



European Monitoring Centre  
for Drugs and Drug Addiction



**2008 NATIONAL REPORT (2007 Data)  
TO THE EMCDDA  
by the Reitox National Focal Point**

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

**REITOX**

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Dr Jean Long  
Head of Unit

### **This report was written by:**

Johnny Connolly	Jean Long	Brigid Pike
Caroline Forde	Ena Lynn	
Martin Keane	Suzi Lyons	

**This report was edited by Joan Moore with the assistance of Brigid Pike and was compiled by Mairea Nelson**

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## Summary of each chapter

This report, written following European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) guidelines,<sup>1</sup> is divided into two parts. Part A is an overview of new developments and trends in the drugs area in Ireland for 2007 and, in some cases, for the first six months of 2008. These are covered under the following headings:

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

Part B examines one specific issue considered to be important at an EU level. The Selected Issue is:

1. Sentencing

### Main points from Part A

#### 1. National Policies and Context

- The Misuse of Drugs (Amendment) Regulations 2007, SI No. 200 of 2007, allows for registered nurses to prescribe certain controlled drugs in limited circumstances.
- The Maritime Analysis & Operations Centre-Narcotics (MAOC-N) in Lisbon was established to address the trafficking of cocaine from South America and the Caribbean into Europe. This agreement involving Ireland and six other EU member states was signed by Brian Lenihan, TD, Minister for Justice, Equality and Law Reform in Lisbon on 30 September 2007.
- The National Drugs Strategy 2001–2008 is due to expire at the end of 2008. At the start of 2008 the Minister of State with responsibility for the Drugs Strategy, Pat Carey TD, established a Steering Group to develop proposals for a new drugs strategy to run from 2009 to 2016.
- Ireland's National Drugs Strategy 2001–2008 document did not make provision for a final review or evaluation (it did call for a mid-term evaluation), and no final evaluation is being undertaken.
- The National Advisory Committee on Drugs (NACD) commissioned an evaluation of the development and delivery of the National Drug Awareness Campaign, which ran between 2003 and 2005. The report on this evaluation was published in January 2008.
- In a Eurobarometer survey of young EU citizens' attitudes and perceptions about the drugs issue, published in May 2008, respondents in Ireland were among the least likely to see the clampdown on drug dealers and traffickers as effective. Conversely, Irish respondents were among the most likely to believe that the treatment and rehabilitation of drug users was an effective way to deal with

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

society's drug problems. Irish respondents were among those who most favoured the legalisation of drugs.

- In February 2008 a new National Public Awareness Campaign focusing on cocaine use was launched. The campaign will inform people about the dangers associated with cocaine use while dispelling the myths that exist around the drug.
2. Drug use in the general population and specific sub-groups
- On 25 January 2008, the National Advisory Committee on Drugs (NACD) and the Drug and Alcohol Information and Research Unit (DAIRU) in Northern Ireland published jointly the results of the second all-Ireland general population drug prevalence survey. The proportion of adults (aged 15–64 years) who reported using an illegal drug in their lifetime increased by five percentage points, from 19% in 2002/3 to 24% in 2006/7. The proportion of adults who reported using an illegal drug in the last year increased marginally, from 6% in 2002/3 to 7% in 2006/7. Cannabis was the most commonly used illegal drug in Ireland. The proportion of adults who reported using cannabis at some point in their life increased from 17% in 2002/3 to 22% in 2006/7. Nine per cent of young adults claimed to have tried ecstasy at least once in their lifetime in 2006/7. Cocaine use increased in 2006/7 compared to 2002/3. The proportion of adults who reported using cocaine (including crack) at some point in their lives increased from 3% in 2002/3 to 5% in 2006/7. The proportion of adults who reported using cocaine in the last year increased from 1% in 2002/3 to 2% in 2006/7.
  - On 29 April 2008, the Department of Health and Children published the third SLÁN Survey of Lifestyle, Attitudes and Nutrition in Ireland. The survey involved 10,364 face-to-face interviews with adults resident in Ireland, which represented a 62% response rate. In the 2007 survey, respondents were asked about their use of illegal drugs in the last year. Six per cent reported that they had used an illegal drug in the year prior to the survey; the reported use of such drugs was higher for men (9%) than for women (4%). As expected, cannabis was the most commonly used drug. The percentage of those who used cocaine in the last year was surprisingly low at 1%. In general, these data are not comparable to the results of the 2006/7 general population survey by the NACD as the SLÁN survey excluded those between 15 and 17 and included those over 65 years.
  - The third Irish HBSC (Health Behaviour in School-aged Children) study, conducted in 2006 by the Health Promotion Research Centre in the National University of Ireland, Galway, was published in August 2007. Data were collected from 10,334 children aged 10–18 years on topics including general health, smoking, use of alcohol and other substances, food and dietary behaviour, exercise and physical activity, self-care, injuries and bullying. Overall, 16% of children reported using cannabis during their lifetime, compared with 12% in 2002; 12% reported using cannabis in the past 12 months, compared with 11% in 2002. Cannabis use was highest for those aged 15–17, with about one in five in this age group using cannabis in the previous 12 months. The rates of reported cannabis use are similar to those in the 2002 HBSC study, except among 15–17-year-old boys, where a decrease is evident. Seven per cent of children reported using cannabis in the previous 30 days.
  - The report *Emotional intelligence, mental health and juvenile delinquency* revealed that young people in detention schools in Ireland experience high rates of psychiatric disorders, engage in serious criminal activity and have significant deficits in emotional intelligence and cognitive ability. Sixty-seven per cent of the offender group met the criteria for at least one substance-related disorder. Approximately equal numbers reported using cocaine (13/30), alcohol (14/30) and cannabis (14/30).



- Between April 2003 and May 2004, 1,011 Caucasian women attending a maternity hospital in Dublin city centre were interviewed to determine their use of illegal drugs, tobacco and alcohol. The definition of illegal drugs used in the survey was not presented in the paper reporting on the study. Of the 1,011 women interviewed, 235 (23.5%) respondents reported that they had taken an illegal drug at some point prior to this pregnancy. As expected, cannabis was the most commonly used illegal drug with 214 (21.2%) respondents reporting that they had used this drug at some point prior to this pregnancy. Seventy (6.9%) respondents had used ecstasy at some point prior to this pregnancy while 64 (5.8%) respondents had used cocaine. Ninety (8.9%) women had used more than one illegal drug. Eleven (1.1%) women had used an illegal drug during this pregnancy.

### 3. Prevention

- The National Drug Awareness Campaign 2003-2005 was evaluated. The results show that the initial stages of the campaign were well developed with formative evaluation methods. However, subsequent evaluation showed that, overall, the design and implementation of the campaign exhibited many shortcomings.
- Training to improve the professionalism of the community sector in reducing demand for drugs in local drug task forces is on the increase.
- Quality standards to improve the professionalism of drug education workers have been published and the Drug Education Workers Forum (DEWF) is planning a training programme for drug education workers based on these standards.
- Research shows that there is a need for a more integrated, targeted approach to recreational drug users referred by the Courts for drug education on foot of being in possession of drugs at music festivals and recreational events.
- The latest phase of the National Drug Awareness Campaign emphasises the risks and consequences of cocaine use targeting 'recreational users'.
- Evaluation of a community-based, targeted intervention for at-risk families in Tallaght, Dublin, shows that this work can contribute to improvement in quality of life. However, the need for more strategic planning and outcome evaluation for this type of intervention is also highlighted.

### 4. Problem Drug Use (PDU) and the treatment demand population

- No new valid national prevalence and incidence studies have been carried out or published during the reporting period January 2007 to June 2008. The 2000/2001 three-source capture–recapture study to estimate the number of problem opiate users living in Ireland is being repeated using 2006 data. The results of this study will be presented in the 2009 national report.
- On 14 May 2008, Reynolds and colleagues published a paper on trends in treated problem drug use based on data reported to the National Drug Treatment Reporting System (NDTRS) and to the Central Treatment List (CTL). There were 68,754 cases (rather than individuals) treated between 2001 and 2006, of which 31,620 entered treatment during the six-year period. Of these cases, 29,373 (93%) lived in Ireland at an identified address, 2,203 (7%) lived in Ireland at an unidentified address and 44 (0.1%) did not live in Ireland. The **prevalence** (all cases) of treated problem drug use among 15–64-year-olds living in Ireland, expressed per 100,000 of the population, increased by 15%, from 372 in 2001 to 426 in 2006. The **incidence** (new cases) of treated problem drug use among 15–64-year-olds living in Ireland was marginally lower in 2006 (74.8 new cases per 100,000) than in 2001 (75.7 new cases). The relatively stable incidence observed during the period masks separate trends in the former health board areas. The number of new cases increased outside of Dublin. An opiate (mainly heroin) was the most common main problem drug reported by new cases who lived in Dublin. There was a 31%

decrease in the number of new opiate cases who lived in Dublin, from 675 in 2001 to 468 in 2006, indicating that the heroin epidemic in this area has abated. In contrast, there was a 96% increase in the number of new opiate cases who lived outside Dublin, from 226 in 2001 to 442 in 2006. The main problem drugs reported by new cases were cannabis (41%), opiates (39%) and cocaine (9%). The vast majority (72%) of new cases treated between 2001 and 2006 reported problem use of more than one substance (polysubstance use). In general, problem drug users are young and male, have low levels of education and are unlikely to be employed. Though small, the proportion of cases who reported being homeless and the proportion not born in Ireland increased steadily during the reporting period.

- Information on drug testing in prisons from 2005 to 2007 was obtained from the Irish Prison Service. According to this data, more than 20,000 voluntary tests were carried out each year to monitor drug use and responses to treatment. These tests included those carried out on committals (new entries) as well as on existing inmates. It may be assumed therefore that some of the positive test results relate to drugs or alcohol consumed outside the prison. Between one-third and one-half of those screened tested positive for at least one drug. The common metabolites detected indicated use of cannabis, benzodiazepines and opiates. It is not clear whether the numbers of positive cases excluded prisoners who were prescribed benzodiazepines; if they do not, these figures overstate the extent of unregulated use of benzodiazepine in prisons. Cocaine and alcohol were detected in a small number of tests.

#### 5. Drug-related treatment

- A study was conducted to estimate the availability of and requirements for residential treatment beds for problem drug and alcohol users in Ireland. In highlighting a deficit of 356.5 beds (104 inpatient detoxification and 252.5 rehabilitation), the working group noted the estimated 66 beds in psychiatric units and hospitals that are currently used for alcohol and drug problems and which will no longer be available as a result of the restructuring proposed in the report of the expert group on mental health policy. Of the estimated 63 beds required for inpatient detoxification for drug users, one 50-bedded unit should be provided between the Dublin Mid-Leinster and Dublin North East HSE regions where, the data indicate, the majority of opiate and benzodiazepine users live. The remaining 13 beds should be divided between the HSE Southern and HSE Western Regions. In the case of services focusing primarily on the treatment of alcohol problems (detoxification and residential), the beds need to be evenly spread over the four HSE regions (16 per region) since the data suggest a more even distribution of alcohol-related problems throughout the country. The authors of the report recommended that *Quality in Alcohol and Drugs Services* (QuADS) suite of organisational standards and the *Drug and Alcohol National Occupational Standards* (DANOS), developed in the UK by Alcohol Concern and Drugscope and Skills for Health, be adapted for use by drug and alcohol services in Ireland.
- The HSE's *National Service Plan 2008* (NSP) outlines the agency's plans in the drugs and alcohol area during 2008. The HSE's Addiction Services, including both illicit drugs and alcohol, are delivered through Social Inclusion Services, which is part of the Primary, Community and Continuing Care (PCCC) directorate. The performance targets for Addiction Services in 2008 have been set as follows: Percentage of substance misusers for whom treatment commenced within one month is to exceed the 84% level achieved in 2007. The average number of clients in methadone treatment per month is to reach 7,000, the same level as in 2007. No target has been set for a third performance measure – the number of substance misusers under 18 years for whom treatment is commenced.
- In 2006, 12,744 cases were treated for problem drug use. Of these, 7,269 opiate cases continued in treatment from 2005 and 5,475 drug cases entered or returned

to treatment during 2006 (includes double counting). This figure does not include cases who reported alcohol as their main problem drug but used other drugs.

- Just over 2,300 methadone treatment places have been created since the beginning of the current National Drugs Strategy (2001–2008) and the number of outpatient services has increased by 25%.
- Of the 5,191 cases entering treatment for problem drug use in 2006 and residing in Ireland, 51% received counselling as an initial intervention, 39% received methadone substitution, 17% received a brief intervention and 14% attended medication-free therapy. Thirty-six per cent of cases received more than one initial treatment intervention.
- New services and programmes for addicted prisoners were developed in 2006. These were delivered by the IPS in partnership with the Health Service Executive (HSE) and contracted private services. In addition interventions were taken to decrease drug supply to prisoners.
- ROSIE Findings 3 demonstrates that participation by opiate users in an abstinence-based treatment programme in Ireland is followed by positive outcomes in relation to drug use, involvement in crime, and physical and mental health symptoms. The outcomes for ROSIE participants in abstinence-based treatment compare favourably with international outcome studies. The forthcoming results from the ROSIE three-year follow-up will provide stronger evidence on the effectiveness of abstinence-based treatment programmes and on whether improvements observed at one year have been sustained.
- On 12 November 2007 a client evaluation study of the Keltai (abstinence-based) treatment centre in Dublin was published. The study reported that a large proportion of those who started treatment completed it (83%, 58/70). Half (29/58) of those who completed treatment were drug free in the month prior to this study interview. The abstinence rate for men (50%) was higher than that for women (39%). The proportion who committed at least one crime during the 30 days prior to interview was lower among those who had not used drugs in that time than among those who had, 15% compared to 30%. Five of the 29 who had used at least one drug in the last month had injected it. These findings are in line with the ROSIE findings 3.
- ROSIE Findings 2, the second bulletin from the Research Outcome Study, provides a summary of the outcomes for the 81 people in the detoxification modality one year after treatment intake. The authors noted that the findings presented in this paper demonstrate that participation in a detoxification programme is followed by reduced drug use and injecting, decreased involvement in crime, improved physical and mental health and increased contact with social care services. The outcomes for ROSIE participants in detoxification treatment are positive when compared with national and international research. As noted in the paper, detoxification is part of a process that enables individuals to engage in further treatment (such as residential rehabilitation). Additional analysis of the ROSIE data is required in order to determine the effects of aftercare or follow-on interventions on treatment outcomes for those who have successfully completed a detoxification programme.
- A series of seminars was held on 8 April with health care professionals and community and voluntary groups to introduce intra-agency community methadone detoxification protocols. It aimed to give opportunities for discussion around offering community detoxification as a viable alternative option for people.
- These protocols will be piloted in the North Inner City Drugs Task Force (NICDTF) area over the next 18 months. They aim to provide an option for people who find it difficult to take up a residential detoxification bed due to family or work commitments. They may also benefit individuals who want to reduce their

methadone dosage in order to access a residential programme. They were developed in response to concerns voiced by the community and by drug users that people were being 'parked' on long-term methadone maintenance.

- On 24 February 2007 the combination drug Suboxone was launched in Ireland. The Department of Health and Children has established an expert group to consider the implications of the introduction of this drug and its use as a treatment for opiate dependency. In order for this drug to be prescribed, a system similar to that existing for methadone, including a protocol and a central register, will be required.
- In December 2007 the Dublin Simon Emergency Shelter started to implement the Safetynet methadone programme. Safetynet is a primary care network funded by the HSE that aims at providing GP and nursing services to homeless people. Fourteen residents were initiated on a methadone programme during a six-month project period. With little more additional budget than the standard cost for dispensing methadone, the programme proved to be successful. An evaluation after the six-month period highlighted many benefits such as:
  - reduction in drug use
  - decrease in morbidity, especially skin conditions and abscesses, largely attributed to the decrease in injecting by clients
  - reduction in the number of evictions from the shelter
  - reduction in crime
  - improvement in social functioning
  - increase in numbers moving to more permanent accommodation
- ROSIE Findings 4 provides a summary of the 1-year outcomes for people in the methadone modality one year after treatment intake. The authors state that the findings presented in this paper demonstrate that retention in methadone treatment is high, and continued participation in a methadone programme substantially reduces opiate use, injecting drug use and involvement in crime. The outcomes for ROSIE participants in the methadone modality compare favourably with international outcome studies. Although rates of improvement in physical and mental health were disappointing, it is hoped that results from the ROSIE three-year follow-up will provide evidence of a positive association between long-term treatment and improvements in physical and mental health.
- A study of 440 patients on methadone maintenance therapy at the Drug Treatment Centre Board in Dublin during a three-month period in 2004 was published in 2007. This study aimed to measure the rates of ongoing heroin use among these patients, and to identify patient and treatment characteristics associated with poorer outcome. Just over one-third (34%, 147) of patients had opiate-negative urine samples during the period under observation and a further 20% (90) had opiate-negative urine samples at least 80% of the time. Those with opiate-positive urines more than 20% of the time were considered unsuccessful treatments. Factors significantly associated with lower rates of opiate abstinence were a methadone dose of less than 60 mg, cocaine abuse and intermittent benzodiazepine abuse.

#### 6. Health correlates and consequences

- The first round of data collection (1998 to 2005) for the National Drug Related Deaths Index has been completed. It can now provide all data for direct and indirect drug-related deaths and so give a reliable estimate of the total burden of mortality related to drug use in Ireland.
- Between 1998 and 2005, opiate-type drugs were implicated in 75.8% of all single drug overdoses and 96.0% of all poly-substance overdoses.

- The majority of poisonings were due to poly-substances (59.7%). Prescription drugs including benzodiazepines and alcohol also contributed to many poly-substance deaths.
- Indirect deaths have risen steadily, from 64 cases in 1998 to 168 cases in 2005.
- Drug overdose was the most common form of deliberate self-harm, representing 74% of all such episodes reported in 2006-2007. Forty-two per cent of all drug overdoses involved a minor tranquilliser, 30% involved paracetamol-containing medicines and 22% involved anti-depressants/mood stabilisers. There was evidence of alcohol consumption in 41% of all episodes of deliberate self-harm emphasising the strong association between alcohol consumption and suicidal behaviour.
- There were 54 newly-diagnosed HIV cases in 2007, who reported injecting drug use. Of the 54 new HIV cases among injecting drug users reported to the HPSC in 2007, 35 were male and 15 were female and the average age was 31 years. All 39 cases for whom place of residence was known lived in the HSE Eastern Region (Dublin, Kildare and Wicklow).
- Murphy and Thornton (2008) reported that there were 1,558 cases of hepatitis C reported in 2007, compared to 1,130 cases in 2004, and 85 cases of hepatitis 'type unspecified' in 2003. Of the cases reported in 2007, 77% were notified by services in Dublin, Kildare and Wicklow and the remainder by HSE areas outside these counties. Age-standardised hepatitis C rates per 100,000 of the population living in each former health board area were calculated, by the authors for the years 2004 to 2007. In 2007, the rate was highest in the Eastern Region (over 70 per 100,000) and lowest in the North West (at 10 per 100,000). The rate of hepatitis C cases per 100,000 of the population increased in each of the former health board areas in 2007 compared to 2004. Sixty-three per cent of hepatitis C cases reported were male. Of the cases for whom age was known, 92% were aged between 20 and 54 years.
- In 2006, 663 cases were admitted to psychiatric facilities with a **drug disorder**, of whom 250 were treated for the first time. The report containing this information does not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate.
- A study was conducted to determine the proportion of those attending the Mater University Hospital's (in Dublin) psychiatric service that are homeless. A total of 628 patients were seen in Mater University Hospital during the study period, and 13.8% were homeless. Of the homeless, 56.3% were seen as emergency referrals in the A&E, 23% were inpatients (including the psychiatric unit and consultations in medical/surgical wards) and 20.7% were seen in the outpatient department. Of all the A&E referrals to psychiatry, 34.8% were homeless. The homeless presented most commonly in suicidal crisis (26.6%), compared with 12.5% in the non-homeless group. Substance-abuse disorders were the primary diagnosis in 42.3% of the homeless group, accounting for 14.2% in the housed sample.
- The total number of overdose cases involving known illicit drugs for 2005 was 264. In 16% (41) of these overdose cases more than one known illicit drug was used. Cocaine occurred in over a quarter of cases (27.5%, 71). Opiates occurred in 29.5% (76) of cases. Of note, benzodiazepines were used in conjunction with a known illicit drug in 15% (39) of cases. The poisoning was intentional in 37.6% (97) of cases and 80% were male.

## 7. Responses to health correlates and consequences

- A study which aimed 'to explore drug users' experiences and perspectives of overdose' was carried out in Dublin in 2006. The numbers of personal overdoses

among the participants ranged from two to 30. The most recent overdose was accidental in six cases and intentional in four cases. All 10 had engaged in polydrug use in their most recent overdose. Five of the six participants who had accidentally overdosed had used heroin, and one of the four who had intentionally overdosed had used heroin. The most common drug used was methadone and all 10 participants had consumed methadone in their most recent overdose. Three of the participants reported intentionally overdosing on a combination of prescribed methadone and other prescription medication. Trigger factors for intentional overdoses included sexual abuse, physical abuse, depression and recent bereavement. Perceived reasons for accidental overdoses included reduced tolerance to drugs following a period of abstinence, variation in the quantity and quality of heroin used, and polydrug use, especially of benzodiazepines or alcohol in conjunction with heroin. Only one of the 10 participants was able to name the heroin antidote given to overdose victims. All 10 participants had witnessed another person overdosing. They were questioned about their knowledge of overdose intervention, how they had intervened and, if they had not, why they had not. Interventions such as slapping the victim, walking them around, dousing them with water, using mouth-to-mouth resuscitation and placing them in the recovery position were implemented before an ambulance was called. In general, an ambulance was called only in cases where there was serious danger, and only then after a delay of at least 10 minutes. In cases where the participants witnessed an overdose and did not intervene, the most common reason given was fear of police involvement.

