) Limitations in data availability

The data available on drug use among prisoners in Ireland remains limited. However, there does appear to be an interest on the part of the Irish prison service to encourage and facilitate research on the issue. This is encouraged alongside policy and practice developments in the area of drug use among prisoners in Ireland.

b) Future needs

Among the implications of the findings of Dillon's (2001) study was that there is a need for further research to be carried out on the subject of drug use among prisoners. It is argued that with only a few exceptions (O'Mahony 1997b; Allwright *et al.* 1999; Long *et al.* 2000), there has been little information available to guide policy and practice in the area of drug use among prisoners in Ireland. The need to base policy and service developments on a sound knowledge base is identified. Research needs were identified on both a general and specific level:

On a general basis, there is a need for routine data on prisoners to be collected, so that trends and changes in the prison population can be monitored. The lack of routine statistics on those in custody should be addressed.³⁶ Furthermore, the prison services should encourage and facilitate the collection of data for the National Drug Treatment Reporting System. This reporting system will provide important epidemiological information on those prisoners who access drug treatment in the prison, and could be used to identify trends over time, as well as changes in patterns of drug use.

Routine data collection needs to be complemented by special surveys, which would provide more detailed information on sub-groups and specific issues of particular concern. Some of the areas in need of further research, which arose from Dillon's (2001) study were:

- the extent to which a drugs culture exists in other Irish prisons, the perceived impact of different prison environments on prisoners' drug-using behaviour and their overall experience of prison;
- the drug–crime relationship in the Irish context;
- the extent to which drug users change their drug-using behaviour in the prison setting and the nature of these changes;
- the risk behaviours engaged in by those using illicit drugs in the prison setting, the context in which these occur and how they compare to those in the community;
- the processes surrounding initiation into injecting drug use, with a particular focus on initiation in the prison setting;
- perceptions and knowledge among prisoners of the health risks involved in sharing injecting equipment;
- on-going monitoring and evaluation of prison-based drug treatment and healthcare services; and
- prison officers' perceptions of the drug situation within the prison and their attitudes toward a comprehensive service provision profile.

c) Methodological proposal

A range of methodologies would need to be adopted to carry out research in the areas identified in section 13.7 (b). Both qualitative and quantitative would need to be used and a variety of sampling methods invoked including randomised sampling and techniques such as network sampling. Methodologies developed must also take consideration of the particular ethical issues that arise from carrying out research within the prison setting.

In her exploratory study on drug use among Irish prisoners Dillon (2001) carried out in-depth qualitative interviews with a sample of prisoners. A network/snowball sampling method was used for sample selection. 'Categories' of prisoners were developed based on general characteristics relating to an individual's drug-using history. Initial contacts were made through probation and welfare officers and respondents selected according to these categories. Respondents located in this way were asked to refer the

³⁶ The last annual report on prisons and places of detention was for the year 1994 (Department of Justice, Equality and Law Reform, 1998).

researcher on to other potential study participants in the prison. Interviews were tape-recorded, with participants' consent, and fully transcribed for analysis. The methodology used in this study (Dillon 2001) was found to be very effective in facilitating an exploration of the particularly sensitive subject of drug use among prisoners.

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Databases – Software – Internet Addresses

a) Databases used in this report:

- General Mortality Register

Principal Use – Contains data on mortality statistics

Users – politicians, policy makers, police, medical practitioners, researchers, the public.

- Hospital Inpatient Enquiry database

Principal Use – A computer based health information system designed to collect medical and administrative data regarding discharges from acute hospitals (excluding private hospitals).

Users – politicians, policy makers, medical practitioners, hospital and health services staff, researchers.

- National Drug Treatment Reporting System

Principal Use – The national epidemiological database on treated drug misuse in Ireland

Users – politicians, policy makers, researchers, drug treatment services, local drug task forces, the public.