- A booklet titled *You are not alone: help and advice on coping with the death of someone close* was published recently. It provides practical advice and support to those who have been affected by suicide or an unexpected death. The booklet is divided into five sections: immediate reactions; natural responses; events that occur following a death; sorting out your affairs; and getting help for you and your family. Each section deals with the different stages of the bereavement process.
- The Ballyfermot Hepatitis C Campaign was run in 2007 to raise awareness of hepatitis C and of the options for its investigation and treatment at appropriate services. As part of the campaign, information booklets were published for three different audiences – active drug users, ex-drug users who injected at some time in the past, and GPs caring for people with hepatitis C.
- On 19 May 2008, the *Blood Borne Virus Forum* marked *World Hepatitis Day* with an Open Day at *Community Response*, Carman's Court. The purpose of the open day was to raise awareness about hepatitis and in particular about hepatitis C. Two short films were shown - *Hidden I* and *Hidden II* – both of which were produced by Community Response Drama Group and developed through improvisation and role play. *Hidden I* is an educational drama about drug use, pregnancy and hepatitis C, while *Hidden II* continues the story and educates the viewer about testing and treatment for hepatitis C. A new *Hidden* hepatitis C awareness board game and DVD were launched at the event.
- On 3 April 2008, Merchants Quay Ireland (MQI) launched the booklet *Safer injecting* at a seminar focused on reducing the harm associated with injecting drug use. This safer injecting guide is produced for people who inject drugs. The booklet includes advice about safer injecting practices and different types of injecting – into a vein or muscle, or under the skin (skin popping).
- Adverse drug reactions account for approximately 5% of acute medical admissions. Falconer and Molloy (2007) published a case history about a 34-year-old male patient who received antiretroviral therapy, methadone and flurazepam and then presented to the emergency room following collapse with associated loss of consciousness. Cardiac monitoring demonstrated marked Q-T prolongation followed by the cardiac arrhythmia, known as torsade de pointes. The patient made a full recovery following withdrawal of the antiretroviral therapy and a reduction in

methadone dose. Methadone is a recognised cause of this potentially fatal cardiac arrhythmia, which is more likely to occur when methadone metabolism is inhibited by drugs such as HIVtease inhibitors.

#### 8. Social correlates and consequences

- Research among homeless young people aged 16–25 in the south of Ireland revealed that being in state care, experiencing abusive family situations and family conflict and exhibiting problematic behaviour such as abusing drugs and alcohol can create 'pathways to homelessness' and further exclusion.
- Unemployment and early school leaving were a problem for a significant proportion of drug users reporting for treatment over the period 2001-2006.
- Although cannabis as a proportion of possession offences prosecuted decreased in 2006, cannabis-type substances have consistently accounted for the majority of these prosecutions, representing 6,947 (49.6%) of the total in 2006.
- Annual total recorded incidents of driving/in charge of a vehicle while under the influence of drugs have increased since 2004. The largest increase was recorded between 2006 and 2007, when these incidents doubled. This was followed by an increase of 140% (49) between quarter 1 of 2007 and of 2008.
- A study titled *Recidivism in the Republic of Ireland* was published in 2008. This study explored the levels and patterns of recidivism in the Irish context, while also drawing out the implications of the patterns observed. A previous sentence was found to be one of the strongest predictors of recidivism in Ireland. Drug offenders represented 42.07% of the total sample studied who were re-imprisoned within 36 months of completing a sentence.
- A number of specific measures have been taken in order to combat the supply of drugs into prisons. There are new prison visiting arrangements, involving greater control over the number and identity of visitors. In addition, there is enhanced supervision of such visits. Prisoners may only receive visits from identified and known persons, reducing the likelihood of visitors attempting to pass drugs on. Improved technology for searching cells and prison property was also introduced.
- Information on drug testing in prisons from 2005 to 2007 was obtained from the Irish Prison Service. More than 20,000 voluntary tests were carried out each year to monitor drug use and responses to treatment. Between one-third and one-half of those screened tested positive for at least one drug.
- The Irish Prison Service (IPS) Annual Report 2006 stated that of the 12 deaths in custody in 2006, five were suspected drug overdoses.

#### 9. Responses to correlates and consequences

- Measures tackling vocational training, employment and educational opportunities for drug users are being planned and developed on foot of recommendations made in the Report of the Working Group on Drugs Rehabilitation.
- An evaluation of the Georges Hill Step-Down facility shows the merits of inter-agency collaboration in improving accommodation outcomes for individuals who have been in residential drug treatment.
- An evaluation of the Bridge to Workplace Initiative shows the benefits of an inter-agency response to improving the employability of drug users by successful work placements.

- Participants on the Keltoi Residential Drug Treatment programme achieved paid employment 1–3 years following residential treatment.
- Research shows that for some drug users, difficulties persist in obtaining medical cards which has implications for accessing basic healthcare.
- An innovative programme of intra-agency community-based methadone detoxification protocols was introduced which may benefit methadone clients who are in employment.
- The *IPS Annual Report 2006* details the enhancement of treatment services to prisoners during that year. This was achieved by the development of new services and programmes for prisoners with an addiction. These services are being delivered by the IPS in partnership with community based services, including the Health Service Executive and contracted private services.
- The Local/Regional Drugs Task Force Community Representatives Conference, facilitated by CityWide Drugs Crisis Campaign and hosted by the National Drugs Strategy Team (NDST) and the Inter-Departmental Group on the National Drugs Strategy (IDG), took place at the Killeshin Hotel in Portlaoise from 4 to 6 April. In light of the development of the new National Drugs Strategy 2009–2016, the main objective of this conference was to consult with community representatives so as to identify priority actions needed to address drug misuse in communities.

#### 10. Drug markets

- The upward trend since 2004 in relevant legal proceedings for drug supply continued in 2006. Although the majority of such proceedings still take place in the Dublin Metropolitan Region (DMR), the proportion of the total number which takes place outside the DMR has increased since 2004.
- With regard to cocaine, Customs Drug Law Enforcement (CDLE) reported an ongoing trend of import by air passengers and express mail service post.
- CDLE also reports the continued involvement of West African Organised Crime Gangs (OCGs) in organising importations of cocaine.
- There have been media reports that methamphetamine (meth) has become available on the Irish illicit drug market. To date very few seizures have been made. However, CDLE reports there have been a number of detections of ephedrine tablets in the post since January 2008. This indicates the possible production of methamphetamine within the State.
- Cannabis seizures accounted for the majority of all drugs seized in 2006. Of the 8,417 reported drug seizures that year, 4,243 (50.4%) were cannabis-related.
- Data published by the Central Statistics Office in 2008 show that there has been a continuous steady rise in cocaine seizures since 2003. Heroin seizures rose sharply during 2006, increasing from 763 in 2005 to 1,254 in 2006. The number of seizures of ecstasy-type substances also rose in 2006, following a steady decline since 2003.
- The data for 2007 include the largest ever seizure of cocaine in Ireland where 1550, kg of cocaine were recovered from Dunlough Bay in County Cork after drug smugglers ran into difficulties in stormy weather conditions. Evidence from their subsequent trial suggests that the cocaine may not necessarily have been destined for Ireland but may, according to CDLE, represent a 're-emergence of the threat from the maritime sector'.



- A review of the Forensic Science Laboratory (FSL) has found that approximately one-third of drug samples submitted by the Garda Síochána for analysis between 2000 and 2006 were not processed because of resource limitations. The review concluded that the current resource limitations have implications for crime control and law enforcement
- A report due to be published by the Health Research Board in October 2008 used a Rapid Situation Assessment technique to determine the nature and extent of the crack cocaine market in the Dublin region.
- Despite widespread concern about the societal impact of illicit drug markets and related crime, there has been an almost total absence of in-depth research and analysis of the organisation and operation of illicit drug markets in Ireland. A study currently being undertaken by the Alcohol and Drug Research Unit of the Health Research Board seeks to fill this significant knowledge gap. This study was commissioned by the National Advisory Committee on Drugs (NACD).

#### 11. Sentencing statistics

- The Courts Service, the Central Statistics Office (CSO) and the Irish Prison Service (IPS) are the three bodies which provide statistical information in relation to sentencing in Ireland. Recent improvements in data automation throughout the criminal justice system have enhanced our understanding of the operation of the system. However, there remain a number of limitations in the available information on sentencing practices throughout the criminal justice system. A recent study examined both levels and predictors of recidivism, and highlighted the data limitations within the criminal justice system. For example, the sharing of information on offences or offenders between the police, courts, prisons and probation data systems is not possible. This is despite the fact that recidivism rates are integral to evaluations of the efficacy of different judicial sentences and punishments.
- There is also limited evidence of a coherent sentencing policy in Ireland, although there have been a number of pronouncements on the issue over time, particularly in support of the use of alternatives to custody and the introduction of mandatory minimum sentences for certain drug supply offences. A complication which arises in the context of sentencing policy in Ireland relates to the role of judicial discretion in the determination of the appropriate sentence. The separation of powers ensures that judges ultimately have discretion when it comes to sentencing. On occasion, the judiciary has come under scrutiny by policy makers as the latter have suggested that judicial discretion is not being exercised in a manner consistent with policy as determined by the legislature, particularly in relation to the reluctance to implement mandatory minimum sentences in drug cases. The Criminal Justice Act 2007 has introduced new provisions to address this issue.
- With regard to disposing of offences, the Garda Síochána have a range of options available, including confiscation and informal warning, caution, juvenile diversion, arrest referral or prosecuting in the District Court. The courts have extensive discretion and a range of options at their disposal: community service orders, entering into recognisance, detention, suspended detention, dismissal, fines, imprisonment, suspended imprisonment, peace bond, contributing to the poor box, probation, acquittal, intensive community supervision and supervision during deferment of penalty. Offenders can also be referred to the drug treatment court.
- Fines continued to be the most common response to drug offences in 2006, accounting for 27% (2,418) of such offences. This was followed by cases struck out (21%) owing to insufficient evidence, imprisonment/detention (10%) and community service (2%). In general, convictions were by far the most common outcome for possession of drugs for sale or supply and possession for personal use offences between 2003 and 2006. Cases pending increased steadily, representing the most

common outcome in 2006 for summary drug offences. A recent review of the drug treatment court reported that 22 participants graduated between January 2001 and July 2008, implying that one in five entries (23%) to the Drugs Court is successful.

# Part A: New Developments and Trends

## 1. National Policies and Context

### 1.1 Overview

The classification of drugs and precursors in Ireland is made in accordance with the three United Nations conventions of 1961, 1971 and 1988, which introduced controls in relation to legitimate scientific or medical use of drugs and precursors that also take into account the particular risks to public or individual health. Irish legislation defines as criminal offences the importation, manufacture, trade in and possession, other than by prescription, of most psychoactive substances. The principal criminal legislative framework is laid out in the Misuse of Drugs Acts (MDA) 1977 and 1984 and the Misuse of Drugs Regulations 1988. The offences of drug possession (s.3 MDA) and possession for the purpose of supply (s.15 MDA) are the principal forms of criminal charge used in the prosecution of drug offences in Ireland. The Misuse of Drugs Regulations 1988 list under five schedules the various substances to which the laws apply.

Since 2001, the National Drugs Strategy 2001–2008 has provided an implementation framework for illicit drugs policy. The Strategy has an overall strategic objective, 'To significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research'. A mid-term review of the National Drugs Strategy in 2005 recommended the inclusion of a fifth 'pillar' to realise the strategic objective – Rehabilitation. A hierarchy of 'inter-agency co-ordinating mechanisms' helps co-ordinate the policies and activities of over 20 statutory agencies, multiple service providers and community and voluntary groups involved in delivering the Strategy at government, national, regional and local levels.

Priorities for public expenditure on the drugs issue are set out in the National Drugs Strategy and the National Development Plan. Public funding comes from the annual parliamentary Estimates process; also funded through the Estimates process are social inclusion measures, which have an impact on the drugs issue. Other funding mechanisms include the Dormant accounts and National lottery.

This section provides an overview of recent legislative developments in the context of illicit drugs. It also reviews recent developments in drug interdiction and drug law enforcement. It also provides an update on developments in the institutional framework, strategies and policies, on the most recent budget and public expenditure data, and the social and cultural context.

### 1.2 Legal framework

#### 1.2.1 Laws, regulations, directives or guidelines

The Misuse of Drugs (Amendment) Regulations 2007, SI No. 200 of 2007, allows for registered nurses to prescribe certain controlled drugs in limited circumstances.

The Maritime Analysis & Operations Centre-Narcotics (MAOC-N) in Lisbon was established to address the trafficking of cocaine from South America and the Caribbean into Europe. This agreement involving Ireland and six other EU member states was signed by Brian Lenihan, TD, Minister for Justice, Equality and Law Reform, in Lisbon on 30 September 2007. At its meeting in July 2008 the Government confirmed the final arrangements to give effect to Ireland's being bound by the agreement. A Customs Officer is to be assigned to MAOC-N in due course. A Garda member is also to be assigned.

The Criminal Justice (Mutual Assistance) Act 2008 commenced on 1 August 2008. The Act defines the competent authorities in relation to controlled deliveries and confirms current procedures adopted in relation to controlled deliveries of drugs. The associated memorandum of understanding and operational protocol has been placed in the library of the Oireachtas (Irish Parliament).

### **1.2.2 Laws implementation**

For an update on the establishment of Joint Policing Committees, provided for under the Garda Síochána Act 2005, see section 9.3.2.

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

### **1.3.1 Co-ordination**

There have been no new developments in the last 12 months. The proposed National Drug Rehabilitation Implementation Committee, described in last year's national report, has not yet been established.

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

The National Drugs Strategy 2001–2008 is due to expire at the end of 2008. At the start of 2008 the Minister of State with responsibility for the Drugs Strategy, Pat Carey TD, established a Steering Group, chaired by the Department of Community, Rural and Gaeltacht Affairs and comprising representatives of the key statutory, community and voluntary interests involved in tackling problem drug use, to develop proposals for a new drugs strategy to run from 2009 to 2016. The Steering Group is scheduled to present its recommendations to the Minister of State on a new drugs strategy before the end of 2008. In April 2008 the Minister of State announced a series of public meetings to be held in 15 locations countrywide as part of the consultation process (Carey 2008). The Minister of State said, 'I see these meetings as being central to the work of formulating a new National Drugs Strategy. It is very important for me to hear the views of a cross-section of the public, young and old, as part of the development of a new Strategy.' He added: 'I will also be holding an extensive series of meetings with Government Departments and agencies and with community and voluntary interests. But the public consultation phase allows members of the public who are not directly represented by any of these groups to air their views and to put forward proposals on drug misuse and associated issues. The new Strategy will run for eight years and, though there will be opportunities for review during that period, it is important that we get it right from the outset so that we can best tackle this major issue in our society.'

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

The Social Inclusion Report Ireland 2006–2007 (Office for Social Inclusion 2007) reported progress against the targets/actions contained in NAPinclusion 2007–2016 (Government of Ireland 2007). Under the heading 'Children' it reported progress on various initiatives impacting on the drugs issue, including the European School Survey Project on Alcohol and other Drugs (ESPAD), the Survey of Lifestyles, Attitudes and Nutrition (SLÁN) and the Health Behaviour in School-aged Children Survey (HBSC); early school-leaving initiatives; implementation of the provisions in the Children Act 2001; the management of Youthreach Centres; the Youth Homeless Strategy; and the Young Peoples' Facilities and Services Fund (YPFSF). Under the heading 'Communities' it reported progress in respect of the Dormant Accounts Fund, a revised Community Development Programme 2007–2013, the RAPID Programme and the National Drugs Strategy.

### **1.3.4 Evaluation of policies and strategies**

Ireland's National Drugs Strategy 2001–2008 document did not make provision for a final review or evaluation (it did call for a mid-term evaluation), and no final evaluation

is being undertaken. See under National plan/strategies section above for an outline of the approach being taken to the development of the new strategy.

The National Advisory Committee on Drugs (NACD) commissioned a team of external researchers to evaluate the development and delivery of the National Drugs Awareness Campaign, which ran between 2003 and 2005. The report on this process evaluation was published in January 2008 (Sixsmith and NicGabhainn 2007). In an extensive review of the literature, the evaluation team identified best practice criteria for developing a drugs awareness campaign. The development and implementation of the national campaign were assessed against these criteria. See Section 3.2.2 for an account of the evaluation findings.

## **1.4 Budget and public expenditure**

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

With regard to public expenditure in Ireland on drugs since 2001, the Minister of State with responsibility for the Drugs Strategy, John Curran TD, provided the following information (Curran 29 May 2008). Please note, the figure for public expenditure for the year ended 31 December 2007 was not available at the time he provided this information.

The following table [Table 1.4.1] sets out the amounts estimated to have been spent on the National Drugs Strategy in the period since 2001. In this context, it should be noted that expenditure under the Young Peoples Facilities and Services Fund (YPFSF) was managed by the Department of Education and Science up to 2002. Responsibility for this funding transferred to my Department from 2003, which significantly increased the overall departmental spend on the drugs area in that year.

The drop in expenditure by my Department in 2004 arose from the mainstreaming of a number of community based drugs projects to other Departments and agencies that year. The relevant funding to support the ongoing activities of the projects transferred to the other Departments and agencies in this context.

Expenditure by other Departments on the drugs area has been compiled since 2005. The figures for 2005 and 2006 should be interpreted as indicative, however, as they relate only to services that are considered to be directly attributable to dealing with problem drug use. They do not take account of mainstream services that are available generally to the public, but which problem drug users can also avail of.

Finally, the Deputy should note that the allocation under the Drugs Initiative/Young Peoples Facilities & Services Fund in my Department's Vote for this year is €64.332m, an increase of 25% on the outturn for last year.

Expenditure to date this year is approximately €26m.

Table 1.4.1 Public expenditure on drugs since 2001

Year	Expenditure		Total
	Dept. of Tourism, Sport and Recreation/ Dept. of Community, Rural and Gaeltacht Affairs	Other Departments/ Agencies	
	€m	€m	€m
2001	8.743	Not known	Not known
2002	13.467		
2003	36.463		
2004	27.510		
2005	33.962	160.97	194.932
2006	41.304	169.82	211.124
2007	51.518	Being compiled	
2008 to date	25.770		
Total	238.737		

Source: Curran 29 May 2008

### 1.4.1 Funding arrangements

There have been no new developments in the last 12 months.

## 1.5 Social and cultural context

### 1.5.1 Public opinions of drug issues

Landsdowne Market Research carried out a survey on behalf of Eireann Healthcare on public attitudes towards and knowledge about over-the-counter (OTC) medicines.<sup>2</sup> Key findings from the survey showed that:

More than one in four people (26%) think aspirin helps stomach pain.

Less than one-third of people surveyed know that OTC medication is available for thrush and would visit a GP for prescription medication rather than self-medicate.

Almost half of respondents (45%) were unaware that OTC medication was available for eczema and would visit a GP for prescription medication.

Almost half of respondents (48%) would give aspirin to children under 16.

Only 34% of female respondents knew about the dangers of taking paracetamol during pregnancy.

Eighty five per cent of people surveyed would be confident to receive OTC treatment for a minor illness from a pharmacist rather than a GP if the option was available.

### Flash Eurobarometer on young people and drugs

In May 2008 Eurobarometer published the results of a survey of young EU citizens' attitudes to and perceptions of the drugs issue (The Gallup Organisation 2008). The fieldwork was carried out between 14 and 18 May 2008. Over 12,000 randomly selected 15–24-year-olds were interviewed across the 27 EU member states. The survey was carried out by telephone, with web-based computer assisted telephone interviewing (WebCATI).<sup>3</sup> The findings relating to Irish respondents are summarised below.

### Potential and actual sources of information on drugs

Ireland had the highest proportion of respondents who would choose to talk to a friend when looking for more information about illicit drugs and drugs use. Irish young people were also among those most liable to talk to their parents or relatives about drugs and

<sup>2</sup> Nalini Nathan of First Medical Communications provided an outline of the survey results for this report. [www.firstmedical.ie](http://www.firstmedical.ie)

<sup>3</sup> To correct for sampling disparities, a post-stratification weighting of the results was implemented, based on socio-demographic variables.

drug use. While Irish respondents favoured talking to a health professional such as a doctor or nurse, they clearly did not favour talking to a counsellor or someone else at a specialised drug centre. When asked about information channels used in the past year, Irish respondents reported a rather different pattern: they had drawn principally on media campaigns, followed by friends, and then Internet sources.

### **Perceived health risks of using drugs**

Respondents were asked to rank the health risks associated with various substances as high, medium or low. Substances seen by most Irish respondents as posing a medium or high risk to health were heroin (98.7%), cocaine (98.5%) and ecstasy (95%). Smaller percentages of respondents regarded as medium or high the risk posed to health by tobacco (78.8%), cannabis (74.2%) and alcohol (73.5%). Only 12.7% perceived alcohol as posing a high risk, while 28.4% deemed tobacco and 30.1% deemed cannabis as posing a high risk.

### **How should society's drug problems be tackled?**

Respondents were asked to rank a series of actions that public authorities could take to deal with the drug problem as either the 'most effective' or the 'second most effective' way of combating the problem. Respondents in Ireland were among the least likely to see the clampdown on drug dealers and traffickers as effective. Conversely, Irish respondents were among the most likely to believe that the treatment and rehabilitation of drug users was an effective way to deal with society's drug problems. Irish respondents (22%), along with those in the UK and The Netherlands, most favoured the legalisation of drugs.

### **To ban or regulate illicit drugs, alcohol and tobacco?**

Substances that most Irish respondents felt should continue to be banned were heroin (97%), cocaine (95%) and ecstasy (95%). Just 61% of Irish respondents believed that cannabis should continue to be banned, and 39% believed that it should be regulated. With regard to alcohol, the largest proportions of respondents who supported continued regulation were found in The Netherlands and Ireland (96%); just 4% of Irish respondents favoured the banning of alcohol. With regard to tobacco, 80% of Irish respondents believed that it should continue to be regulated, while 20% believed it should be banned.

### **Access to illicit drugs, alcohol and tobacco**

With regard to illicit drugs, Irish respondents were among the most likely to say that it was easy to obtain heroin, cocaine, ecstasy and cannabis, if they wanted to. Young people in Ireland were among those most likely to say that they could easily obtain alcohol and tobacco. Cross-tabulating respondents' perceptions of the health risks associated with drug use and their answers relating to the ease of obtaining the drugs showed that young people who found it easier to obtain the substances also perceived the health risks associated with drug use to be less serious.

## **1.5.2 Attitudes to drugs and drug users**

A report on public attitudes to mental health was published (National Office for Suicide Prevention 2007). One thousand adults were interviewed in their own homes in January and February 2007. The overall objective of the research was to obtain a comprehensive view of attitudes to mental health, including alcohol and substance use. The findings of the study will be used to inform a mental health awareness and attitudes campaign.

Among the findings, it was found that there was an under-estimation of the prevalence of mental health problems in Ireland. Two-thirds estimated a prevalence of one in ten or less, while only 5% estimated a prevalence of one in four. Suicide (25%), alcoholism (19%) and depression (19%) were identified as the top three most important mental health problems that needed to be tackled. Drug dependence was cited by 13% as the single most important mental health problem. Men were more likely than women to

identify alcoholism (22% vs. 19%) or drug dependence (17% vs. 13%) as the most important mental health problem.

While a substantial proportion of people (85%) agreed that 'anyone can experience mental health problems', the report revealed that stigma still exists in relation to mental health. Sixty-two per cent of respondents would not want people knowing about it if they themselves were experiencing mental health problems; 52% agreed that people with mental health problems should not be allowed to do important jobs, as doctors or nurses, for instance; and just 48% believed that the majority of people with mental health problems do recover.

Opinion was quite polarised on some issues related to mental health and there appeared to be fear among the general public surrounding mental health problems. Thirty-nine per cent felt that the public should be better protected from people with mental health problems; 36% felt that people with mental health problems were often dangerous; and 33% admitted that they would find it hard to talk to someone with mental health problems. However, 65% agreed that people with mental health problems were not to blame for their problems and 43% feared that they themselves might experience mental health problems in the future. Overall, there appeared to be an inherent acceptance that we are all potentially vulnerable to mental health problems.

### **1.5.3 Initiatives in parliament and civil society**

No new initiatives were taken by Parliament.

In April 2008 the NGO Merchants Quay Ireland (MQI), which provides a range of services for the homeless and for drug users, hosted a seminar 'An Injection of Common Sense', to mark the launch a new guide to safer injecting techniques for drug users (Merchants Quay Ireland 2008). The seminar was opened by the Minister of State with special responsibility for the Drug Strategy, Pat Carey TD. Speaking about the importance of harm reduction measures, the director of MQI, Tony Geoghegan, said, 'In the new national strategy we need to see a commitment to the extension of needle exchange programmes nationwide including evenings and weekends. It is also important to explore some of the interventions which have been successful internationally, e.g. Safer Injecting Facilities, where drug users are allowed to inject drugs onsite in an effort to reduce the sharing of injecting equipment, injuries which result from poor injecting techniques and the number of drug related deaths.'

In June 2008 the Irish NGO Drug Policy Action Group (DPAG) launched its third policy paper, on Ireland's prison drugs policy (O'Mahony 2008). Having reviewed the historical background and current issues under the five pillars of the National Drugs Strategy, the author concluded:

- There is an urgent need for properly designed and resourced custodial drugs treatment centres, where useful, abstinence-oriented programmes, such as therapeutic communities and cognitive behavioural therapies, could be provided for suitable prisoners.
- Rehabilitation should be tailored to the individual needs and potential for personal growth of prisoners, who very frequently come from a background of multiple disadvantage and who have often failed disastrously in the normal education system. A rehabilitative approach entails a strong focus on education, training and the purposeful occupation of prisoners. This means that all new prisons should be built at least to the standard of the Dochas Centre Women's Prison, exploiting modern technology and exemplifying positive advances in architectural design.
- In order to achieve a more rational, effective and rehabilitative prison system it is essential to adjust current sentencing policy and reduce the number of minor, non-violent, drug-using offenders sent to prison for short terms. The use of the Drugs



Court, mandatory drugs treatment outside the prison system and non-custodial sanctions should be greatly expanded.

- A more coherent drugs policy for prisons would put less emphasis on supply control and far more emphasis on the reduction of the many different types of harm caused to prisoners by the current drugs culture in prisons. A more coherent policy would place far more stress on abstinence-based treatments than on methadone substitution. A more coherent policy would recognise that improving prison conditions and providing an environment conducive to the general rehabilitation of offenders are absolutely essential to tackling the prison drugs problem.

#### **1.5.4 Mass media campaigns (national and regional)**

In February 2008 a new National Public Awareness Campaign focused on cocaine use was launched. The campaign will inform people about the dangers associated with cocaine use while dispelling the myths that exist around the drug. The key messages are:

- The high risk of poly-drug use, particularly alcohol and cocaine
- That cocaine is not a clean drug
- That cocaine is directly linked to crime
- That there is a cost to use – both personal and financial.

See section 3.3.1 for an account of the campaign approaches.

## **2. Drug Use in the General Population and Specific Sub-Groups**

### **2.1 Overview**

This section presents a summary of the findings of a survey estimating drug use among the general population in 2006/7 and compares these findings with those of the 2002/3 survey. One in four people in Ireland used an illicit drug at some point in their life in 2006/7 and one in five used cannabis. Cocaine use increased in 2006/7 compared to 2002/3. The proportion of adults who reported using cocaine (including crack) at some point in their lives increased from 3% in 2002/3 to 5% in 2006/7. This section also contains updated data on drug use among school-children. In the 2006 HBSC survey, 16% of children reported using cannabis during their lifetime, compared with 12% in 2002. Cannabis use was highest for those aged 15–17, with about one in five in this age group using cannabis in the previous 12 months.

Drug prevalence surveys of the general and school-child population are important in that they can shed light on the patterns of drug use, both demographically and geographically and, when repeated, can track changes over time. In Ireland such surveys are conducted every three to four years. These surveys help to increase our understanding of drug use, and to formulate and evaluate drug policies. They also enable informed international comparisons provided countries conduct surveys in a comparable manner.

### **2.2 Drug use in the general population**

#### **2.2.1 Drug use in the general population, 2006/7: repeat survey**

On 25 January 2008, the National Advisory Committee on Drugs (NACD) and the Drug and Alcohol Information and Research Unit (DAIRU) in Northern Ireland published jointly the results of the second all-Ireland general population drug prevalence survey.

The Irish survey followed best practice guidelines recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The questionnaire, based on the 'European Model Questionnaire', was administered in face-to-face interviews with respondents aged between 15 and 64 years normally resident in households in Ireland and Northern Ireland. With the exception of two questions and two show cards, the questionnaire employed for the 2006/7 survey was the same as that used in 2002/3. Fieldwork was carried out by MORI MRC during late 2006 and early 2007. The final achieved sample was 4,967 in Ireland. This represented a response rate of 65%. The sample was weighted by gender, age and region to ensure that it was representative of the general population. The main measures of use were lifetime (ever used), use in the last year (recent use) and use in the last month (current use). The detailed methodological background to the general population survey on drug use and the results are presented in Standard Table 1.

The proportion of adults (aged 15–64 years) who reported using an illegal drug in their lifetime increased by five percentage points, from 19% in 2002/3 to 24% in 2006/7 (Table 2.2.1). The proportion of young adults (aged 15–34 years) who reported using an illegal drug in their lifetime also increased by five percentage points, from 26% in 2002/3 to 31% in 2006/7. As expected, more men reported using an illegal drug in their lifetime than women.

The proportion of adults who reported using an illegal drug in the last year increased marginally, from 6% in 2002/3 to 7% in 2006/7 (Table 2.2.1). The proportion of young adults who reported using an illegal drug in the last year increased from 10% in 2002/3 to 12% in 2006/7. The proportion of adults who reported using an illegal drug in the last month remained stable.

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

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

\* Illegal drugs in this context are amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (Bulletins 1, 2005 & 2008)

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

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

Cannabis use	Adults 15–64 years		Males 15–64 years		Females 15–64 years		Young adults 15–34 years	
	%		%		%		%	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
Lifetime	17.4	21.9	22.4	27.0	12.3	16.6	24.0	28.6
Last year	5.0	6.3	7.2	8.5	2.9	3.9	8.6	10.4
Last month	2.6	2.6	3.4	4.0	1.7	1.1	4.3	4.2

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (Bulletins 1, 2005 & 2008)

Nine per cent of young adults claimed to have tried ecstasy at least once in their lifetime in 2006/7 (Table 2.2.3).

**Table 2.2.3 Lifetime, last-year and last-month prevalence of ecstasy use in Ireland, 2002/3 and 2006/7**

Ecstasy use	Adults 15–64 years		Males 15–64 years		Females 15–64 years		Young adults 15–34 years	
	%		%		%		%	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
Lifetime	3.7	5.4	4.9	7.2	2.6	3.6	7.1	9.0
Last year	1.1	1.2	1.7	1.8	0.5	0.6	2.0	2.4
Last month	0.3	0.3	0.7	0.5	0.0	0.2	0.6	0.6

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (Bulletins 1, 2005 & 2008)

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

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

**Table 2.2.4 Lifetime, last-year and last-month prevalence of cocaine use (including crack) in Ireland, 2002/3 and 2006/7**

Cocaine use	Adults 15–64 years		Males 15–64 years		Females 15–64 years		Young adults 15–34 years	
	%		%		%		%	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
Lifetime	3.0	5.3	4.3	7.0	1.6	3.5	4.7	8.2
Last year	1.1	1.7	1.7	2.3	0.5	1.0	2.0	3.1
Last month	0.3	0.5	0.7	0.8	0.0	0.2	0.7	1.0

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (Bulletins 1, 2005 & 2008)

The considerable increase in the proportions using any illegal drug at some point in their lives was influenced by the facts that drug use in Ireland is a recent phenomenon and that the population of lifetime and recent drug users in Ireland is relatively young. Drug use is measured among adults aged 15–64, and those leaving this age group over the next fifteen to twenty years are less likely to have been exposed to drug use than those entering the measurement cohort.

Survey data on drug use in the last year shows an increase in the proportions using cannabis and, to a lesser extent, cocaine. These results follow trends observed in treatment data.

When compared to the 19 other countries that completed a general population survey on drug use using the European model questionnaire, Ireland ranks seventh highest for lifetime use of cannabis, fourth for lifetime use of amphetamines, fourth for use of cocaine, third for ecstasy and third for LSD.

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

On 25 June the NACD published (2008a) a bulletin outlining drug prevalence data for 2006/7 by regional drugs task force (RDTF) area. As expected, the use of illegal drugs was lowest in the north west and highest in the east of the country (Table 2.2.5).

### The lifetime use of:

- Cannabis was the most commonly reported illegal drug in each of the RDTF areas, with proportions ranging between 13% in the North West and 36% in the East Coast areas (Table 2.2.6).
- Ecstasy was among the four most commonly reported drugs in each of the RDTF areas, with proportions ranging between 2% in the North West and 11% in North Dublin. (Table 2.2.7).
- Cocaine was among the top four drugs ever used by the survey respondents in all areas except the North West (Table 2.2.8). Lifetime cocaine use was highest in the North Dublin and East Coast areas.
- Poppers were among the four most commonly used drugs in the North West while amphetamines were among the more commonly used drugs in the South East.

Though the proportions were small, there was a significant increase in lifetime use of cocaine in five regional drugs task force areas in 2006/7 when compared to 2002/3 (Table 2.2.8).

**Table 2.2.5 Proportion of respondents who reported lifetime, last-year and last-month use of illegal drugs, by regional drugs task force area of residence**

RDTF area of residence	Percentage that used any illegal drugs*					
	Ever in lifetime		In year prior to survey		In month prior to survey	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
East Coast	25.9	38.4 <sup>†</sup>	6.3	12.4 <sup>†</sup>	4.1	5.3
North Dublin City & County	29.5	32.2	8.4	12.8	5.3	8.2
South West (Dublin)	24.0	25.6	7.5	7.4	4.3	2.0
South East	18.5	25.4	6.9	7.9	3.1	3.6
North Eastern	18.9	22.9	6.4	5.7	2.4	1.1
Midland	11.0	19.6 <sup>†</sup>	2.8	4.4	1.0	1.7
Mid West	12.0	18.0	3.2	5.8	1.6	1.4
Southern	12.1	16.3	4.7	4.9	2.1	2.0
Western	12.5	23.3 <sup>†</sup>	2.9	4.7	1.9	1.6
North West	10.6	14.5	2.6	2.9	0.2	0.3

\*Illegal drugs in this context are amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

<sup>†</sup>Significant changes in proportion for the two survey periods

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (Bulletins 2, 2005 & 2008)

**Table 2.2.6 Proportion of respondents who reported lifetime, last-year and last-month use of cannabis, by regional drugs task force area of residence**

RDTF area of residence	Percentage that used cannabis					
	Ever in lifetime		In year prior to survey		In month prior to survey	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
East Coast	24.5	35.9 <sup>†</sup>	6.1	11.3 <sup>†</sup>	3.8	4.2
North Dublin City & County	26.9	28.8	7.7	11.9	4.5	7.9
South West (Dublin)	23.2	24.0	7.3	6.7	3.9	1.8
South East	16.8	23.3	5.8	5.1	2.1	2.8
North Eastern	17.8	19.5	5.2	4.6	1.9	0.8
Midland	10.7	17.0	2.8	4.1	1.1	1.1
Mid West	10.9	17.0	3.0	4.7	1.6	1.4
Southern	11.6	15.0	4.4	4.6	2.1	2.0
Western	12.0	21.0 <sup>†</sup>	2.0	4.3	1.3	1.6
North West	9.3	12.8	2.2	2.9	0.2	0.3

<sup>†</sup>Significant changes in proportion for the two survey periods

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (Bulletins 2, 2005 & 2008)

**Table 2.2.7 Proportion of respondents who reported lifetime, last-year and last-month use of ecstasy, by regional drugs task force area of residence**

RDTF area of residence	Percentage that used ecstasy					
	Ever in lifetime		In year prior to survey		In month prior to survey	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
East Coast	5.4	7.6	2.5	2.3	0.9	0.5
North Dublin City & County	6.5	11.2	1.6	2.9	0.3	1.0
South West (Dublin)	5.9	4.1	1.3	0.5	0.0	0.0
South East	4.3	6.5	1.3	1.9	1.3	0.3
North Eastern	2.6	5.4	0.5	0.9	0.0	0.0
Midland	2.0	5.8 <sup>†</sup>	0.9	0.9	0.0	0.3
Mid West	1.7	2.9	0.6	0.8	0.0	0.3
Southern	2.8	3.5	0.9	0.6	0.2	0.2
Western	1.8	4.4	0.3	0.9	0.3	0.3
North West	0.3	2.2 <sup>†</sup>	0.0	0.3	0.0	0.3

<sup>†</sup>Significant changes in proportion for the two survey periods

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (Bulletins 2, 2005 & 2008)

**Table 2.2.8 Proportion of respondents who reported lifetime, last-year and last-month use of cocaine, by regional drugs task force area of residence**

RDTF area of residence	Percentage that used cocaine*					
	Ever in lifetime		In year prior to survey		In month prior to survey	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
East Coast	6.3	9.1	2.3	3.1	0.5	0.8
North Dublin City & County	5.2	11.0 <sup>†</sup>	1.7	3.3	0.8	1.4
South West (Dublin)	5.0	3.8	1.5	0.8	0.6	0.3
South East	2.5	6.7 <sup>†</sup>	1.7	2.4	0.0	0.9 <sup>†</sup>
North Eastern	1.2	5.6 <sup>†</sup>	0.0	1.5	0.0	0.0
Midland	1.3	4.4 <sup>†</sup>	0.3	1.7	0.3	0.9
Mid West	1.1	2.9	0.6	1.0	0.0	0.0
Southern	1.9	3.1	0.7	1.1	0.4	0.2
Western	1.6	3.5	0.7	1.5	0.4	0.4
North West	0.0	1.6 <sup>†</sup>	0.0	0.3	0.0	0.3

\*Cocaine in this context is cocaine powder and crack.

<sup>†</sup>Significant changes in proportion for the two survey periods

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (Bulletins 2, 2005 & 2008)

### 2.2.3 Drug data from third SLÁN survey

On 29 April 2008, the Department of Health and Children published the third SLÁN Survey of Lifestyle, Attitudes and Nutrition in Ireland. This survey was completed by Morgan and colleagues (2008) at the Royal College of Surgeons in Ireland.

The survey involved 10,364 face-to-face interviews with adults resident in Ireland, which represented a 62% response rate. The sample was drawn from the GeoDirectory, using a multi-stage probability procedure, and was stratified by townland, urban–rural location, age and social class.

Respondents were asked a number of questions about their drug use. The responses were weighted for age, gender, marital status, country of birth and ethnicity. The authors noted that the findings must be interpreted with caution because of the change in sample selection and data-collection methods in 2007 compared to those in 2002 and 1998, as shown in Table 2.2.9.

**Table 2.2.9 Summary of SLÁN methods, 1998, 2002 and 2007**

	SLÁN 1998	SLÁN 2002	SLÁN 2007
Population	Adults aged 18+	Adults aged 18+	Adults aged 18+
Sampling frame	Electoral register	Electoral register	GeoDirectory
Sample	Multi-stage sample, drawn by electoral division	Multi-stage sample, drawn by electoral division	Multi-stage probability sample
Stratification	Percentage distribution across each of 26 counties, locality and gender	Percentage distribution across each of 26 counties, locality and gender	Percentage distribution across townlands, age groups, social classes and urban–rural location
Methods	Self-completion questionnaire and self-completion of Food Frequency Questionnaire	Self-completion questionnaire and self-completion of Food Frequency Questionnaire	Face-to-face interview and self-completion of Food Frequency Questionnaire
Obtained sample	6,539	5,992	10,364
Response rate	62%	53%	62%

Source: SLÁN (2008)

In the 2007 survey, respondents were asked about their use of illegal drugs in the last year (Table 2.2.10). Six per cent reported that they had used an illegal drug in the year prior to the survey; the reported use of such drugs was higher for men (9%) than for women (4%). As expected, cannabis was the most commonly used drug. The percentage of those who used cocaine in the last year was surprisingly low at 1%. In general, these data are not comparable to the results of the 2006/7 general population survey by the NACD as the SLÁN survey excluded those aged between 15 and 17 and included those over 65 years.

**Table 2.2.10 Last-year prevalence of illegal drug use in Ireland**

	Adults 18 years or over	Males 18 years or over	Females 18 years or over
	%	%	%
Illegal drug use*	6.0	9.0	4.0
Cannabis	5.0	8.0	3.0
Ecstasy	1.0	1.0	<1.0
Cocaine	1.0	2.0	<1.0

\* Illegal drugs in this context are amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

Source: SLÁN (2008)

In general, the use of confidence intervals would allow commentators to rule out sampling variation when comparing the SLÁN surveys, both over time and with other surveys completed at the same time.

## 2.2.4 Polydrug use among the general population, 2002/3

On 22 March 2007 the NACD and the DAIRU published jointly the fifth and sixth bulletins of results from the 2002/3 all-Ireland general population drug prevalence survey (NACD and DAIRU 2007a, 2007b). Bulletin 5 focuses on polydrug use in the adult population (15–64 years) and Bulletin 6 focuses on sedative, tranquilliser or anti-depressant use in the adult population.

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

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

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

- 0.2% had used alcohol, tobacco, at least one illegal drug, and sedatives, tranquillisers or anti-depressants
- 0.1% had used tobacco, at least one illegal drug, and sedatives, tranquillisers or anti-depressants

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

### **2.2.5 Sedative, tranquilliser and anti-depressant use among the general population, 2002/3**

For the purpose of Bulletin 6 which was published at the same time as Bulletin 5 (see Section 2.2.4 above), sedatives, tranquillisers and anti-depressants were grouped as a collective.

The key findings were:

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

## **2.3 Drug use in the school and youth population**

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

The third ESPAD survey was published in December 2004 (Hibell *et al.* 2004). The results were presented in the 2005 and 2006 national reports. The fourth ESPAD survey was conducted in 2007 and results will be presented in the 2009 report.

### **2.3.2 Third HBSC study reports findings**

The third Irish HBSC (Health Behaviour in School-aged Children) study, conducted in 2006 by the Health Promotion Research Centre in the National University of Ireland, Galway, was published in August 2007 (Nic Gabhainn *et al.* 2007). HBSC is a cross-national research study conducted every four years in collaboration with the World Health Organization, and in 2006 there were 41 participating countries and regions. The overall aims of the HBSC are to gain insight into and increase understanding of young people's health and well-being, health behaviours and their social context.

HBSC is a school-based survey with data collected through self-completed questionnaires administered by teachers in the classroom. The sampling frame consists of primary and post-primary schools. A two-stage process identifies study participants: individual schools within regions are first randomly selected, and class groups are then randomly selected for participation. Sixty-three per cent of invited schools and 83% of students sampled participated in the 2006 HBSC survey. Data were collected from 10,334 children aged 10–18 years on topics including general health, smoking, use of alcohol and other substances, food and dietary behaviour, exercise and physical activity, self-care, injuries and bullying.

This report also studied cannabis use among school children. Overall, 16% of children reported using cannabis during their lifetime, compared with 12% in 2002; 12% reported using cannabis in the past 12 months, compared with 11% in 2002. Cannabis use was highest among those aged 15–17, with about one in five in this age group using cannabis in the previous 12 months. There was little evidence of a social class effect. The rates of reported cannabis use are similar to those in the 2002 HBSC study, except among 15–17-year-old boys, where a decrease is evident.

Seven per cent of children reported using cannabis in the previous 30 days. This was slightly higher for boys (8%) than for girls (5%). Those aged 15–17 were more likely to report recent cannabis use than younger children. A clear social class effect was evident among 15–17-year-old boys regarding recent cannabis use; 10% of boys in the highest social class grouping reported recent cannabis use compared to 15% in the lowest social class grouping.

In conclusion, there was little change between 2002 and 2006 in reported cannabis use.

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

### **2.4.1 Young people in detention schools**

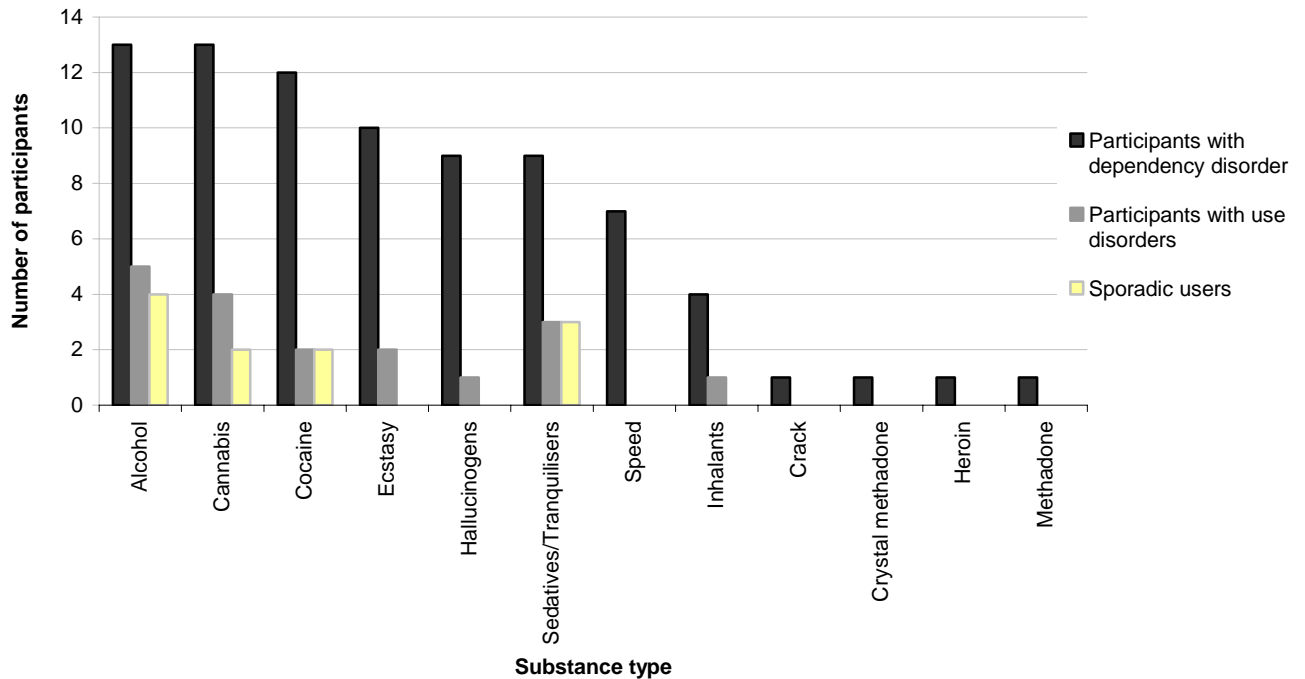
The report *Emotional intelligence, mental health and juvenile delinquency* revealed that young people in detention schools in Ireland experience high rates of psychiatric disorders, engage in serious criminal activity and have significant deficits in emotional intelligence and cognitive ability (Hayes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

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

Sixty-seven per cent of the offender group met the criteria for at least one substance-related disorder. Approximately equal numbers reported using cocaine (13/30), alcohol (14/30) and cannabis (14/30). Based on participants' reports of substance use in the 12 months prior to interview, researchers assigned them to one of three categories: dependency disorder (those addicted to one or more substances, n=14); use disorder (regular users of one or more drugs but who did not have a diagnosis of addiction, n=5); sporadic users (those who had used drugs in the past 12 months but not in sufficient quantities to warrant a diagnosis of dependency or use disorder, n=5) (Figure 2.4.1). One member of the offender group reported not having taken any drugs or alcohol in the previous 12 months.