- National Psychiatric Inpatient Reporting System

Principal Use – Provides information on the activities of the inpatient psychiatric service (admissions, discharges and deaths) in Ireland

Users – politicians, policy makers, psychiatric and health services staff, researchers, the public

Software Used:

- Microsoft Word
- Microsoft Excel
- SPSS 9.0 (1999). Statistical Package for the Social Sciences. USA: SPSS Inc.

b) **Internet Addresses:**

<u>www.clubscene.ie</u>	Club scene website
<u>www.coolchoices.ie</u>	Cool choices website
<u>www.cpa.ie</u>	Combat Poverty website
<u>www.dnedrugstaskforce.ie</u>	Dublin North East Drugs Task Force
<u>www.drugawareness.ie</u>	Drug Awareness website
<u>www.erha.ie</u>	Eastern Regional Health Authority
<u>www.incb.org/e/cpnv</u>	International Narcotics Control Board
<u>www.irishprisons.ie</u>	Irish Prisons website
<u>www.kildare.ie/drugsawareness</u>	Drug Awareness website for Kildare
<u>www.kildare.ie/outreach/index/htm</u>	Outreach website for Kildare
<u>www.mqi.ie</u>	Merchants Quay Ireland website
<u>www.nehb.ie</u>	North Eastern Health Board
<u>www.penal-reform.ie</u>	Penal Reform website
<u>www.rutlandcentre.org</u>	Rutland Centre website

ANNEX

➤ **Drug monitoring systems and sources of information – Mary O’Brien & Lucy Dillon**

The core information systems, used to monitor the drug problem and to inform policy making, are in the health and law enforcement areas.

- **National Drug Treatment Reporting System [NDTRS]**

The Drug Misuse Research Division [DMRD] of the Health Research Board (HRB) operates the *National Drug Treatment Reporting System [NDTRS]*. The NDTRS is an electronic database providing information on people who present to drug treatment services nationwide. The data are collected by health services personnel at regional health board level, and are co-ordinated by the DMRD. Data co-ordinators are in the process of being appointed at regional level.

- **Infectious diseases data**

The National Disease Surveillance Centre (NDSC) took over statutory responsibility for reporting on sexually transmitted infections (STIs), including HIV/AIDS, from the Department of Health and Children (DOHC) on July 1st 2000. On 1st July 2000, the Infectious Diseases (Amendment) Regulations, 2000 (S.I. No 151 of 2000) came into force. Under these regulations the National Disease Surveillance Centre (NDSC) was assigned responsibility for the collation and analysis of weekly notifications of infectious diseases, taking over from the Department of Health and Children. This includes responsibility for reporting on drug-related infectious diseases. While hepatitis B is a notifiable disease but it is generally accepted that there is under-reporting in Ireland and that the notification system is not a good indication of the true incidence of infection. Furthermore, while data are collected on the number of positive tests carried out for hepatitis B by the Virus Reference Laboratory, no behavioural data is collected and therefore those infected through drug use cannot be identified. There is no routine data collection in the area of hepatitis C. Only total numbers of individuals who test positive in a given year are available- as with hepatitis B it is not possible to identify those who have become infected through injecting drug use.

The most complete data available on drug-related infectious diseases are those on HIV. Up until July 2000, the Department of Health and Children, in collaboration with the Virus Reference Laboratory, was responsible for producing statistics on HIV positive tests which are published every six months. Data on HIV/AIDS are now provided directly to the NDSC by the Departments of Public Health of each health board. In their first six months of data collation (July 2000-December 2000), data were collected by the NDSC in the same manner as previous years. However, in July 2001 a new HIV case-based reporting system has been developed. The aim of the new HIV case based reporting system has been noted as “to ensure the collection of accurate and complete epidemiological data on the distribution and mode of transmission of HIV infection” (O’Donnell, Cronin & Igoe, 2001: 21). The socio-demographic data that will be collected within this new system are the

patient's age, gender, county of residence (if Dublin, then the postal code) and country of birth (if not Ireland then year of first arrival in Ireland). Furthermore, an expanded list of probably routes of transmission is included on the form (for further information see section 3.3 of the report)..

- **General Mortality Register**

Data on drug-related mortality are currently obtained from the General Mortality Register operated by the Central Statistics Office. Mortality data are collected by regional Registrars of Births and Deaths, from a number of sources (medical practitioners, police, coroners) and returned centrally to the Registrar General's Office. These data are reported upon (*Report on Vital Statistics*) by the Central Statistics Office (CSO). Data on drug related deaths are not routinely published. A new development is that the possibility of setting up a Special Register to record drug related death is being explored. This came about as a result of discussions, which took place at Workshops organised by the DMRD, in the context of the harmonisation of key indicators of drug misuse.

- **National Psychiatric In-patient Reporting System**

The *National Psychiatric In-patient Reporting System [NPIRS]*, which provides information on the activities of the inpatient psychiatric service in Ireland, is maintained by the Mental Health Research Division of the Health Research Board. This monitoring system collects data on admissions to and discharges from public and private psychiatric hospitals and units in Ireland. It provides information on the activities of the inpatient psychiatric service (admissions, discharges and deaths). Primary and secondary psychiatric diagnoses are recorded. An annual report provides information on gender, age, marital status, socio-economic group, legal status, diagnosis (ICD-10) and length of stay. A review of changes over time is also provided by the system, from computerised data going back to 1971.

- **Hospital In-Patient Enquiry System**

The *Hospital In-Patient Enquiry System [HIPE]*, records details on discharges and deaths for all acute public hospitals in Ireland. The database is maintained by the Economic and Social Research Institute. It is a computer based health information system designed to collect medical and administrative data regarding discharges from acute hospitals (excluding private hospitals). Data on principal diagnoses and principal procedures performed are collected. Each discharge record represents one episode of care and patients may have been admitted to hospital more than once with the same or different diagnoses. These records facilitate analyses of hospital activity rather than incidence of disease, with information on primary and secondary diagnoses (ICD-9).

- **Central Methadone Treatment List**

The *Central Methadone Treatment List* is a register of all clients who receive prescribed methadone. The information collected consists of:

- the operative/issue date
- client's name
- client's date of birth

- void date
- reason for void.

These data, which are used to avoid duplication of methadone prescription, are confidential and are not published.

- **Police data**

In the area of *law enforcement*, national data are collected by the Garda Síochána and published annually. These data are a reflection of police activity and include the number of criminal charges for drug offences. The published data refer to *drug-related offences* under the Misuse of Drugs Acts where proceedings are commenced. Breakdown is given by drug and whether it was intended for possession or traffick/supply. The data are event-based, individuals cannot be identified so the number of individual persons involved is not known.

Collection of *drug seizures* data is carried out by the Gardaí and the Customs Service. Information includes the quantity (by weight) and the number of seizures of illegal drugs as well as type of drug involved. These data are inter alia a reflection of the activity of the police and the Customs authorities. Methods of detection, for example the number of personnel involved in the detection of such crimes, the availability of detection equipment or sniffer dogs, could influence the consistency of the data over time. Information on drug product purity is collected by the police from seizures of drugs. The *purity of drugs* is analysed by scientists at the Forensic Science Laboratory and tests are carried out on samples of all products seized, except in the case of cannabis where tests are carried out on random samples of seizures.

Information on the *price of drugs* is collected by the police at street level. The quality of the latter data is difficult to ascertain. Price and purity information is not included in published Garda reports.

- **Prison data**

An annual report of prisons and places of detention is supposed to be produced which includes *data on those imprisoned* under the Misuse of Drugs Acts. However, the most recent statistics providing such a breakdown relate to 1994- from 1995 to date no such data have been produced by this source. A new computer system was to be established within the prison system from January 2001, but at the time of writing (September 2001) there continues to be problems with the practice of routine reporting and the publication of annual statistics from this source. Furthermore, two categories of law offences have been used in the statistics produced up until 1994: sale or supply of drugs; and, possession/production/cultivation/import/export of drugs. These do not correspond with data collected by the Gardai, as they are categories according to the offence under the Misuse of Drugs Act.