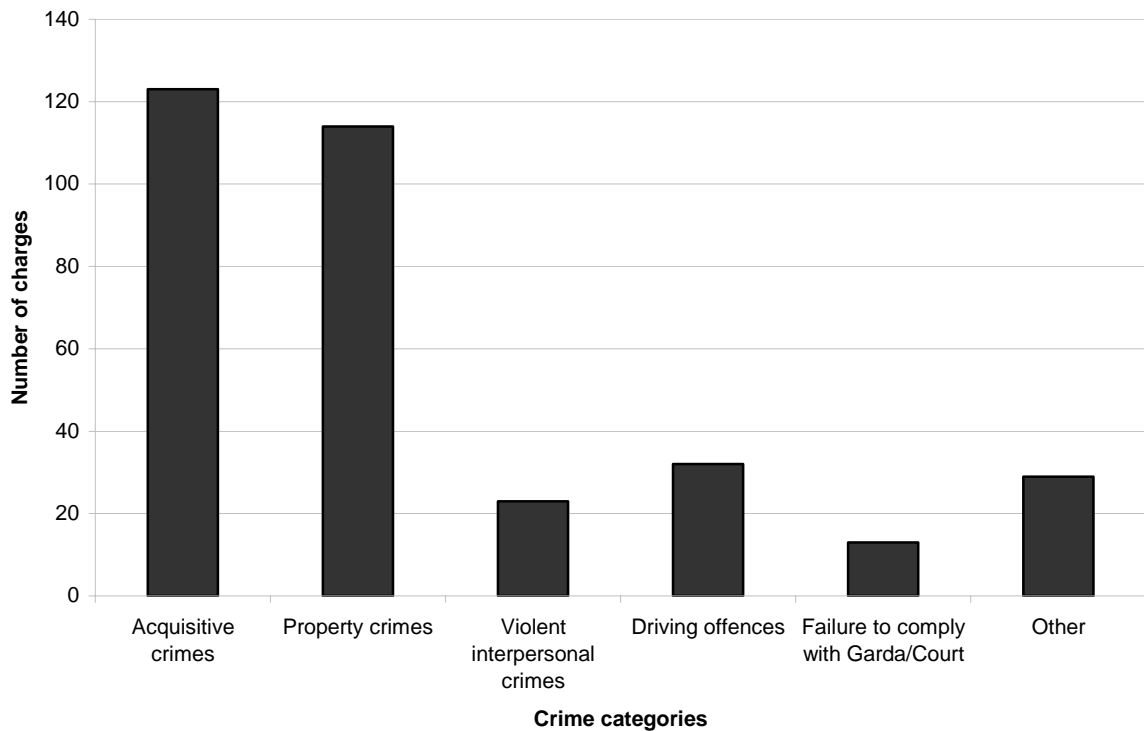


Detainees with substance dependency disorders reported that they first began to use alcohol and cannabis at an average age of just nine years, and cocaine at 13 years. The majority did not receive treatment for psychiatric or substance use problems. Despite incarceration, these boys had continued access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



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

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



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

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

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

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

#### **2.4.2 Substance use among Irish women expecting their first baby**

Between April 2003 and May 2004, Donnelly and colleagues (2008) interviewed 1,011 Caucasian women attending a maternity hospital in Dublin city centre to determine their use of illegal drugs, tobacco and alcohol. The definition of illegal drugs used in the survey was not presented in the paper. The study participants were expecting their first baby, were less than 20 weeks pregnant and were aged between 16 and 40 years. Women were interviewed at private, semi-private and public antenatal clinics. The study response rate was very high at 95%.

Of the 1,011 women interviewed, 235 (23.5%) respondents reported that they had taken an illegal drug at some point prior to this pregnancy. As expected, cannabis was the most commonly used illegal drug with 214 respondents (21.2%) reporting that they had used this drug at some point prior to this pregnancy. Seventy (6.9%) respondents had used ecstasy at some point prior to this pregnancy while 64 (5.8%) respondents

had used cocaine. Ninety women (8.9%) had used more than one illegal drug. Eleven women (1.1%) had used an illegal drug during this pregnancy.

In relation to tobacco use, 574 (57%) of the women interviewed reported that they had smoked cigarettes at some point in their lives; 282 (28%) reported that they were current smokers, of whom 87 smoked more than 10 cigarettes a day.

In relation to alcohol use, 545 women (54%) said that they had drunk alcohol on at least one occasion since their first positive pregnancy test, of whom 500 (91.7%) had drunk between one and four units, 33 (5.1%) between five and 10 units and 12 (2.2%) more than 10 units.

Alcohol consumption and cigarette smoking were associated with illegal drug use: smokers were 2.8 times more likely to use illegal drugs than non-smokers, while women who drank alcohol were 1.8 times more likely use illegal drugs than non-drinkers. The type of clinic attended or the level of education achieved were not found to be associated with the use of illegal drugs. High levels of alcohol use among pregnant women in Ireland has been reported elsewhere.

This survey does not report confidence intervals so it is not possible to estimate the use among the population of primigravid women.

### **2.4.3 People with intellectual disabilities who misuse alcohol and drugs**

Very little research has explored alcohol/drug use and misuse by people with intellectual disabilities. The aims of Taggart and colleagues' (2007) study were twofold: (1) to examine the insights of 10 people with intellectual disabilities into the reasons why they might misuse alcohol or drugs, and what impact this behaviour might have on them; and (2) to explore the services that they received. Ten individuals with intellectual disabilities who were deemed to be misusing alcohol/drugs were purposively selected and interviewed. One overarching theme arising from the reasons for use was labelled 'self-medicating against life's negative experiences'. This was divided into two sub-themes: 'psychological trauma' and 'social distance from the community'. All the participants reported that their main source of support came from intellectual disability services, acting in both educational and liaison roles. Although seven of the individuals were referred to mainstream addiction services, they perceived this service as negative. In order to address these underlying problems, the authors recommended that better access to a wider range of specialist services is required. Intellectual disability and mainstream addiction service providers also need to be more effective in the prevention and treatment of substance misuse by employing techniques such as motivational interviewing.

### **3. Prevention**

#### **3.1 Overview**

The evaluation of the National Drug Awareness Campaign 2003-2005 found a number of shortcomings in design and implementation. Training to improve the professionalism of the community sector in reducing demand for drugs is improving and quality standards to improve the professionalism of drug education workers have been published. Research by Crosscare shows that there is a need for a more integrated targeted approach to individuals referred by the Courts for drug education on foot of being in possession of drugs at music festivals and recreational events. The latest phase of the National Drug Awareness Campaign targets the information needs of recreational cocaine users. Evaluation of targeted intervention for at-risk families in Tallaght, Dublin shows the merits of this work in improving their quality of life; however, the need for more strategic planning and outcome evaluation is also highlighted in the piece of work.

#### **3.2 Universal prevention**

##### **3.2.1 School**

No new information available

##### **3.2.2 Family**

The National Drug Awareness Campaign was developed and launched in May 2003. The overall aim of the campaign was to 'increase awareness among the general population about current problem drug use and its consequences across society through the achievement of measurable change in the knowledge and attitude of targeted groups'. Although the campaign was in theory targeted at the general population, families were a central target group in the overall delivery of the campaign.

The campaign relied heavily on multi-media components, including radio and TV advertising and a website. Live roadshows featuring question and answer sessions were staged, and booklets, posters and a helpline were developed. The campaign slogan, 'Drugs. There are answers' was intended to convey a positive message; this approach was preferred to one that used scare tactics.

The National Advisory Committee on Drugs (NACD) commissioned a team of external researchers to review the development and delivery of the campaign from 2003 to 2005. The final report of this evaluation was published in 2007 (Sixsmith and Nic Gabhainn 2007).

Sampling strategy and data collection:

Purposive sampling was used to select interviewees from among those actively involved in the campaign development and members from the target groups. In total, 94 semi-structured interviews were conducted between November 2003 and September/October 2005 across the three phases of the campaign's development.

Key findings of the evaluation:

In an extensive review of the literature, the evaluation team identified certain criteria to inform best practice in developing a drug awareness campaign. The development and implementation of the national campaign were assessed against these criteria.

Theoretical base, aims and objectives:

The majority of respondents did not consider that any formal theory, model or framework had been applied to the development of the campaign. The evaluation team point out that the objectives set for the campaign, even if they were met, were incapable of achieving the stated aim of the campaign. In addition, as the campaign

developed, key stakeholders reported a growing sense of confusion as to what its objectives were.

Target audiences:

The interview participants did not perceive the target groups to be well defined from the start of the campaign, and felt the focus to be ad hoc rather than planned.

Multi-component media interventions:

The campaign fared poorly in this area as the roadshows represented the only attempt to bolster the use of multi-media channels with a community dimension.

Message development:

According to the evaluators, the theme of empowerment conveyed in the campaign slogan should have encouraged brand consciousness throughout the campaign.

However, interviewees reported that they failed to recognise this and that there had been a lack of coherence to the campaign components.

Formative evaluation and process evaluation:

Formative evaluation generally involves pilot-testing campaign messages, materials and lines of communication as the campaign is being formed. In this case, the development of the campaign scored highly as it used formative evaluation to assess the roadshows, the cannabis campaign and the convenience advertising. The tracking of the development of the campaign over three years by a team of external evaluators culminated in the final evaluation report presented in this article.

The findings of this evaluation suggest that this campaign suffered from a lack of coherence, because it did not have a specific theoretical framework that could have linked the various components together and given structure. Information awareness campaigns such as this one tend to be based on an implicit assumption that the target audience will react rationally to the messages, and take appropriate steps to avoid the consequences inherent in the behaviour being highlighted, for example, misuse of drugs. It is important that future drug awareness campaigns learn from this evaluation, and that their development is informed by meaningful debate and reflection on the appropriate theoretical approach to take. Such a move will contribute to an evidence-based approach to what is effective in raising awareness about drugs and changing attitudes and behaviours associated with their use.

### **3.2.3 Community**

Recent interventions targeting the community sector have focused on developing professionalism among individuals working in local drug task force (LDTF) areas and on community based projects. This is a recent innovation in developing the role of the community sector in reducing demand for drugs and is a welcome development. The second round of training for community representatives on LDTF concluded in November 2007. Participants came from six LDTF areas and one regional drugs task force (RDTF). Funded by the Department of Community, Rural and Gaeltacht Affairs (DCRGA) through the Drugs Strategy Unit and designed by Citywide, this is the only course of its kind running in Ireland. The course is accredited by FETAC<sup>4</sup> at level 5 and covers eight primary areas:

1. How Local Drugs Taskforces Work
2. Introductions to Building Effective Relationships
3. Understanding your Role & Responsibilities
4. Negotiations Theory and Practice
5. Communications Skills
6. Developing Leadership & Influencing skills
7. Handling Problems and conflict / Problem Solving Techniques
8. Consensus Decision Making and strategising

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<sup>4</sup> Further Education and Training Awards Council (FETAC)

## Training for drug project managers leads to graduation

Eleven drug project managers who completed the National College of Ireland (NCI) certificate in Managing Organisations in the Community & Voluntary Sector (FETAC level 6 module) graduated in October 2007. This was the first course specifically designed to meet the training and support needs of managers of community based drug projects. The course delivered four units focusing on providing practical support for the participant group. The core contents of the four units are summarised below.

### Unit 1: Processes

This module draws on organisational theory and practice, and identifies sociological, psychological and managerial perspectives of organisations in order to understand organisational processes and behaviour.

### Unit 2: Practice

This module introduces the functions of management, enabling students to appreciate and apply this knowledge in practice

### Unit 3: People

This module examines the core components of Human Resource Management (HRM) and the effective management of people within organisations.

### Unit 4: Planning

This module builds an understanding of strategic management, it develops analytical and decision-making skills to formulate, explain, implement and evaluate organisational development and planning strategies.

A manual in quality standards in substance use education was launched on 10 September 2007 (Butler *et al.* 2007). The manual, the first of its kind to be produced in Ireland, was compiled and produced by members of the Drug Education Workers Forum (DEWF), a voluntary organisation committed to identifying and responding to the needs of voluntary, community and statutory drug education workers in Ireland. DEWF has clearly defined drug education as the range of interventions available which aim to enhance the knowledge, skills and competencies of individuals with regard to their decisions around substance use or misuse. DEWF has identified a need for 'clear, practical information on best practice in substance use education in Ireland.' The aim of the manual is to provide a clear framework for those offering substance use education, such as workers in drug education, youth workers and health promotion staff, and for individuals and agencies commissioning substance use education, such as youth work management boards and school boards of management.

The manual is based on a substantial review of international research and provides guidelines for the development and enhancement of substance use education in school, youth-work and community-based settings. Three working groups were set up, each designed to address the needs of one of these settings. Members of the working groups had experience and expertise in these settings. Other individuals and agencies were invited to contribute their expertise, and a series of focus groups was held with programme participants and substance use education providers.

The manual is highly structured and provides a consistent framework of standards across the three education settings. Elements common to the school and youth-work settings include substance use policy, managing incidents, and staff development. Elements in the community-based setting include education with drug service users, Travellers, and parents and guardians.

The manual also includes a 'core skills and competencies' audit for practitioners at three levels:

- foundation level, including core knowledge, attitudes and skills;

- generalist competencies, including substance use education and prevention work, targeted education, advice giving, programme delivery etc;
- specialist competencies.

DEWF is developing a training schedule to accompany the manual. It is envisaged that a two-day 'training of trainers' programme will be offered by members of the DEWF working groups. DEWF has emphasised the evaluation component of the manual. It is hoped that users will become involved in an evaluation process, to enable further development and enhancement of the standards over time. The production of the manual was funded under the National Drugs Strategy. Further information can be found on the DEWF website [www.dewf.ie](http://www.dewf.ie).

### **3.3 Selective prevention**

#### **3.3.1 Recreational settings**

Court-prescribed drug education for first-time offenders

The Drug and Alcohol Programme (DAP) run by Crosscare works with small numbers of individuals referred either by the courts or by their legal teams for drug education, following arrest for first-time and minor drug-related offences. Such offences often occur in the context of outdoor concerts and music festivals. Crosscare recently commissioned research to investigate two questions:

- Is the DAP service the appropriate mechanism to meet the needs of this target group and, if so, how can it be developed further?
- What is best practice in meeting the needs of this target group?

This research has now been published, and draws attention to an area that has received little attention so far (Giaquinto 2008). The report notes that in 2007 fewer than five individuals referred to the DAP had been arrested for minor cannabis or ecstasy offences at music festivals. However, this number may be an underestimation as the DAP does not usually record the reasons for referral. It is claimed that individuals are often referred to the programme on an ad hoc basis, with no clear links developed between the courts and the drug education providers and no attempt to monitor or evaluate the service. The report recommends improved collaboration between the courts, the Probation Service and drug education providers, and questions whether the current service run by Crosscare is the appropriate mechanism, in the absence of the necessary collaborative supports outlined.

The National Drug Awareness Campaign: The next phase targeting recreational cocaine users

The National Public Awareness Campaign on Drugs was launched in February 2008. The new campaign, jointly funded by the Health Service Executive (HSE) and the DCRGA, is called 'The Party's Over' and focuses on cocaine use. It is an integrated public awareness campaign comprising several print, online and broadcasting initiatives. It includes a website ([www.drugs.ie](http://www.drugs.ie)) which provides information about drugs and available services and podcasts of discussions on drug-related topics. Visitors to the site can also have live chats with experts at certain times.

The campaign was developed with the intention that it would be sustainable over the next three years. In the first phase, the primary aim is to communicate the dangers of cocaine use, with a particular focus on so-called recreational cocaine users in the 15-34 year age group. The campaign is utilising appropriate media, such as social network websites, billboard and bus advertising as well as radio advertising to target this age group.

The health promotion unit of the HSE has also published two leaflets “Know the Facts about Drugs” and “Cocaine - the Facts” to accompany the campaign. Relevant information on cocaine and related services will also be available on the drugs information website [www.drugs.ie](http://www.drugs.ie). In addition, local and regional drug task forces will be supported to provide information awareness initiatives specific to their local communities.

### **3.3.2 At-risk groups**

No new information available.

### **3.3.3 At-risk families**

The Killinarden Drugs Primary Prevention Group (KDPPG) established the WRENS<sup>5</sup> project in 2002, initially to assist women who experienced marginalisation from their communities as a result of the anti-social behaviour of a family member. Based on the principles of community development, the project has continued to work with parents and families and has developed specific services for young people within the school system and for clients of the Probation Service. The work of WRENS was recently evaluated by Duggan (2007) using documentary analysis and in-depth interviews with project staff, parents, school staff and probation personnel.

According to parents and school staff, the programme for young people is contributing to a reduction in disruptive behaviour and improvements in school retention rates. Disruptive behaviour and early school leaving are indicators of drug use and, in this context, the programme is seen to benefit young people at risk of engaging in drug use. In particular, the intensive one-to-one work with young people was identified as an effective approach.

Participants in the family programme reported having gained a better understanding of the issues adversely affecting them, improved problem management techniques in the family, increased participation in the community and in some cases the attainment of new skills applicable to a range of settings. However, the evaluation noted that some parents were potentially becoming dependent on the support provided by the programme and that, in the long run, measures ought to be taken to empower these parents to progress to independent management of the issues affecting them.

Among the small number of participants who were supervised by the Probation and Welfare Service, a number of notable changes in behaviour and lifestyle were reported. For example, participants reported a greater awareness of the consequences of their offending behaviour and of ways of changing such behaviour. They also reported greater structure in their lives, increased awareness of alcohol and drug addictions and improved relations with the Probation and Welfare Service.

Overall, the evaluation reported that the KDPPG, through the WRENS project, was doing excellent work in delivering community development interventions to individuals and families with specific needs. These interventions benefited the individuals, the families and their communities, and delivered added value to the work of the statutory sector. However, it was noted that the KDPPG could improve its strategic planning and begin systematic data collection so as to monitor and evaluate its own service and to share its experience with other agencies responding to drug use.

A lack of strategic planning and systematic data collection is common among drug prevention interventions based on community development principles. This is often influenced by the fluid and organic nature of community development, where the aim is to empower individuals and families through face-to-face interventions in the community so that they can resolve their own problems and contribute to greater community cohesion, rather than to provide evidence of effectiveness.

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<sup>5</sup> WRENS stands for Women Reviewing Equality Networking Standards



### **3.4 Indicated prevention**

#### **3.4.1 Children at risk (psychological problems)**

No new information available.

## 4. Problem Drug Use (PDU) and the Treatment Demand Population

### 4.1 Overview

This section provides an overview of new developments and trends in the prevalence and characteristics of problem drug use in Ireland for 2007 and early 2008. In 2001 the prevalence of problematic opiate use among the population was 5.6 per 1,000 of the population. The 2000/2001 three-source capture–recapture study to estimate the number of problem opiate users living in Ireland is being repeated using 2006 data. The results of this study will be presented in the 2009 national report. It is not possible to estimate the number of injecting drug users or problem cocaine users in Ireland as the National Drug Treatment Reporting System does not have a unique identifier and this is the most reliable source of such data.

The **prevalence** (all cases) of treated drug use among 15–64-year-olds living in Ireland, expressed per 100,000 of the population, increased by 15%, from 372 in 2001 to 426 in 2006. The **incidence** (new cases) of treated drug use among 15–64-year-olds living in Ireland was marginally lower in 2006 (74.8 new cases per 100,000) than in 2001 (75.7 new cases). The main problem drugs reported by new cases were cannabis, opiates or cocaine. The vast majority (72%) of new cases treated between 2001 and 2006 reported problem use of more than one substance (polysubstance use).

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

### 4.2 Prevalence and incidence estimates of PDUs

#### 4.2.1 Estimating the prevalence of problem opiate use

No new valid national prevalence and incidence studies have been carried out or published during the reporting period January 2007 to June 2008. The 2000/2001 three-source capture–recapture study to estimate the number of problem opiate users living in Ireland is being repeated (by Kelly and colleagues) using 2006 data. The results of this study will be presented in the 2009 national report.

#### 4.2.2 Other studies estimating prevalence of opiate use

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

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

- From Tables 4 and 5, we calculate a figure of either 523.5 or 557.9 – considerably greater than that arrived at by the authors.

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

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

- Table 2 and Table 3 in their paper give slightly different figures for the number 'ever arrested' and the number 'excluded' (a note to both tables defines excluded cases as those for whom the question was 'not relevant, clients who chose not to answer the question, clients who did not know, spoiled responses and data not collected').
- The authors do not explain these differences.
- The authors do not deduct the excluded cases (whether 61 or 63) from the initial sample, and use 404 as the denominator, rather than 343 (or 341).
- Using the denominator of 343 cases, the proportion of opiate users with the experience of interest – and therefore the correct multiplier – is 4.1%.
- The multiplier is based on the experience in a sample rather than a population and does not provide a range to control for the effect of sampling variation.

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

#### **4.2.3 Data limitations with respect to identifying the number of problem drug users in Ireland**

It is not possible to estimate the number of injecting drug users or problem cocaine users in Ireland as the National Drug Treatment Reporting System does not have a unique identifier and this is the most reliable source of such data. This issue has been raised in a number of strategy submissions and it is hoped that this issue will be addressed in the forthcoming health information bill.

### **4.3 Treatment demand indicator**

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

#### **4.3.1 Type of treatment centres providing data**

##### **Outpatient services (see Standard Table TDI 34 outpatients)**

In 2007, there were 173 services providing outpatient services and reporting cases to the NDTRS. Of these services, 64 provided methadone treatment, a small number

provided detoxification using lofexidine, and one provided buprenorphine detoxification. All provided counselling services and a large proportion provided brief interventions. Of the 4,374 cases who entered treatment for the first time or returned to treatment at outpatient services in 2007, 1,041 (24%) were female, 2,144 (49%) were aged between 20 and 29 years and 1,957 (45%) had never previously been treated. The most common source of referral was self-referral (1,441, 33%). More than two-fifths (2,120, 48%) were living with their parents, and a significant minority (419, 10%) were living in unstable accommodation. The majority of cases (2,600, 59%) were not employed and 1,245 (28%) had no formal educational qualifications. The three most common main problem drugs were opiates (2,808, 64%), cannabis (730, 17%) and cocaine (571, 13%).

Of the 4,356 cases whose gender was known and who attended outpatient facilities in 2007, 1,181 (27%) injected their main problem drug; 2,076 (48%) used their main problem drug on a daily basis; and 968 (22%) had not used their main problem drug in the month prior to this treatment episode. The age at which cases commenced use of their main problem drug was associated with the type of drug. Of the 2,808 cases who attended outpatient facilities during the reporting period and reported an opiate as their main problem drug, 1,915 (44%) commenced use of this opiate between 15 and 24 years of age. Of the 571 cases who attended outpatient facilities and reported cocaine as their main problem drug, 387 (68%) commenced use of cocaine between 15 and 24 years of age. Of the 730 cases who were admitted to outpatient facilities and reported cannabis as their main problem drug, 667 (91%) commenced use of cannabis before 20 years of age. The majority of cases (2,794, 64%) reported that they used more than one drug. The four most common additional drugs used were cannabis, cocaine, alcohol and hypnotics or sedatives (mainly benzodiazepines).

Of the 4,374 cases who attended outpatient facilities, 1,846 (42%) had ever injected any drug, and 844 (19%) had injected in the month prior to this treatment episode. Among cases admitted to outpatient services, opiates (usually heroin) were the main type of drug injected; a small number of cases injected cocaine and one case injected amphetamines.

### **Inpatient services (see Standard Table TDI 34 inpatients)**

There were 27 inpatient services reporting cases to the NDTRS in 2007. These facilities provided one of the following: medical detoxification, therapeutic community, Minnesota Model, other medication-free service or psychiatric treatment combined with counselling. Of the 1,024 cases who were admitted to residential facilities in 2007, 204 (20%) were female, the majority (557, 54%) were aged between 20 and 29 years, and 449 (44%) had never previously been treated. The most common source of referral was from another treatment centre (273, 27%). At the time of admission, 506 (49%) were living with their parents and 131 (13%) were living in unstable accommodation; 699 (68%) were not employed and 232 (23%) had no formal educational qualifications. The three most common main problem drugs were opiates (541, 53%), cannabis (198, 19%) and cocaine (188, 18%).

Of the 1,021 cases whose gender was known and who were admitted to residential facilities in 2007, 198 (19%) injected their main problem drug and 479 (47%) used their main problem drug on a daily basis, while 262 (26%) did not use their main problem drug in the month prior to this treatment episode. The age at which cases commenced use of their main problem drug was associated with the type of drug used. Of the 539 cases who reported an opiate as their main problem drug, 370 (69%) commenced its use between 15 and 25 years of age. Of the 187 cases who were admitted to residential facilities and reported cocaine as their main problem drug, 123 (66%) commenced its use between 15 and 25 years of age. Of the 198 cases who were admitted to residential facilities and reported cannabis as their main problem drug, 186 (94%) commenced its use between 10 and 19 years of age. The vast majority of cases (882, 86%) reported that they used more than one drug. The four most common additional drugs used were cannabis, cocaine, alcohol and stimulants.

Of the 1,024 inpatient cases, 291 (28%) had ever injected any drug and 112 (11%) had injected in the month prior to this treatment episode. Opiates (usually heroin) were the main type of drug injected. A small number of cases injected cocaine.

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

In 2007, there were five services providing solely low-threshold services and reporting cases to the NDTRS. Two of the services were based in the North and South-Western Areas of Dublin. Of these services, one provided low-threshold methadone maintenance and one provided crisis counselling. The remaining three services were based in the South East of the country and provide crises counselling and motivation to attend formal treatment services. For many of the community services, it is difficult to separate low-threshold activities from treatment interventions and services. Both crisis interventions and counselling services have been and continue to be classified as outpatient treatment services. Of the 89 cases who attended low-threshold services in 2007, 30 (34%) were female, 56 (63%) were aged between 20 and 34 years, and 31 (35%) had never previously been treated. The most common sources of referral were referral by social services (29, 33%), followed by family or friends (25, 28%). A large number (34, 38%) were living with their parents and a significant minority (16, 18%) were living in unstable accommodation. A large proportion of cases (54, 60%) were not employed. The three most common main problem drugs were opiates (54, 61%), cannabis (11, 12%) and cocaine (9, 10%).

Of the 89 who attended low-threshold services, 40 (45%) used their main problem drug on a daily basis and 19 (21%) had not used their main problem drug in the month prior to this treatment episode. A high proportion of cases (67, 75%) used more than one drug. The four most common additional drugs used were cannabis, benzodiazepines, stimulants or cocaine.

Of the 89 cases who attended low-threshold services, 48 (54%) injected at least once in their lifetime and 23 (26%) injected in the month prior to this treatment episode. Opiates (usually heroin) were the most common type of drug injected.

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

In 2007, there were 258 general practitioners providing methadone treatment, of which 82% reported data to the NDTRS. Eighty-three general practitioners reported new entries to treatment. Of the 288 cases who entered treatment with a general practitioner in 2007, 77 (27%) were female, 160 (56%) were aged between 25 and 34 years, and 38 (13%) had never previously been treated. The most common source of referral was from another drug treatment centre (170, 59%). A large number (106, 37%) were living with their parents and only a small number (10, 3%) were living in unstable accommodation. Almost two-fifths (121, 42%) were not employed. All cases (288) reported an opiate as their main problem drug and 47% injected it.

Of the 288 cases who attended general practitioner services, 79 (27%) used their main problem drug on a daily basis and 155 (54%) had not used their main problem drug in the month prior to this treatment episode. A low proportion of cases (112, 39%) used more than one drug. The three most common additional drugs used were cannabis, cocaine and hypnotics and sedatives (mainly benzodiazepines).

Of the 288 cases who attended general practitioner services, 170 (59%) injected at least once in their lifetime and 41 (14%) injected in the month prior to this treatment episode.

#### **4.3.2 Trends in treated problem drug use in Ireland, 2001 to 2006**

On 14 May 2008, Reynolds and colleagues published a paper on trends in treated problem drug use between 2001 and 2006, based on data reported to the National Drug Treatment Reporting System (NDTRS) and to the Central Treatment List (CTL). It

is important to note that the reporting system collects data on episodes of treatment, rather than the number of individual people treated each year. This means that individuals may appear more than once if they attend more than one treatment service in a year, and may reappear in subsequent years.

The main findings and their implications are:

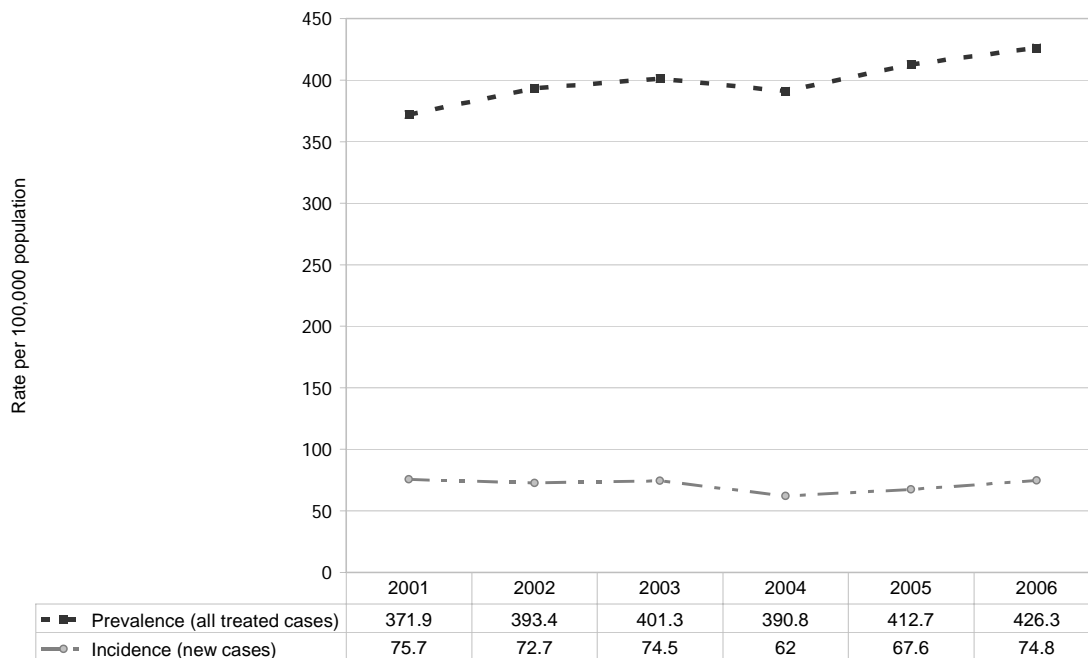
- There were 68,754 cases treated between 2001 and 2006, of which 31,620 entered treatment during the six-year period. Of these cases, 29,373 (93%) lived in Ireland at an identified address, 2,203 (7%) lived in Ireland at an unidentified address and 44 (0.1%) did not live in Ireland. Table 4.3.1 presents data by year.

**Table 4.3.1 Number (%) of cases in treatment in Ireland, by treatment status, reported to the NDTRS, 2001 to 2006**

Treatment status	2001	2002	2003	2004	2005	2006
	Number (%)					
All cases in treatment	10098	11062	11515	11235	12100	12744
Cases continuing in methadone treatment from previous year	4963 (49.1)	5601 (50.6)	5944 (51.6)	6433 (57.3)	6924 (57.2)	7269 (57.0)
Entries to treatment each year	5135	5461	5571	4802	5176	5475
Previously treated cases returning to treatment	2837 (28.1)	3072 (27.8)	3192 (27.7)	2765 (24.6)	2970 (24.5)	3000 (23.5)
New cases	2108 (20.9)	2131 (19.3)	2245 (19.5)	1858 (16.5)	2054 (17.0)	2278 (17.9)
Treatment status unknown*	190 (1.9)	258 (2.3)	134 (1.2)	179 (1.6)	152 (1.3)	197 (1.5)

\*Relevant data not recorded on the NDTRS form returned.

- In Ireland, treatment for problem drug use is provided in outpatient, inpatient, low-threshold and general practice settings. Of the 68,754 cases treated between 2001 and 2006, the majority (68%) attended outpatient services.
- The number of individuals in methadone treatment from the preceding calendar year and carried forward on 1 January each year increased by 46%, from 4,963 in 2001 to 7,269 in 2006.
- The **prevalence** (all cases) of treated problem drug use among 15–64-year-olds living in Ireland, expressed per 100,000 of the population, increased by 15%, from 372 in 2001 to 426 in 2006 (Figure 4.3.1). The **incidence** (new cases) of treated problem drug use among 15–64-year-olds living in Ireland was marginally lower in 2006 (74.8 new cases per 100,000) than in 2001 (75.7 new cases per 100,000).



**Figure 4.3.1** Incidence and prevalence of treated problem drug use among 15–64-year-olds living and treated in Ireland, based on returns to the NDTRS and the CTL per 100,000 population, 2001 to 2006

- The relatively stable incidence observed during the period masks separate trends in the former health board areas. The number of new cases increased by 100% in the Western, by 57% in the Midland, by 37% in the North Eastern and by 33% in the Mid-Western health board areas between 2001 and 2006. The number of new cases increased by 89% in the South Eastern Health Board area between 2001 and 2005 and then stabilised.
- An opiate (mainly heroin) was the most common main problem drug reported by new cases who lived in Dublin. There was a 31% decrease in the number of new opiate cases who lived in Dublin, from 675 in 2001 to 468 in 2006, indicating that the heroin epidemic in this area has abated. In contrast, there was a 96% increase in the number of new opiate cases who lived outside Dublin, from 226 in 2001 to 442 in 2006.
- The main problem drugs reported by new cases were cannabis (41%), opiates (39%) and cocaine (9%). The number of new cases who reported cocaine as their main problem drug increased noticeably, from 43 in 2001 to 342 in 2006. The number of new cases reporting cannabis as their main problem drug increased marginally.
- The vast majority (72%) of new cases treated between 2001 and 2006 reported problem use of more than one substance (polysubstance use). New cases entering treatment reported alcohol, cannabis, ecstasy and cocaine as the most commonly used additional problem drugs. From 2002 to 2003 alcohol and ecstasy were ranked as the two most common additional problem drugs, but in 2004 cannabis replaced ecstasy as the second most common additional problem drug. The use of alcohol and cocaine as additional problem drugs by new cases rose by 70% and 114% respectively over the period under review.
- In total, 2,473 new injector cases entered treatment between 2001 and 2006. Over half of these were still injecting on entry to treatment, and 47% reported sharing injecting equipment. The proportion of injector cases who reported sharing equipment decreased from 51% in 2001 to 44% in 2006, which indicates the positive effect of proactive outreach work.

- In general, problem drug users are young and male, have low levels of education and are unlikely to be employed, indicating the importance of personal development and educational and employment opportunities as part of the drug treatment and reintegration process.
- Though small, the proportion of cases who reported being homeless and the proportion not born in Ireland increased steadily during the reporting period. The increase in the proportion of other nationalities seeking treatment may have implications for service provision as drug treatment interventions rely heavily on verbal communication.

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

##### **4.4.1 Type, numbers and intensity of drug use**

###### **Description of clients attending harm reduction**

There is up-to-date national data on drug users attending needle exchanges. This is presented in standard table 10 and structured questionnaire 23.

###### **National Registry of Deliberate Self-Harm – annual report 2006-2007**

The sixth annual report from the National Registry of Deliberate Self-Harm was published in September 2008. The report contains information relating to each episode of deliberate self-harm from persons presenting to all general hospital and paediatric hospital A&E departments in Ireland in 2006 and 2007, giving a complete national coverage of hospital-treated deliberate self-harm. The Registry defines deliberate self-harm as ‘an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or physical consequences’.

According to the report there were 10,700 presentations of deliberate self-harm, involving 8,200 individuals, to hospital A&E departments in 2006. Taking the population into account, the age-standardised rate of deliberate self-harm was 184 per 100,000, compared with 198 per 100,000 in 2005, representing a 7% decrease. However, there were 11,100 presentations by 8,600 individuals in 2007, a rate 2% higher than in 2006. Reviewing data collected by the Registry for a six-year period, 2002–2007, the report indicates that the rate of persons presenting to hospital owing to deliberate self-harm is relatively stable.

The national rate of deliberate self-harm for both 2006 and 2007 was one third (32% and 33%) higher among females than among males. Concordant with previous reports, deliberate self-harm was largely confined to the younger age groups. Almost half (46% in 2006 and 47% in 2007) of all presentations were by persons less than 30 years of age, and 88% by persons less than 50 years of age.

The peak age range for females presenting was 15–19 years, at 600 per 100,000. The peak age range for males presenting was 20–24 years, at 392 per 100,000. This indicates that one in every 165 Irish adolescent girls was treated in hospital each reporting year as a result of deliberate self-harm.

Increased deprivation and social fragmentation were associated with increased rates of deliberate self-harm. Rates were higher in urban settings, with the highest rate reported in HSE Dublin/North East Region.

Repetition of deliberate self-harm accounted for almost one in four (23.1% in 2006 and 22.4% in 2007) of all presentations, with men more at risk of repeated self-harm.



Drug overdose was the most common form of deliberate self-harm, representing 74% of all such episodes reported in 2006–2007. Overdose rates were higher among females (80%) than among males (65%). On average, 31 tablets were taken in episodes of drug overdose. The total number of tablets taken was known in 78% of cases. Forty-two per cent of all drug overdoses involved a minor tranquilliser, 30% involved paracetamol-containing medicines and 22% involved anti-depressants/mood stabilisers. According to the report the withdrawal of the prescription paracetamol-containing analgesic, distalgesic, in January 2005 has had an impact. Distalgesic was involved in approximately 40 cases in 2007 compared to approximately 400 cases reported annually in 2002–2005. There was evidence of alcohol consumption in 41% of all episodes of deliberate self-harm, emphasising the strong association between alcohol consumption and suicidal behaviour.

Self-cutting was the second most common method of deliberate self-harm, representing 21% of all episodes. In contrast to drug overdoses, self-cutting was more common among males than among females.

The emergency department was the only treatment setting for more than half (53%) of all deliberate self-harm patients.

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

- continued support of the national mental health awareness campaign and related mental health promotion initiatives to reduce levels of psychiatric and psychological morbidity in the population
- additional resources to support mental health promotion, and specialist mental health services for adolescents aged 15–19 years
- evidence-based interventions targeting persons who repeatedly self-harm with focus on high-risk groups
- consider restricting availability of minor tranquillisers
- a mechanism for linking data collected by the Registry with data on suicide mortality to improve understanding of the relationship between deliberate self-harm and the risk of suicide in the future
- extension of the core Registry dataset to support evaluation of progress on actions in the strategy document on suicide prevention, *Reach Out* (Health Service Executive, National Suicide Review Group and Department of Health and Children 2005), and increase our understanding of deliberate self-harm.

### **Zopiclone misuse: an update from Dublin**

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

The prevalence of zopiclone misuse in 158 clients attending a methadone maintenance programme in Dublin was measured through detection of its degradation product, 2-amino-5-chloropyridine (ACP), in urinalysis (Bannan *et al.* 2007). Urine samples were also tested for the presence of metabolites of opiates, benzodiazepines, cocaine, alcohol and cannabis. Thirty seven (23%) clients tested positive for ACP, of whom 23 (62%) were interviewed. The average age of those interviewed was 32 years, 74% were women, 95% had ever injected illicit drugs and 70% were hepatitis C positive. All interviewees had a history of opiate, benzodiazepine and cannabis use. The most common drugs used at the time of the study were benzodiazepines (100%) and opiates (61%). The average age at which clients started consuming zopiclone was 28 years. The daily doses of zopiclone ranged between 15 mg and 300 mg. All interviewees preferred zopiclone to benzodiazepines because it caused a lower level

of amnesia. According to the interviewees, zopiclone was used with heroin to increase heroin's sedative and tranquillising effects. The street price of zopiclone was one euro per tablet, which is double the commercial price. According to the authors, zopiclone is being misused by drug users in Dublin in the context of many other drugs. Prescribing of zopiclone should be restricted, especially among drug misusers.

### **Identifying new drugs and new drug trends with the help of drug helplines**

In May 2008 the European Foundation of Drug Helplines (FESAT) published the results from its twelfth monitoring project (Hibell 2008). Since the beginning of 2001 FESAT has been collecting information every six months on the types of person contacting helplines, the content of these calls and how this has changed compared to the previous six months. According to the author, the main objective of this monitoring is to identify early the emergence of new drugs and new drug trends; the data collected cannot quantify the size of any change. Of the 31 relevant FESAT helplines, 20 helplines in 13 European countries, including Ireland, participated in the project. This article will describe some of the main changes that were reported by the helplines during the first half of 2007.

The smallest of the 20 participating helplines answered an average of one call per day, and the largest, 121 calls. Four helplines answered five or fewer calls per day, 13 helplines answered between five and 20 calls per day, and three helplines answered 21 or more calls per day. The Drugs/HIV Helpline in Ireland answered an average of 15 calls per day, though this figure included calls about sexual health. There were 1,905 calls between January and June 2007 (Aileen Dooley, personal communication, 2008). Some European helplines provide services by email as well as by phone, which makes their advice more accessible; the Irish helpline does not have this facility.

The FESAT report notes a continuation of the upward trend in the number of calls about cannabis (6 helplines) and about cocaine (6 helplines). The number of calls about alcohol also increased. The numbers of calls about injecting heroin and about ecstasy decreased.

The Irish Drugs/HIV Helpline reported a large increase in the number of calls about intravenous heroin use in the first half of 2007 compared with the second half of 2006. There was also a large increase in the number of calls referring to benzodiazepines. There was some increase in the number of calls referring to cannabis and certain opiates (methadone, Subutex, codeine and DF118). There was no significant change in the number of calls referring to cocaine. Calls from male drug users aged between 20 and 25 years, and from parents or guardians, increased considerably during the first half of 2007. The number of calls referring to alcohol decreased.

Three helplines received calls about drugs that had not been reported to them before. A helpline in Norway reported a call about a substance called Polarmine, which is an antihistamine with sedative effects. The helpline in Belgium reported calls about LSA, or morning glory, which has hallucinogenic effects. The German helpline reported calls about fentanyl, which is a synthetic opiate. The Drugs/HIV Helpline in Ireland did not report any calls about new drugs during this period.

### **Drug tests in Irish prisons**

Information on drug testing in prisons from 2005 to 2007 was obtained from the Irish Prison Service by The Irish Times under the Freedom of Information Act, and by the Alcohol and Drug Research Unit (ADRU) of the Health Research Board in order to clarify points raised in the subsequent Irish Times articles on drug testing in Irish prisons between 2005 and 2007. According to the data obtained by ADRU, more than 20,000 voluntary tests were carried out each year to monitor drug use and responses to treatment. These tests included those carried out on committals (new entries) as well as on existing inmates. It may be assumed therefore that some of the positive test results relate to drugs or alcohol consumed outside the prison. Between one-third and one-half of those screened tested positive for at least one drug. The common

metabolites detected indicated use of cannabis, benzodiazepines and opiates (Table 4.4.1). It is not clear whether the numbers of positive cases excluded prisoners who were prescribed benzodiazepines; if they do not, these figures overstate the extent of unregulated use of benzodiazepine in prisons. Cocaine and alcohol were detected in a small number of tests. The profile of positive drug tests was similar among prisoners tested in Mountjoy, Wheatfield, Limerick, Midland and Cloverhill prisons. The proportion of positive tests was low in St Patrick's Institution and in Castlerea and Cork prisons.