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➤ **List of Abbreviations**

A&E	Accident and Emergency
ADHA	Attention Deficit Hyperactivity Disorder
ADM	Area Development Management Ltd
AIDS	Acquired Immune Deficiency Syndrome
ARC	Addiction Response Crumlin
BMW	Border, Midlands and Western region
CAB	Criminal Assets Bureau
CAP	Community Addiction Programme
CARP	Community Addiction Response Programme
CASP	Clondalkin Addiction Support Programme
CCBDI	Clonmel Community Based Drugs Initiative
CDB	County/City Development Board
CDVEC	City of Dublin Vocational Educational Committee
CLAD	Carlow Community Awareness of Drugs
COREPER	Committee of the Permanent Representatives (of the member states of the EU)
CSO	Central Statistics Office
CWCBDI	Co. Waterford Community Based Drugs Initiative
DAG	Darndale/Belcamp Drugs Awareness Group
DAP	Drug Awareness Programme
DDRAM	Drug Dependence: Risk and Monitoring
DICE	Drugs Information Community Education Project
DMRD	Drug Misuse Research Division
DofHC	Department of Health and Children
DofTSR	Department of Tourism, Sport and Recreation
DPP	Director of Public Prosecutions
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECPT	European Committee for the Prevention of Torture and inhuman or degrading treatment or punishment
EDDRA	European Database of Demand Reduction Activities
EDIT	Edenmore Drugs Intervention Team
EDU	Europol Drugs Unit
EHB	Eastern Health Board
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ERHA	Eastern Regional Health Authority (formerly Eastern Health Board)
ESPAD	European Schools Survey Project on Alcohol and other Drugs
EU	European Union
Europol	European Police Office
FAN	Finglas Action Now
GMR	General Mortality Register (at CSO)
GNDU	Garda National Drugs Unit
GP	General Practitioner
HBSC	Irish Health Behaviours in School Aged Children
HBSS	Irish Health Behaviours Schools Survey
HCV	Hepatitis C Virus
HIPE	Hospital Inpatient Enquiry database

HPU	Health Promotion Unit
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
ICGP	Irish Council of General Practitioners
ICT	Information and Communications Technologies
IDG	Inter-Departmental Group
IDU	Injecting drug user
INCADDS	Irish Council of Attention Deficit Disorder Support Groups
IRA	Irish Republican Army
ISP	Integrated Services Process
IVDU	Intravenous drug user
JADD	Jobstown Assisting Drug Dependency
JLO	Juvenile Liaison Officer
KAB1	Drug Related Knowledge, Attitudes and Beliefs, a survey of the general adult population in Ireland, published by the Drug Misuse Research Division
KAB2	An expanded study, following KAB1, to be published by the Drug Misuse Research Division
KCCP	Kilbarrack Community Coast Programme
KDI	Kilkenny Drugs Initiative
LDTF	Local Drug Task Force
LIP	Labour-Market Inclusive Project
MBRS	Medical Bureau of Road Safety
LSD	Lysergic Acid Diethylamide
MDA	Methylenedioxyamphetamine
MDA	Misuse of Drugs Acts, 1977 & 1984
MDMA	MethyleneDioxyMethAmphetamine
MHB	Midland Health Board
MQP	Merchants Quay Project
NA	Narcotics Anonymous
NACD	National Advisory Committee on Drugs
NAHB	Northern Area Health Board
NAPS	National Anti-Poverty Strategy
NCDP	National Community Development Plan
NDP	National Development Plan
NDSC	National Disease Surveillance Centre
NDST	National Drug Strategy Team
NDTRS	National Drug Treatment Reporting System
NEP	Needle Exchange Programme
NIMBY	Not In My Back Yard
NPIRS	National Psychiatric Inpatient Reporting System
NTORS	National Treatment Outcomes Research Study
NUI	National University of Ireland
NWHB	North Western Health Board
PESAT	European Foundation
PPF	Programme for Prosperity and Fairness
RAPID	Revitalising Areas by Planning, Investment and Development
RASP	Rehabilitation and Support Programme
RDTF	Regional Drug Task Force
REITOX	European Information Network on Drugs and Drug Addiction

S&E	Southern and Eastern region
S.P.H.E.	Social, Personal and Health Education programme
SHB	Southern Health Board
SLÁN	Survey of Lifestyles, Attitudes and Nutrition
SMI	Strategic Management Initiative
STD	Sexually-transmitted disease
UCD	University College Dublin
UN	United Nations
UVF	Ulster Volunteer Force
VEC	Vocational Education Committee
VIP	Vital Information Pack
WHB	Western Health Board
WHO	World Health Organisation
YPFSF	Young People's Facilities and Services Fund