**Table 4.4.1 Number of tests, by prison, and number (%) of positive tests, by prison and by drug type, 2007**

Prison	No. of tests	Cannabis	Benzodiazepines	Opiates	Cocaine	Alcohol	Amphetamines
Mountjoy Main	3,680	1,860 (51%)	1, 871 (51%)	2,112 (57%)	78 (2%)	23 (0.6%)	29 (0.8%)
Dochas Centre	2,464	844(34%)	1,294 (50%)	751 (46%)	85(11%)	55 (3%)	14 (1%)
Wheatfield	4,369	2,122 (49%)	1,572 (36%)	1,842 (44%)	51 (1%)	31 (0.7%)	35 (0.8%)
Cloverhill	3,301	833 (25%)	1,206 (37%)	1,141 (35%)	267 (8%)	79 (2%)	31 (0.9%)
St Patrick's Inst.	3,489	245 (7%)	179 (5%)	86 (3%)	12 (0.3%)	14 (0.4%)	20 (0.6%)
Castlerea	92	14 (15%)	17 (19%)	9 (10%)	0 (0%)	0 (0%)	2 (2%)
Loughan House	407	128 (32%)	55 (14%)	16 (4%)	7 (2%)	9 (2%)	8 (2%)
Shelton Abbey	382	97 (25%)	45 (12%)	22 (6%)	19 (5%)	12 (3%)	10 (3%)
Limerick	518	189 (37%)	223 (43%)	228 (44%)	3 (0.6%)	18 (3%)	5 (1%)
Cork	97	3 (3%)	8 (8%)	1 (1%)	0 (0%)	1 (1%)	0 (0%)
Midland	1,694	263 (16%)	422 (25%)	871 (51%)	18 (1%)	9 (0.5%)	9 (0.5%)
Portlaoise	20	3 (15%)	4 (20%)	4 (20%)	0 (0%)	1 (5%)	0 (0%)

Source: Data received from the Irish Prison Service

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

### **5.1 Overview**

On 1 January 2005, the ten health boards managing the health services in Ireland were replaced by a single entity, the Health Service Executive (HSE), which manages Ireland's public health sector. The HSE's Addiction Services, including both illicit drugs and alcohol, are delivered through Social Inclusion Services, which is part of the Primary, Community and Continuing Care (PCCC) directorate. Treatment is provided through a network of statutory and non-statutory agencies. Two broad philosophies underlie the approaches to treatment: medication-free therapy and medication-assisted treatment. Various types of counselling are provided through both philosophies of treatment and independent of either type of treatment. Alternative therapies, such as acupuncture, are provided through some community projects. The results at one-year follow-up (ROSIE, Research Outcome Study in Ireland, 2006) showed a positive association between opiate treatment and a reduction in criminal behaviour.

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

### **5.2 Treatment system**

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

#### **5.2.1 Residential services for alcohol and drug users**

The National Drugs Strategy (NDS) 2001–2008 provides the strategic framework for drug services in Ireland. The strategy is based on four pillars, supply reduction, prevention, treatment and research, and is underpinned by 100 actions which are the responsibility of various government departments and agencies. Through the NDS, the Health Service Executive (HSE) (formerly the 10 health boards), is mandated to provide a range of treatment options, including residential components, to drug users experiencing problems.

In 2005, a mid-term review of the NDS recommended that rehabilitation be adopted as a fifth pillar of the Strategy. Arising from this recommendation, the HSE appointed an expert working group in 2006 to describe residential treatment services for problem drug and alcohol users in Ireland, to calculate their current capacity and to estimate future requirements. The report of that group has now been published (O'Gorman and Corrigan 2008).

The working group mapped existing inpatient detoxification, rehabilitation and aftercare services, and reviewed the international literature. The literature examined four specific areas: models of care, the evidence base for opiate and alcohol detoxification, methods employed to calculate the number of places required for detoxification, and the standards for measuring quality of care. Available data from existing reporting systems, such as the Hospital In-Patient Enquiry scheme, the National Drug Treatment Reporting System and the National Psychiatric In-patient Reporting System, were

analysed. A number of submissions were made to the group. A population-based approach was adopted to estimate the level of residential services required. The availability of and requirements for residential treatment beds are shown in Table 5.2.1.

**Table 5.2.1 Availability of and requirements for residential treatment beds**

<b>Bed type</b>	<b>Current provision</b>	<b>Total beds required</b>	<b>Shortfall</b>
Medical detoxification and stabilisation	23	127, of which: 50% for alcohol (64), and 50% for drugs (63)	104
Community-based residential detoxification	15	Assessment not completed	
Residential rehabilitation	634.5, of which 31% are reserved for use by people with problem alcohol use only	887, of which: 205 for illicit drug users transferring from inpatient detoxification services; 382 for problem alcohol users transferring from inpatient detoxification services; and 300 to address the needs of drug or alcohol users who have attended outpatient detoxification services; The above 3 categories are each to reserve between 14 and 37 beds for a specific adolescent service.	252.5
Step-down/halfway house	155, of which 76% are for use by men only	296 (required by 30% of service users)	141

The key **recommendations** of the working group are:

- The four-tier model of service delivery, which offers clients the least intensive intervention appropriate to their need, should be adopted as the framework for the future delivery of alcohol and drug services in Ireland. It was acknowledged that all four tiers need to be fully resourced for this model to be effective.
- A standardised assessment protocol which allows for the systematic identification of each client's needs is required.
- Inpatient detoxification should, as a rule, be provided in dedicated units. Detoxification must be followed up by rehabilitation and aftercare interventions. The transition from a detoxification programme to rehabilitation should be seamless so as to avoid waiting lists, relapse and (in the case of opiates) overdose.
- The number of inpatient detoxification and residential rehabilitation beds needs to be increased (see Table 5.2.1 above).
- Where there is unused capacity at present in a service or unit because of staffing shortages, such capacity needs to be brought on stream immediately.
- In highlighting a deficit of 356.5 beds (104 inpatient detoxification and 252.5 rehabilitation), the working group noted the estimated 66 beds in psychiatric units and hospitals that are currently used for alcohol and drug problems and which will no longer be available as a result of the restructuring proposed in the report of the expert group on mental health policy.
- Of the estimated 63 beds required for inpatient detoxification for drug users, one 50-bedded unit should be provided between the Dublin Mid-Leinster and Dublin North East HSE regions where, the data indicate, the majority of opiate and benzodiazepine users live. The remaining 13 beds should be divided between the HSE Southern and HSE Western Regions.
- In the case of services focusing primarily on the treatment of alcohol problems (detoxification and residential), the beds need to be evenly spread over the four HSE regions (16 per region) since the data suggest a more even distribution of alcohol-related problems throughout the country.
- Clients with co-morbidity issues who are in residential drug and alcohol services should be provided with adequate support by the mental health services, with clear pathways into residential mental health services when required.
- There is a need to review community-based or outpatient detoxification services, including the possible role of Level 2 GPs in their provision.
- The Prison Service needs to extend its detoxification and rehabilitation programme in Mountjoy Prison, and establish similar programmes in all other prisons within the State.

- The provision of step-down or halfway-house accommodation for newly released prisoners and homeless people who have been detoxified or who have started rehabilitation programmes is particularly important.
- A unique identifier and mechanism to track progression from treatment services to rehabilitation is required.
- A directory of current residential services needs to be developed and updated annually.
- Families of drug and alcohol users could be more involved in the overall careplans of recovering users. Innovative approaches to care for the children of drug users while in treatment are required.
- The *Quality in Alcohol and Drugs Services* (QuADS) suite of organisational standards and the *Drug and Alcohol National Occupational Standards* (DANOS), developed in the UK by Alcohol Concern and Drugscope and Skills for Health, should be adapted for use by drug and alcohol services in Ireland.
- There must be quality standards for the residential facilities themselves, and the HSE should discuss with the Health Information and Quality Authority (HIQA) the possibility of bringing such facilities under the regulation of HIQA's social services inspectorate. This would help avoid duplication of effort when quality audits are undertaken.
- It is particularly important that relevant stakeholders ensure that all detoxification procedures meet the highest standards of clinical governance, care and patient safety.
- The level of provision set out in this report should be reviewed in March 2010.

### **5.2.2 HSE outlines plans for drug and alcohol services in 2008**

The HSE's *National Service Plan 2008* (NSP) outlines the agency's plans in the drugs and alcohol area during 2008. The HSE's Addiction Services, including both illicit drugs and alcohol, are delivered through Social Inclusion Services, which is part of the Primary, Community and Continuing Care (PCCC) directorate. Table 5.2.2 summarises the deliverables identified for 2008 in respect of illicit drugs and alcohol, together with the outputs achieved in 2007.

The performance targets for Addiction Services in 2008 have been set as follows: Percentage of substance misusers for whom treatment commenced within one month is to exceed the 84% level achieved in 2007. The average number of clients in methadone treatment per month is to reach 7,000, the same level as in 2007.

No target has been set for a third performance measure – the number of substance misusers under 18 years for whom treatment is commenced. The NSP explains, 'Additional staff to support key service developments for under-18 services with addiction has been identified for 2008. The impact of these appointments on current levels of service provision will be monitored through our service plan reporting.'

The focus of the Population Health Directorate of the HSE in 2008 will include, among other things, further developing, in conjunction with the departments of Education and Health, the delivery of the Social Personal and Health Education (SPHE) programme; further research and education initiatives on alcohol in pregnancy; starting a health impact assessment project on alcohol off-sales; and continuing to work with the Department of Health on matters such as alcohol advertising and off-sales.

The establishment of a unified health system is seen as an opportunity to establish new structures and mechanisms to promote the reduction of health inequalities. The HSE is extending social inclusion from its traditional focus on the care and support needs of vulnerable groups such as drug users, to enhancing the responsiveness of all services at all levels of care and thus improving access to health services for all service users. Initiatives include:

- A new contractual framework for the GMS and other publicly-funded services involving GPs has been developed. One objective is to achieve greater

responsiveness to the needs of vulnerable patients such as the homeless or those with addiction problems. In 2008 this new framework will be signed off on by HSE management, and engagement with key stakeholders will commence.

- A review was completed in 2007 of the current arrangements for the management of health and personal social services provided by the non-statutory sector, in recognition of the need to develop standardised processes that safeguard service users, ensure transparency and fairness in the awarding of funding, link payments to service levels and outcomes, and use formal service level agreements. A new management framework was adopted and during 2008 this new approach will be implemented in the HSE.

**Table 5.2.2 Addiction Services in 2008 (after HSE NSP 2008: 51–52)**

Focus	Outputs 2007	Deliverables 2008
<b>National Drugs Strategy</b> The National Drugs Strategy comes to an end in 2008 and is being reviewed. The Department of Community, Rural and Gaeltacht Affairs is currently establishing a structure for this review. The HSE will have a critical role to play in this.		Participate in review of the National Drugs Strategy.
<b>Cocaine treatment</b>	National co-ordinator employed to lead the National Addiction Training Programme, with initial emphasis on cocaine training.	Implementation of the National Addiction Training Programme progressed.
<b>Development of treatment services for under-18s</b>	Primary notification in place for multidisciplinary team enhancement and developments.	Development of multidisciplinary team enhancements and related services.
<b>Data collection</b> The provision of robust information to underpin service planning in drug and alcohol services is a priority for Social Inclusion services.	Glossary agreed with the Health Research Board (HRB). Mapping completed and gaps identified in data-collection systems from treatment services.	Examination and reconfiguration of performance indicators for drug and alcohol. Mapping of data collection systems.
<b>Health Atlas</b> The Health Atlas aims to enable web-based mapping of health related data on a national basis.	Mapping services completed and framing of 4-tier model progressed to Health Atlas.	Drug and alcohol information input to Health Atlas.
<b>Quality initiatives / standards</b> Quality in alcohol and drug services (QUADS) and Drug and Alcohol Occupational Standards (DANOS) are benchmarking standards for the drug and alcohol service.	QUADS / DANOS accepted as the benchmarking standards.	Use of QUADS mapped around the country. Ramifications for implementing DANOS explored.
<b>Drugs task force mainstreaming</b> The Department of Community, Rural and Gaeltacht Affairs has funded a number of drugs task force pilot projects.	Working group established to plan mainstreaming of drugs task force projects. Mainstreaming proposal document developed. Review under way of the list of projects to ensure they are in line with HSE policy.	Process agreed with DCRGA and DOHC to manage mainstreaming of the National Drugs Strategy projects that have been evaluated. Project-by-project analysis of drugs task forces undertaken. Projects mainstreamed.
<b>Links to HSE Working Group on Alcohol</b>	Cross-directorate process established with Office of the CEO, Primary, Community and Continuing Care, and National Hospitals Office.	Cross-directorate strategic focus on alcohol developed. Best-practice guidelines for the alcohol services developed.
<b>National Drugs Rehabilitation Strategy</b> Rehabilitation is a key priority in 2008.	National Drugs Strategy report on rehabilitation completed.	National Drug Rehabilitation Implementation Committee developed.

### 5.2.3 RDTF strategies and treatment

The regional drugs task forces (RDTFs) are responsible for co-ordinating the implementation in the regions of national drug policies, as set out in the National Drugs Strategy. Pike examined the responses of the RDTFs under the Treatment pillar and published her findings in Drugnet Ireland (Issue 25: 7).

The RDTFs endorse the approach to drug-related treatment set out in the National Drugs Strategy and call for full implementation in their regions – including, for example, the continuum of care model and the use of key workers; the targeting of under-18s;

the integration of prison-based and community-based treatment services; the provision of childcare facilities; and the exploration of alternative medical and non-medical treatments. The RDTF strategies also endorse the responses to emerging needs identified in the Mid-Term Review of the National Drugs Strategy, including the need to develop comprehensive rehabilitation services, and to provide support services for the parents and families of drug users as well as for drug users themselves.

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

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

The possibilities of drug testing, not mentioned in the National Drugs Strategy, are discussed. The South-East RDTF comments, 'Those young people most at risk will be helped through increased outreach and community treatment. They could also benefit from new initiatives including drug testing, referral to innovative and increasing treatment facilities, drop-in centres, mentoring and one-to-one counselling facilities as well as awareness raising programmes'. The Southern RDTF canvasses the idea that, 'With due recognition of the rights of every citizen before the Courts, urine samples should be sought from young people in this situation and evidence of illegal drugs in the system should be taken into account in deciding how best to respond to the needs of that person,

### **Harm reduction principles on which the South-East RDTF predicates its drug strategy**

- Accepts, for better and for worse that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than ignore or condemn them.
- Understands drug use as a complex, multi-faceted behavioural phenomenon, ranging between severe abuse and total abstinence, and acknowledges that some ways of using drugs are safer than others.
- Establishes quality of individual and community life and well-being – not necessarily cessation of all drug use – as the criteria for successful interventions and policies.
- Calls for the non-judgemental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drug users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognises that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimise or ignore the real and tragic harm and danger associated with licit and illicit drug use.



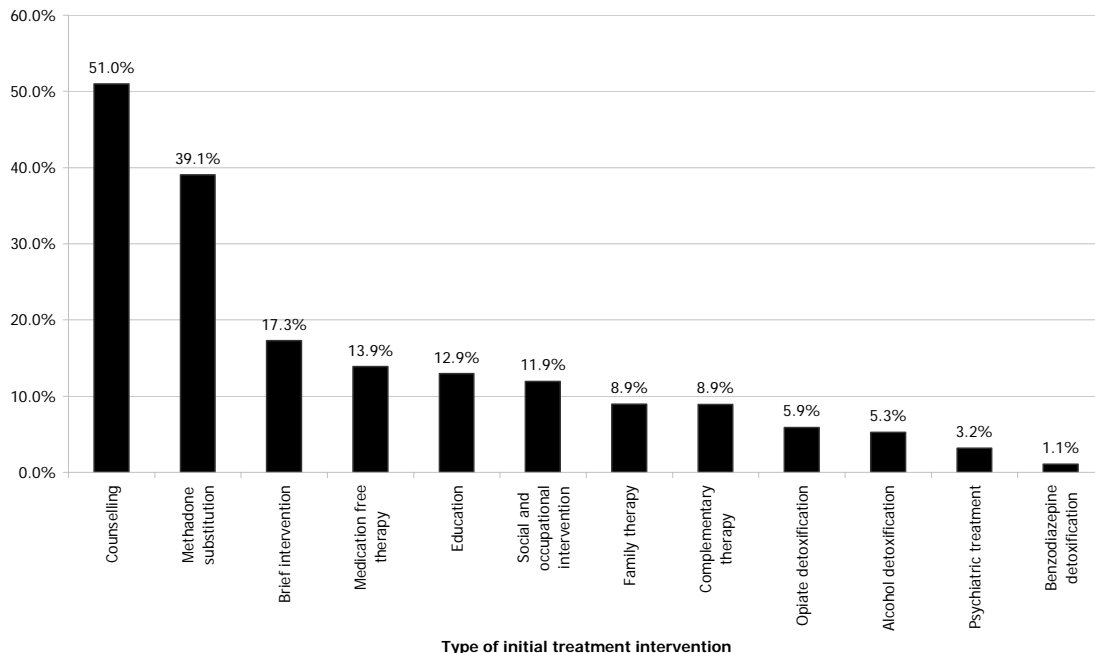
## 5.2.4 Drug treatment demand

The total number of drug treatment services available in Ireland and participating in the NDTRS increased between 1998 and 2005. The number stabilised in 2006 when compared to 2005 but increased again in 2007 (Standard Table TDI 34). The largest increase was in outpatient treatment services and general practitioner services. In the HSE Eastern Region, counsellors employed by statutory services did not consistently return information on cases who received counselling only; therefore there is an under-representation of cases treated for use of drugs other than opiates in this region. At present the Prison Service does not participate in the NDTRS, although it does provide drug treatment services.

In 2006, 12,744 cases were treated for problem drug use. Of these, 7,269 opiate cases continued in treatment from 2005 and 5,475 drug cases entered or returned to treatment during 2006. When double counting within treatment centres was controlled for, 5,285 cases entered treatment and were reported to the NDTRS during 2006. These figures do not include cases who reported alcohol as their main problem drug but used other additional drugs

Just over 2,300 methadone treatment places have been created since the beginning of the current National Drugs Strategy (2001–2008) and the number of outpatient services has increased by 25%.

Of the 5,191 cases entering treatment for problem drug use in 2006 and residing in Ireland, 51% received counselling as an initial intervention, 39% received methadone substitution, 17% received a brief intervention and 14% attended medication-free therapy. Thirty-six per cent of cases received more than one initial treatment intervention (Figure 5.2.1).



**Figure 5.2.1** Percentage of cases living and entering treatment in Ireland who availed of each type of initial treatment intervention provided, reported to the NDTRS, 2006

## 5.2.5 Developments in health care in Irish prisons in 2006

The Irish Prison Service (IPS) annual report for 2006 was published in December 2007. In 2006 there were 12,157 committals to prison: 5,642 under sentence; 5,311 on remand; 1,196 under immigration law; and eight for contempt of court. These committals related to 9,700 individuals. Of the 5,642 sentenced committals, 113 were

for intoxication (by alcohol) in a public place and 395 for drug offences (up 29% on the 2005 figure).

The IPS aims 'to provide a range of care services to prisoners to a standard commensurate with that obtaining in the wider community' (Irish Prison Service 2006a). Included are medical, dental, psychiatric, psychological, education, vocational training, work, welfare, spiritual, counselling and recreational services. Healthcare is provided by psychiatrists, general practitioners, nurses, counsellors and medical orderlies.

### **Drugs and prison**

In May 2006 the Minister for Justice launched the IPS drugs policy and strategy document, *Keeping drugs out of prisons* (Irish Prison Service 2006b). This sets out the steps required to tackle the supply of drugs into prisons, to provide adequate treatment services to those who are addicted to drugs, and to ensure that developments in the prisons are linked to those in the community. The IPS has reported significant progress in implementing this strategy.

### **Treatment and rehabilitation services**

New services and programmes for addicted prisoners were developed in 2006. These were delivered by the IPS in partnership with the Health Service Executive (HSE) and contracted private services.

- Seven nurse officers and five prison officers were allocated to dedicated drug treatment teams in Cloverhill and Wheatfield prisons.
- An additional consultant in addiction was provided to improve the quality and co-ordination of drug treatment in prisons.
- A contract was awarded to Merchants Quay Ireland to provide access for prisoners to addiction counselling (a total of 1,000 hours per week).
- The Dormant Accounts Fund financed four community groups to provide addiction counselling and other supports to prisoners while in prison and on release in the community.
- A consultant-led infectious diseases service was contracted from St James's Hospital to provide treatment to prisoners who suffer from infectious diseases. It is hoped to expand this service to other sites.
- An HSE consultant in forensic psychiatry in the Western Region was contracted to provide dedicated sessions in Limerick Prison.
- The second contracted pharmacy service was introduced to Loughan House (an open prison) in April 2006.
- A contract for dedicated pharmacy services to provide drug treatment was developed and awarded. This will provide pharmacy services in a number of closed prisons.
- The psychology service in Irish prisons increased its team to seven clinical psychologists, eight counselling psychologists and one forensic psychologist.
- Further work was undertaken to promote and facilitate the use of the prison medical record system through training and support, and the development of changes based on user feedback.

Nine prisons provided methadone treatment to 1,579 prisoners in 2006, of whom 162 were receiving methadone for the first time (Table 5.2.3). It is noteworthy that methadone treatment was not provided in two large prisons, Cork and Castlereagh.

**Table 5.2.3 Numbers of individuals receiving methadone treatment\* in Irish prisons in 2006**

Prisons	Total patients during 2006	New patients in 2006	Patients on 31 December 2006
Cloverhill Prison	678	107	175
Dochas Centre	216	20	32
Limerick Prison	8	0	6
Midlands Prison	19	2	12
Mountjoy Main Prison	416	13	145
Mountjoy Prison Medical Unit	48	2	12
Portlaoise Prison	2	1	2
St Patrick's Institution	8	1	6
Wheatfield Prison	184	16	82
<b>Total</b>	<b>1579</b>	<b>162</b>	<b>472</b>

\*Methadone treatment in this context is either substitution or detoxification.

### **Eliminating the supply of drugs**

During 2006 the IPS intensified its focus on preventing illicit drugs being brought into prisons. The traditional means of effecting supply reduction – staff vigilance, physical searches and supervision of people entering prisons – continue to be reinforced through improving facilities and procedures. Specific measures put in place in 2006 include:

- More secure prisoner visiting arrangements, which involve greater control over the number and identity of visitors, and enhanced supervision of visits
- Enhanced perimeter security through improved netting and closer co-operation with An Garda Síochána
- Enhanced technology for searching of cells and prison property, resulting in improved detection and seizure of contraband
- The introduction of dogs to detect drugs on people entering prisons and to aid searches within prisons.

### ***Prison Chaplains welcome new initiatives to treat drug use among prisoners but call for coordination between treatment and supply***

In November 2007 the *Irish Prison Chaplains Annual Report 2006/07* was submitted to the Minister for Justice. Overall, it argues for a shift from punitive to restorative justice. In respect of drugs, the report states:

The misuse of drugs continues to be a major problem in most of our prisons. We welcome the introduction of drug counsellors and addiction nurses and we hope that their expertise in dealing with drug addiction will help address the drug culture that prevails. Given the ongoing debate around methadone maintenance, we hope this additional service will offer greater possibilities and opportunities to those struggling to remain drug free. We strongly recommend that resources be made available for those prisoners who plead for help in the whole area of drug addiction. To date, at any given time only nine prisoners may avail of a special six-week course in Mountjoy to address their addiction. Surely this must be seen to be insufficient when the drug addiction is the cause of so many prisoners been incarcerated in the first place. There are numerous prisoners who look for a drug free landing in order to stay away from drugs but they are few in number. Many people will in fact have been introduced to drugs initially while they were in prison. Sniffer dogs have been introduced in some prisons, which have reduced the quantity of drugs getting into the prison. This can cause tension on the landings when the supply is short. We call for a systematic approach to be implemented so that as the supply is diminished the appropriate support be offered in its place. [www.cfj.ie](http://www.cfj.ie)

## **5.3 Drug free treatment**

### **5.3.1 Inpatient treatment**

### **Abstinence treatment outcomes at one year**

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

The abstinence modality is defined as: 'any structured programme which required individuals to be drug-free (including free from any pharmacological intervention) in order to participate in, and remain on, the programme'. Participants are required to attend a structured programme of daily activities and are given intensive psychological support. Abstinence-based treatment occurs in both inpatient and outpatient settings. Residential rehabilitation programmes can differ considerably in terms of their underlying philosophy and programme structure. Programmes may be either short-term (4–12 weeks) or long-term (3–12 months).

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

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

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

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

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

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

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

### **Keltoi completes an outcome study**

On 12 November 2007 a client evaluation study of the Keltoi treatment centre in Dublin was published (Sweeney et al. 2008). Funded by the Health Service Executive, the study was a cross-sectional survey of a sample of clients who had been discharged between one and three years prior to interview.

The treatment model employed by Keltoi is unique in Ireland. It is based on international findings that rehabilitation with a focus on developing new living skills produces more favourable outcomes. According to Keltoi, a favourable outcome sees clients developing and successfully maintaining a drug-free lifestyle.

Of the 485 clients referred to Keltoi between 2002 and 2004, 149 (31%) were treated. Ninety-five per cent of clients admitted to the treatment programme had severe opiate dependence problems, and a small proportion had severe cocaine dependence. To be admitted to the programme, clients had to be drug-free for two to six weeks, depending on the individual case and the assessment by the team. Ninety-two participants (62%) agreed to be interviewed, two of whom died prior to the interview date. Eighty questionnaires were completed. The final sample comprised 52 (74%) men, 18 (26%) women and 10 individuals whose gender was not recorded.

The study reported that a large proportion of those who started treatment completed it (83%, 58/70). Half (29/58) of those who completed treatment were drug free in the month prior to this study interview. The abstinence rate for men (50%) was higher than that for women (39%). The proportion who committed at least one crime during the 30 days prior to interview was lower among those who had not used drugs in that time than among those who had, 15% compared to 30%. Five of the 29 who had used at least one drug in the last month had injected it.

Although not directly comparable, these study findings follow the same trend as those of the ROSIE study, which indicated that opiate treatment in residential facilities is reasonably successful. The limitations of this study are that there are no baseline data and drug-free status is self-reported. In addition, it is possible that other treatment interventions may have taken place between discharge from Keltoi and the study interview and these may account for some of the positive findings. Nevertheless, these findings indicate that the Keltoi approach to treatment for drug users can lead to favourable outcomes.

### **5.3.2 Outpatient (including low threshold and general practice) treatment**

#### **A new approach to working with drug users**

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

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

Dr Loose describes how addiction treatment relationships involve emotional expressions (demands for recognition, trying to please, being good, wanting to be loved, accusation, irritation, aggression, transgression, behaving badly etc.), which are signs of the pathology of the client. These emotional expressions are the essence of addiction treatment. The only way for addicts to recover is via verbalisation within a relationship where very difficult and anxiety-provoking experiences can be articulated and worked through. As a result it is in the very nature of addiction to undermine the pact that exists between people. This is what counsellors have to withstand and when this becomes problematic it can lead to counter-transference. It often happens that staff are idealised by addicts. At an unconscious level staff members may identify with this idealisation – there is a need in them to be admired by their clients. The treatment can become destructive if the counsellor's need feeds into the pathology of the client. This will lead to a therapeutic deadlock and the client will be forced to remain dependent on the counsellor/institution.

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

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

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

Key elements of the author's proposed new template:

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

## 5.4 Pharmacologically assisted treatment

### 5.4.1 Withdrawal treatment

#### Detoxification treatment outcomes at one year

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

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

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

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

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

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

The number of participants who reported using heroin, non-prescribed methadone, non-prescribed benzodiazepines, cocaine, cannabis or alcohol in the 90 days prior to interview decreased between treatment intake and one-year follow-up. The most substantial reduction was in the proportion of participants using heroin (79% at treatment intake compared with 39% at one year).

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

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

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

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

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

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

### **Community detoxification pilot scheme**

A series of seminars was held on 8 April 2008 with health care professionals and community and voluntary groups to introduce intra-agency community methadone detoxification protocols. It aimed to give opportunities for discussion around offering community detoxification as a viable alternative option for people. The then Minister of State for Drugs, Pat Carey TD, also addressed the participants.

These protocols will be piloted in the North Inner City Drugs Task Force (NICDTF) area over the next 18 months. They aim to provide an option for people who find it difficult to take up a residential detoxification bed owing to family or work commitments. They may also benefit individuals who want to reduce their methadone dosage in order to access a residential programme. They were developed in response to concerns voiced by the community and by drug users that people were being 'parked' on long-term methadone maintenance.

These protocols are based on best practice guidelines from the UK and input from Irish experts. They emphasise empowerment – drug users are empowered to choose what



treatment option best suits them, but also to take responsibility for their treatment. The protocols are designed to address the concerns of GPs about the risk factors associated with the process, including integrating the necessary social support for their patient for a successful and safe detoxification. The steps in the process are summarised below.

**Assessment** – When the client expresses an interest in undertaking the programme, the process starts with an assessment (including history of drug misuse which may also require testing). The client needs to provide one month's clean urine (free from opiates and illicit use of prescription drugs) and sign a consent form.

Meetings are held with the client, their case manager and GP to explain the process, clarify roles and responsibilities, and provide education on the dangers of relapse and overdose during detoxification. If the urinalysis shows non-compliance, in special circumstances and on agreement between all parties, the detoxification may go ahead.

**The case manager** – The case manager's role is important as it provides the social support essential for a successful and safe detoxification outside a residential facility, which the GP alone cannot provide. The case manager is responsible for assessing the client's suitability for the programme and for ensuring that correct protocols are followed. He/she has primary responsibility for the client's care plan. In consultation with the client, the case manager develops a relapse-prevention and aftercare plan, and works with the client during and after the detoxification (for a minimum of six months).

**The client** – Clients wishing to undergo a community detoxification also have responsibilities under the protocol. As well as providing clean urine samples, they must show willingness to engage regularly and reliably with their case manager and treatment agency. They must also commit to inform the case manager if they relapse or wish to stop the detoxification.

#### **Contra-indications**

- Previous history of epileptic seizures while undergoing detoxification
- Dual addiction, where both addictions are unstable or where a second addiction other than opiates is uncontrolled
- Severe mental health problems that are currently untreated
- Major medical illness
- Active treatment for hepatitis C
- Pregnancy

#### **Example of methadone detoxification schedule**

- Reduce methadone intake by 5ml per week until client reaches 50ml
- Continue at 50ml for one month, then
- Reduce by 3–5ml per week until client reaches 20ml
- Continue at 20ml for one month (attempt to transfer to community pharmacist where possible), then
- Reduce by 3ml per week until client reaches 10ml
- Continue at 10ml for one month, then
- Reduction from 10ml to zero may require:
  - Buprenorphine or lofexidine detox
  - Continued community detox as above
  - Inpatient detox.

**Benzodiazepine detoxification** – The aim of benzodiazepine detoxification is to become drug free, not to be maintained on lower doses. In this case, the client shows their commitment by attending four care planning meetings over a period of two to six weeks. They are also required to fill out weekly drug diaries.

**The future** – This pilot project will be monitored for at least the next 18 months by a steering committee. Caroline Gardner is the Progression Routes Co-ordinator and can be contacted at [progressionroutes@saol.project.ie](mailto:progressionroutes@saol.project.ie).

#### **5.4.2 Substitution treatment**

##### **Support for GPs treating clients throughout the country**

In April 2007 the Irish College of General Practitioners (ICGP) announced that its Methadone GP Co-ordinator, Dr Ide Delargy, was extending her services to GPs outside the former ERHA area. She acts as a resource for GPs already involved in prescribing methadone under the protocol, and aims to increase the number of GPs participating in the protocol throughout the country.

##### **Suboxone licensed in Europe**

On 24 February 2007 the combination drug Suboxone was launched in Ireland (European Medicines Agency 2006). The Department of Health and Children has established an expert group to consider the implications of the introduction of this drug and its use as a treatment for opiate dependency. In order for this drug to be prescribed, a system similar to that existing for methadone, including a protocol and a central register, will be required. The introduction of Suboxone to Ireland provides another choice of treatment for problem opiate use, as well as an opportunity to identify which substitute is most suitable for different sub-groups of patients. The group is expected to report in late 2008.

##### **Evaluation of the Safetynet Methadone Programme Pilot at the Dublin Simon Emergency Shelter**

In December 2007 the Dublin Simon Emergency Shelter started to implement the Safetynet methadone programme. Safetynet is a primary care network funded by the HSE that aims to provide GP and nursing services to homeless people. The results of an internal evaluation undertaken after six months of programme implementation were published in June 2008 (Geraghty *et al.*).

The Shelter provides accommodation to homeless people for up to six months. A large majority of residents are active drug users, most of them injecting heroin. The direct consequences of their drug use include a high level of morbidity, often leading to hospitalisation, a significant number of evictions for anti-social behaviour or non-payment of rent, and generally chaotic drug use behaviour. Most residents were not receiving any form of treatment prior to the Safetynet programme implementation; this is partly due to the waiting lists that prevail in many methadone clinics. Long waiting lists mean that clients would not be able to start treatment before their time in the Shelter is up; it is not only a lost opportunity to address the drug addiction when some stability is provided through temporary accommodation but it is also a significant barrier to progression out of homelessness.

By providing on-site medical and nursing services, as well as a needle exchange service, the Safetynet methadone programme has had a major impact on the residents and staff of the Shelter. Fourteen residents were initiated on a methadone programme during the six-month period. With little more additional budget than the standard cost for dispensing methadone, the first six months of the programme proved to be successful and the evaluation study highlighted many benefits such as:

- reduction in drug use
- decrease in morbidity, especially skin conditions and abscesses, largely attributed to the decrease in injecting by clients
- reduction in the number of evictions from the Shelter
- reduction in crime
- improvement in social functioning
- increase in numbers moving to more permanent accommodation

The report also made the following recommendations:

- increase the number of places from 10 to 55, with 25 of those allocated to residents of the Shelter
- facilitate the transfer of clients to HSE drug treatment centres when it is deemed a more suitable option
- provide counselling service

### **Methadone treatment outcomes at one year**

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

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

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

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

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

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

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

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

### **Factors affecting the outcome of methadone maintenance treatment in opiate dependence**

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

#### **5.4.3 Other pharmacologically assisted treatments**

No new information available.

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

### **6.1 Overview**

Problem drug use can lead to premature death. Death can occur as a result of overdose (both intentional and unintentional), actions taken under the influence of drugs, medical consequences and incidental causes. The number of deaths as a result of poisoning has fluctuated between 1998 and 2003; however, since 2003 the number of cases has risen from 107 cases to 159 cases in 2005. The rise is attributed to cocaine and/or poly-substance use including opiates.

Approximately 70% of opiate users have tested positive for hepatitis C in Dublin. One in twenty opiate users have tested positive for hepatitis B and one in ten opiate users have tested positive for HIV. The data pertain to the period between 1995 and 2001.

There are no national data on the prevalence of psychiatric co-morbidity in Ireland.

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

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

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

The first round of data collection for the new National Drug-Related Deaths Index (NDRDI) in Ireland has been completed and can now provide all data on overdoses (poisonings) and mortality among drug-users in Ireland.

The database extracts information from four sources: coronial records, deaths among in-patients in acute general hospitals throughout Ireland (Hospital Inpatient Inquiry Scheme [HIPE]), the methadone treatment database (Central Treatment List [CTL]) and the General Mortality Register (GMR). Records have been matched to avoid duplication and to maximise the information available on each case. To date, data have been collected for deaths that occurred between 1998 and 2005. Cases include all deaths as a result of overdose (referred to as poisoning in this section). This type of death may also be termed a directly drug-related death. Cases also include deaths among persons with a history of drug use (both dependent and non-dependent abuse), which may or may not have been implicated directly in their death. This type of death may be termed an indirectly drug-related death, or a non-poisoning. Delays in inquests mean that a small number of cases cannot be included in the analysis.

In the past, data have been provided to the EMCDDA using the GMR only. However, as the NDRDI obtains data from a number of data sources and can also collect more details about each case, the new figures from the NDRDI differ from the figures previously reported. It is important to note that data from Ireland prior to 1998 cannot be used alongside these new figures.

Using the EMCDDA (2002) ICD-10 definitions, information was extracted from the NDRDI database based on Selection D<sup>6</sup> to examine drug related deaths as a result of overdoses (poisonings).

Data from 1998 to 2005 have been updated in Fonte to reflect the improved data collection (see Standard Tables 5 and 6).

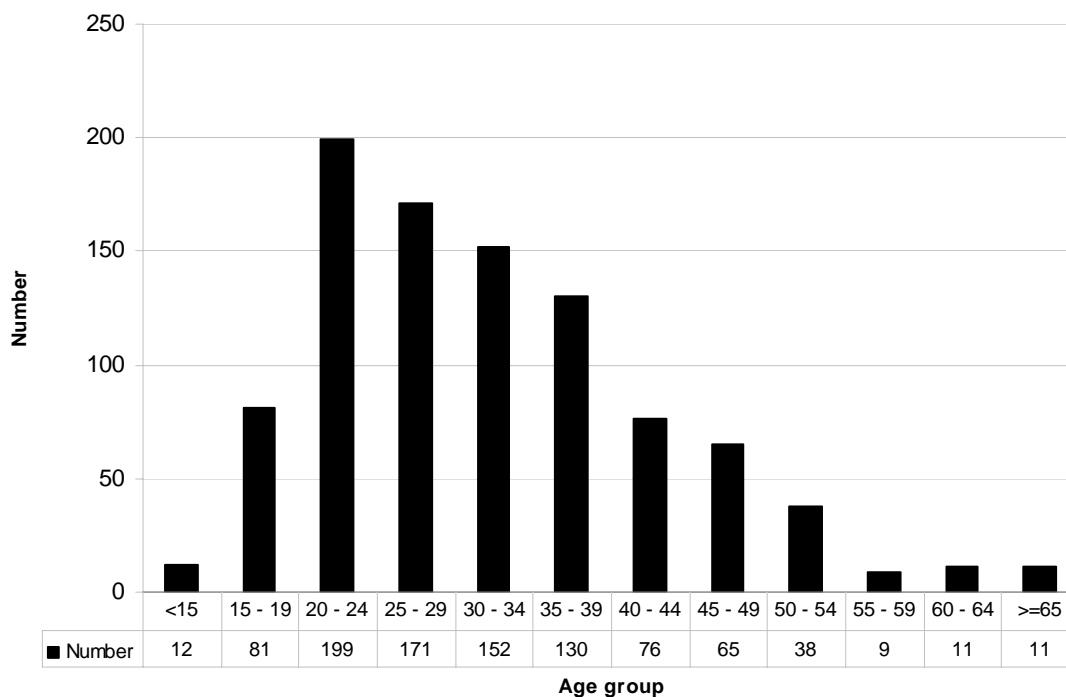
### 6.2.1 Direct overdoses and substances involved

For the first time, Ireland is able to provide data for Selection D. The number of cases in Selection D has fluctuated between 1998 and 2003; however, since 2003 the number of cases (mainly due to cocaine and/or poly-substances including an opiate) has risen from 107 cases to 159 cases in 2005 (Table 6.2.1).

**Table 6.2.1 Poisonings by year (Selection D), 1998 to 2005 (N = 955)**

	1998	1999	2000	2001	2002	2003	2004	2005
Selection D	104	115	113	106	125	107	126	159

Three quarters of cases were male (76.1%, 727). The majority of cases (652, 68.3%) were aged between 20 and 40 years (Figure 6.2.1). Half of all poisonings were aged 30 years or less.



**Figure 6.2.1** Number of poisonings by age group in Ireland (Selection D), 1998 to 2005 (N = 955)

Of the 955 cases collected between 1998 and 2005, 385 (40.3%) were attributed to a single drug. Of these, heroin (or an unspecified opiate compound) accounted for 155 deaths (40.3%), methadone for 61 deaths (15.8%) and analgesics containing an opiate compound (e.g. dextropropoxyphene) accounted for 76 deaths (19.7%). Sixty per cent

<sup>6</sup> The EMCDDA (2002) has developed a standardised method of extracting drug-related mortality data from various sources in all EU member states. This method involves the collection of information on drug-related deaths according to specific categories, using the International Classification of Diseases (ICD) to enable international comparisons. The types of code required varies depending on whether a country provides data from a General Mortality Register (GMR) which is categorised as Selection B or from a Special Register which is categorised as Selection D. Special Registers are usually maintained by the police or forensic services of a country and not all countries have a Special Register. The NDRDI can be considered a Special Register.

of poisonings (570, 59.7%) were attributable to two or more substances, of which 388 (68.1%) involved an opiate (including heroin, methadone or an unspecified opiate compound). A further 159 (27.9%) were attributed to poly-substances, which included an analgesic containing an opiate compound.

Table 6.2.2 presents all drugs and other substances involved in poisonings (both single and poly-substance use). Heroin was implicated in 32.3% of deaths by poisoning while methadone was implicated in a further 31.5%. Other opiates (including unspecified opiate compounds and analgesics containing an opiate) were implicated in 34.6% of poisonings.

The number of poisonings where cocaine was implicated alone or in conjunction with another drug increased steadily from 5 in 1998 to 34 in 2005. In total, cocaine was implicated in 100 cases (10.5%). Of these, 29 (29.0%) were due to cocaine alone. Heroin and/or methadone were often associated with cocaine in poly-substance use.

Selection D does not collect information on deaths from certain substances, either alone or in poly-substance deaths (see Table 6.2.2. below). However, these substances do appear in poly-drug deaths. In Ireland, benzodiazepines (in conjunction with one or more drugs) were recorded as one of the drugs implicated in 31.1% of deaths. Alcohol was implicated in one-fifth of poisoning-related deaths (22.7%) in conjunction with one or more substances.

**Table 6.2.2 All drugs involved in deaths by poisonings in Ireland (Selection D), by year, 1998 to 2005 (N = 955)**

	1998	1999	2000	2001	2002	2003	2004	2005	Total	%
Total number poisonings*	104	115	113	106	125	107	126	159	955	100.0
Other Opiates† **	38	33	45	44	42	44	56	56	358	34.6
Heroin	29	48	37	47	46	28	29	44	308	32.3
Methadone	43	37	40	27	39	33	40	42	301	31.5
Cocaine	5	5	5	8	14	10	19	34	100	10.5
<b>MDMA</b>	<b>4</b>	<b>8</b>	<b>8</b>	<b>6</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>10</b>	<b>69</b>	<b>7.2</b>
Volatile inhalants	3	5	2	3	6	3	2	8	32	3.4
Amphetamines	1	3	0	0	0	1	0	0	5	0.5
Hallucinogens	0	0	0	0	0	0	0	1	1	0.1
Cannabis	0	0	0	0	0	0	0	1	1	0.1
Benzodiazepines‡ **	53	53	48	30	47	37	44	48	360	31.1
Alcohol‡	19	27	21	17	35	28	31	39	217	22.7
Antidepressants‡ **	12	5	13	14	16	12	13	15	100	9.6
Non-opiate analgesics‡	1	0	0	3	1	3	3	2	13	1.4
Other ‡§ **	6	10	13	5	6	8	12	11	71	7.0

\* Column figures may differ from totals and percentages, as cases may have more than one drug implicated in their death

† Other opiates includes unspecified opiate compounds or analgesics containing an opiate compound

‡ Poly-substance deaths only

§ Other includes non-benzodiazepine sedatives, anti-psychotics, barbiturates, other prescription medication as well as insecticides, herbicides and over the counter medication

\*\* These categories include a range of medications/substances. Cases may have more than one type of drug from these categories involved in their death so the percentages implicated in deaths may be less than the total counts.

Deaths from volatile inhalants are included in Selection D. It is important to highlight these deaths, as they occur mainly in young people. One third of these cases (31.2%) were aged between 11 and 14 years, while a further 43.8% were aged between 15 and 19 years.

Between 1998 and 2005, there was an increase in cases observed outside Dublin, from 30 in 1998 to 69 in 2005 (Figure 6.2.2). In 2003, for the first time, the number of cases outside Dublin overtook the number inside Dublin. This was mainly due to a drop in deaths from poly-substances inside Dublin. However, in 2004 this reversed again, with more poisonings reported inside Dublin than outside Dublin.

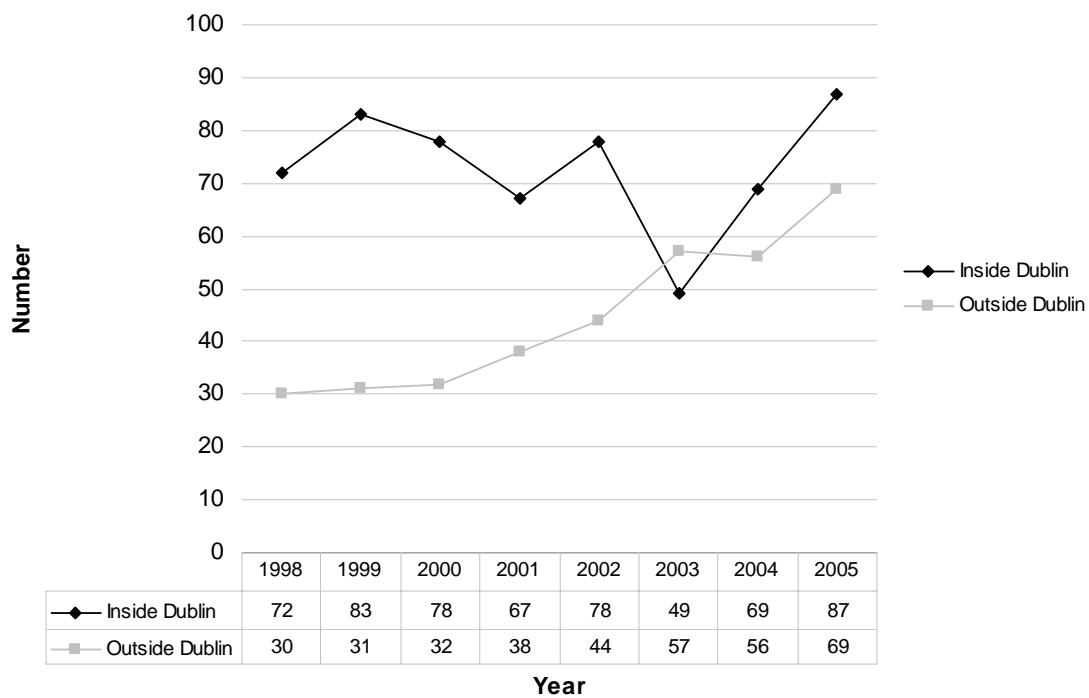


Figure 6.2.2 Number of poisonings by place of origin and year in Ireland (Selection D), 1998 to 2005 (N = 940)

### 6.2.2 Indirectly drug-related deaths

Indirectly drug-related deaths include those individuals with a history of drug dependence, or a history of non-dependent abuse of drugs, whose death may or may not be attributable to drugs of dependence and abuse. Drugs of dependence and abuse are mainly, but not solely, illicit drugs or substances. This is the first time Ireland has been able to report such figures, as the information on each case included in the NDRDI is taken from a wide variety of sources: the coroners' records and death certificates, hospital diagnosis (HIPE) and/or record of treatment with methadone (CTL). This provides a reliable estimate of the total burden of deaths related to drug misuse in Ireland.

The number of indirect deaths has increased steadily between 1998 and 2005, apart from small declines in 2000 and 2003 (Table 6.2.3). The majority of these cases were male (744, 83.7%). This reflects national the ratio of males to females treated for problem drug use (Reynolds *et al.*, 2008).

Table 6.2.3 Number of Indirectly drug-related deaths in Ireland by year, by gender 1998 to 2005 (N = 889)

Year	1998	1999	2000	2001	2002	2003	2004	2005
Indirect deaths	64	84	79	101	126	112	155	168
Male (n = 744)	53	69	64	86	90	92	144	146
Female (n = 145)	11	15	15	15	36	20	11	22

Figure 6.2.3 shows that the majority of cases were aged between 20 and 40 years of age (606, 68.2%). Half of all indirect deaths were aged 31 years or younger.



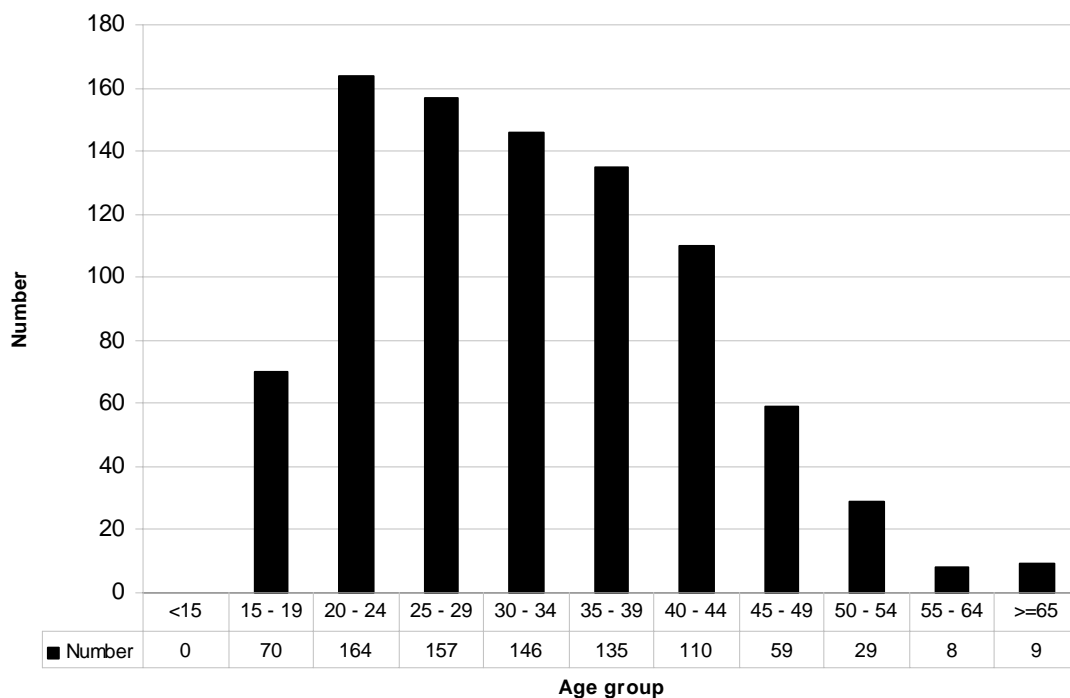


Figure 6.2.3 Number of Indirectly drug-related deaths in Ireland, by age group, 1998 to 2005 (N = 889)

The number of indirectly drug-related deaths has increased steadily inside Dublin over the period, more than doubling from 44 in 1998 to 107 in 2005 (Figure 6.2.4).

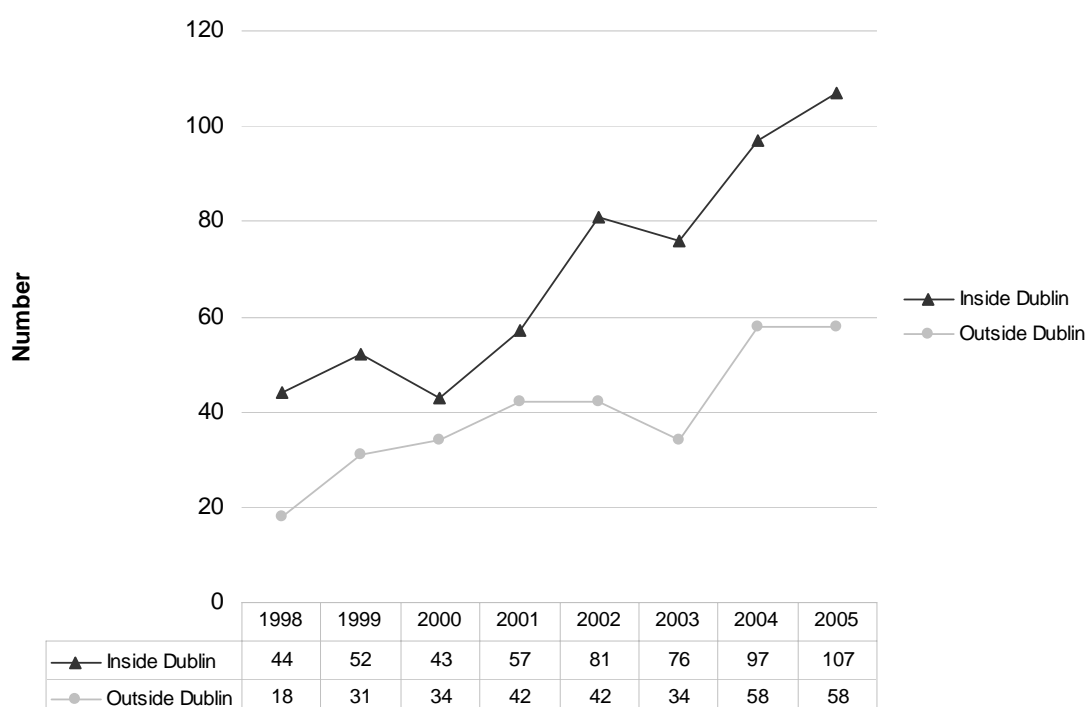


Figure 6.2.4 Number of Indirectly drug-related deaths in Ireland, by place of origin and year, 1998 to 2005 (N=889)

### Methodological issues: data collection and recording of deaths that lead to a coroner's inquest

The Central Statistics Office (CSO) is responsible for classifying the causes of all deaths in Ireland. In 1968 a statistical return (Form 104) was introduced 'to supplement the information on the Coroner's Certificate for the better statistical classification of cause of death'. The form was expanded in 1998 to facilitate a more detailed recording

of the circumstances surrounding unexpected deaths, and now contains a number of mandatory fields: socio-demographic information, medical history, psychosocial factors, circumstances of death and contributing factors.

Deaths that lead to a coroner's inquest generally involve a chain of notifications and information transfers. The Garda Síochána are bound to report to the coroner any death that is unexpected, or is the result of an accident or suicide, or occurs in suspicious circumstances. Following an inquest, the coroner's certificate recording the verdict is forwarded to the Registrar of Births, Deaths and Marriages. The Registrar records the death on a death registration form (Form 102) and sends this form and the coroner's certificate to the CSO. The CSO uses this information to partially complete Form 104, which is then sent to the notifying Garda. The Garda completes the form, including a statement of his/her opinion as to whether the death was accidental, suicidal, homicidal or undetermined, and returns it to the CSO. Staff at the CSO determine the classification of the cause of death using the coroner's certificate, the death registration form (Form 102) and the statistical return (Form 104).

A report by the National Suicide Research Foundation (2007) presents the results of a study analysing data routinely collected in 2002 by means of Form 104. A specific objective was to evaluate the usefulness of this form for collecting routine data on deaths, particularly suicides, that led to an inquest.

In 2002, 1,815 deaths required an inquest, of which 6% were not registered on time and were not included in the official statistics for that year, resulting in an underestimation of the number of deaths and their causes. Almost half (48%) of the inquests took place within six months of death. Fifteen per cent were performed more than a year after death: of these, between 9% and 15% were in regions outside Dublin, and 27% were within Dublin. Over a quarter (26.5%) of inquests in which the cause of death was undetermined took place more than 12 months after death, compared to 8% of inquests that resulted in a verdict of suicide.

A Form 104 was completed for 1,718 (95%) of all the deaths in 2002 that led to an inquest. These forms had a high level of completeness for socio-demographic information (75% and above) but low levels for medical history and contributing factors (35% and below). In 88% of cases, Garda opinion as to the cause of death (as recorded on Form 104) agreed with that of the CSO.

The majority of forms unreturned to the CSE related to deaths registered in Dublin. This may have led to inaccurate recording of causes of deaths in the area. Furthermore, the authors suggest that cases of suicide in Dublin were commonly misclassified as being of 'undetermined intent', which may partially explain the lower suicide rate found in Dublin compared to other areas of the country.

The most important findings were:

- The highest suicide rates occurred on Mondays, and in the months of April, May and June.
- The suicide rate for men (20.5 per 100,000) was much higher than that for women (5.1 per 100,000).
- The suicide rate for unemployed men (88.8 per 100,000) was considerably higher than that for employed men (23.9 per 100,000).
- In general, a higher proportion of male deaths than female deaths were alcohol dependent.
- Fifteen per cent of suicide deaths were alcohol dependent, compared to 20% of deaths by accident, homicide or undetermined cause.
- One-third of undetermined deaths were drug dependent, compared to 13% of accidental deaths.
- Of the homicide deaths, one-quarter of the men were drug dependent, while none of the women were drug dependent.

- Of the suicide deaths, 34% of women were drug dependent, compared to 16% of men, and a higher percentage of women than men were dependent on prescription medication.

Although Form 104 has increased the range of information that can be collected at the time of death, it has some limitations, notably that it does not have a 'natural death' option. This has resulted in submission by Garda members of incomplete forms or separate additional handwritten explanations. During the study period, all records were paper-based and liable to contain transcribing errors, which added to the inconsistencies in the data collected. However, the information is now recorded electronically, which the authors state should lead to a decrease in data-entry errors.

The authors make a number of recommendations:

- A new system should be developed to record medical and psycho-social information on deaths that lead to an inquest.
- Form 104 should be improved where possible but remain in use until a suitable alternative is developed.
- A clear, written protocol should be provided to the gardaí nationally, to standardise information recorded on Form 104, especially for classification of suicides.
- Unnecessary delays in holding inquests should be identified and improvements made where necessary to reduce distress for the bereaved family and improve the timeliness of routine mortality statistics.

## 6.3 Drug-related infectious diseases

### 6.3.1 HIV, new data on newly diagnosed cases

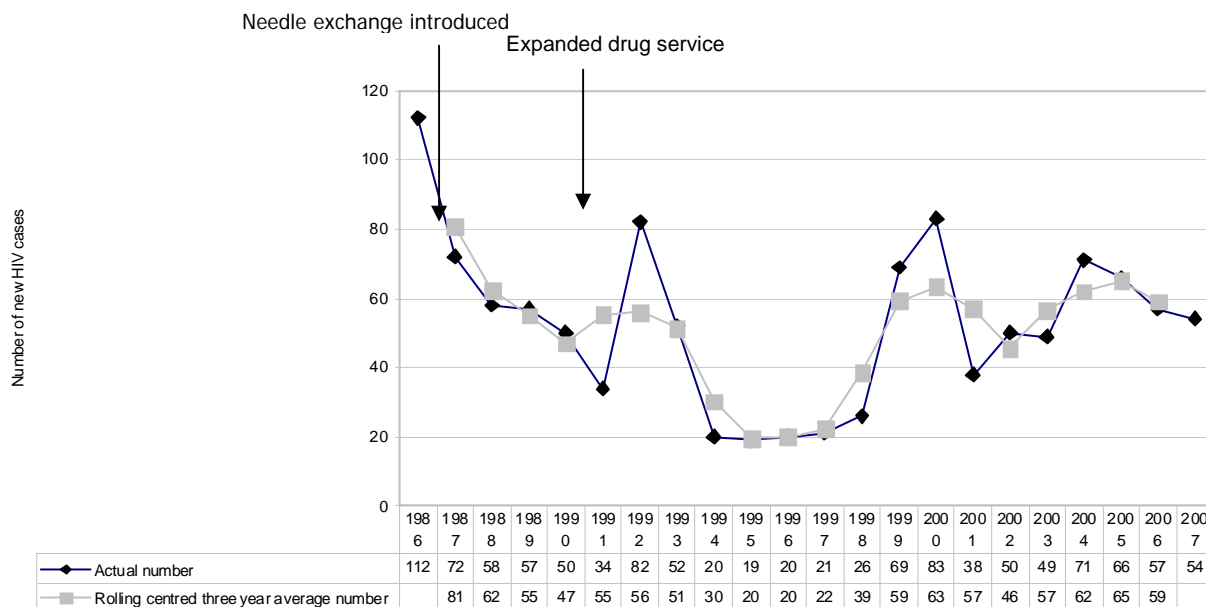
HIV (subsequently known as HIV1) was identified in 1981 and HIV2 was identified in 1986. The virus attaches itself to the CD4 particle of the T-lymphocytes. These T-lymphocytes co-ordinate the body's immune response. HIV may lead to a condition known as acquired immunodeficiency syndrome (AIDS). This condition generally occurs when the CD4 count is below 200 per millilitre and is characterised by the appearance of opportunistic infections. Such infections take advantage of a weakened immune system. The HIV virus is found in all body fluids and is transmitted via sexual intercourse (both heterosexual and homosexual), mother to foetus and baby, infected blood and blood products and procedures with unsterile needles, syringes and skin-piercing instruments. Best evidence available to date indicates that once an individual is infected he or she remains infected for life.

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1985. According to the most recent report of the Health Protection Surveillance Centre (HPSC 2008), at the end of 2007 there were 4,781 diagnosed HIV cases in Ireland, of which 1,381 (29%) were probably infected through injecting drug use.

Figure 6.3.1 presents the number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland; data from 1982 to 1985 were excluded from the figure as these four years were combined in the source records. Figure 6.3.1 is based on data reported to the Department of Health and Children, the National Disease Surveillance Centre and its successor, the HPSC, (Health Protection Surveillance Centre 2007 and 2008) and summarised in an HRB overview of bloodborne viruses among injecting drug users (Long 2006). There was a fall in the number of HIV cases among injecting drug users between 1994 and 1998, with about 20 cases per year compared to about 50 cases each year in the preceding six years. In 1999, there was a sharp increase in the number of cases among injecting drug users, which continued into 2000, with 69 and 83 new cases respectively. Between 2001 and 2007 there was an overall decline in the number of new injector cases (38, 50, 49, 71, 66, 57 and 54 respectively) when compared to 2000 but the number was higher than in 1998. It was difficult to interpret the trend owing to the relatively small numbers diagnosed each

year, so a smoother curve (red plot line in Figure 6.3.1) was calculated using a rolling centred three-year average. This curve presents a true increase in the annual number of HIV cases in 1999; this higher number of cases was sustained between 2000 and 2007 and a new baseline derived.

Of the 54 new HIV cases among injecting drug users reported to the HPSC in 2007 (Health Protection Surveillance Centre 2008), 35 were male and 15 were female and the average age was 31 years. All 39 cases for whom place of residence was known lived in the HSE Eastern Region (Dublin, Kildare and Wicklow). This HPSC report confirms the need, emphasised by the authors of the report on the 2004 data, to continue to promote the use of harm reduction measures among injecting drug users.



**Figure 6.3.1** Actual number and rolling average number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland, 1986 to 2007

### 6.3.2 Hepatitis

#### Hepatitis B surveillance in 2007

Hepatitis B is a vaccine-preventable disease which is transmitted through contact with blood or body fluids of an infected person. The main routes of transmission are mother-to-baby, child-to-child, sexual contact and unsafe injections. The number of cases notified to the HPSC increased each year between 1996 and 2005, and decreased by 7% (to 811) in 2006 (Table 6.3.1). There were 863 cases in 2007, of whom 705 had a chronic infection, 52 had an acute infection and the disease status of 106 cases was unknown. The surveillance system has recorded risk factor data since 2004, but the number of cases notified to the HPSC that include data on risk factors is low (although it increased in 2007 when compared to 2005). In 2007 half (353) of all cases had risk factor data reported, of whom six (2%) reported injecting drug use as their main risk factor. The number of such cases remained consistently low between 2005 and 2007, indicating the effectiveness of routine administration of the hepatitis B vaccine.

**Table 6.3.1 Number (%) of acute and chronic hepatitis B cases reported to the HPSC, by risk factor status, 2005 - 2007**

Risk factor status	Hepatitis B status								
	2005			2006			2007		
	Acute	Chronic	Unknown	Acute	Chronic	Unknown	Acute	Chronic	Unknown
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Total number of cases	72	688	114	93	659	59	52	705	106
% of cases by status	8.2	78.7	13	11.5	81.3	7.3	6	81.7	12.3
Cases <i>with</i> reported risk factor data	52	218	14	70	184	5	43	297	13
% of cases with risk factor data	72.2	31.7	12.3	75.3	27.9	8.5	82.7	42.1	12.3
Of which:									
Injecting drug users	0 (0.0)	3 (1.4)	1 (7.1)	0 (0.0)	4 (2.2)	1 (20.0)	1 (2.3)	5 (1.7)	0 (0.0)
Cases <i>without</i> reported risk factor data	20	470	100	23	475	54	9	408	93
% of cases without risk factor data	27.8	68.3	87.7	24.7	72.1	91.5	17.3	57.9	87.7
<b>Total</b>		<b>874</b>			<b>811</b>			<b>863</b>	

Source: Unpublished data from the HPSC

### Hepatitis C surveillance in 2007

Hepatitis C is one of the most common blood-borne viral infections among injecting drug users and is transmitted through contact with blood of an infected person. The main routes of transmission are mother-to-baby, unsafe injections, transfusion of blood and blood products, and unsterile tattooing and skin piercing. Murphy and Thornton (2008) reported that there were 1,558 cases of hepatitis C reported in 2007 (Table 6.3.2), compared to 1,130 cases in 2004, and 85 cases of hepatitis 'type unspecified' in 2003.

**Table 6.3.2 Number of cases and age-standardised notification rates (ASR) per 100,000 population for hepatitis C, 2004-2007**

Year	Number of cases	Age standardized rate per 100,000
2004	1130	25.5
2005	1433	33.4
2006	1222	28.5
2007	1558	36.8

Of the cases reported in 2007, 77% were notified by services in Dublin, Kildare and Wicklow and the remainder by services in HSE areas outside these counties. The authors calculated age-standardised hepatitis C rates per 100,000 of the population living in each former health board area for the years 2004 to 2007. The rate increased in all of those areas in 2007 compared to 2004, and was highest in the east (over 70 per 100,000) and lowest in the north west (at 10 per 100,000). Sixty-three per cent of hepatitis C cases reported were male. Of the cases for whom age was known, 92% were aged between 20 and 54 years.

An enhanced surveillance system for hepatitis C was introduced in Ireland in 2007. Enhanced surveillance is essential to identify risk factors and for planning prevention and treatment strategies. In 2007, 42% of newly-reported hepatitis C cases had risk factor status reported (Table 6.3.3). As expected, the majority of these cases (75.3%) reported injecting drug use as the main risk factor. Just over 5% of cases said that they were recipients of blood or blood products at some time in the past and according to the HPSC were late reports to the system (N Murphy, HPSC, personal communication, 2008).

**Table 6.3.3 Number (%) of hepatitis C cases reported to the HPSC, by risk factor status, 2007**

Hepatitis C 2007	
Risk factor status	
Total number of cases	1558
Cases <i>with</i> reported risk factor data	658 (42%)
Of which:	
Injecting drug users	496 (75.3%)
Recipients of blood/blood products	34 (5.2%)
Other risk factors	89 (13.5%)
No known risk factor could be identified by patient or doctor	39 (5.9%)
Cases <i>without</i> reported risk factor data	900

Source: Unpublished data from the HPSC

Data from blood-borne viral prevalence studies indicate that around 70% of injecting drug users attending drug treatment tested positive for antibodies to the hepatitis C virus (Long 2006). Injecting practices and prison history were associated with hepatitis C status in some of these studies.

### **Epidemiology of hepatitis C infection, ERHA/HSE Eastern Region**

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

### **Burden of hepatitis C infection in Ireland**

The data provided in this section are abstracted from a paper written by Murphy and Thornton and published in EPI-Insight in July 2008.

#### **Central Statistics Office mortality data**

For 288 people between 1994 and 2005 the underlying cause of death was reported to be primary liver cancer. According to an international review by staff at the HPSC, approximately one third of primary liver cancer cases are due to hepatitis C.

#### **Hospital In-patient Enquiry Scheme data**

The HIPE scheme is a computer-based health information system designed to collect medical and administrative data on discharges and deaths from all acute public hospitals in Ireland (some private hospitals do not contribute data to HIPE). Each discharge record represents one episode of care and patients may have been admitted more than once, or to more than one hospital, with the same diagnosis. HIPE coverage of acute hospitals was 95% between 1999 and 2004. During this period, there were 3,060 discharges with a principal diagnosis of '*other specified viral hepatitis without mention of hepatic coma*'. Most of these are likely to have been due to hepatitis C. A further 778 discharges were associated with a principal diagnosis of primary liver cancer.

## Liver transplants

The liver unit in St Vincent's University Hospital, Dublin carried out 311 liver transplants between 2000 and 2006. Twenty-five of these were known to be a consequence of HCV infection and a further seventeen were known to be due to hepatitis C plus another indication such as alcoholic liver disease or hepatocellular carcinoma.

### 6.3.3 Other infections

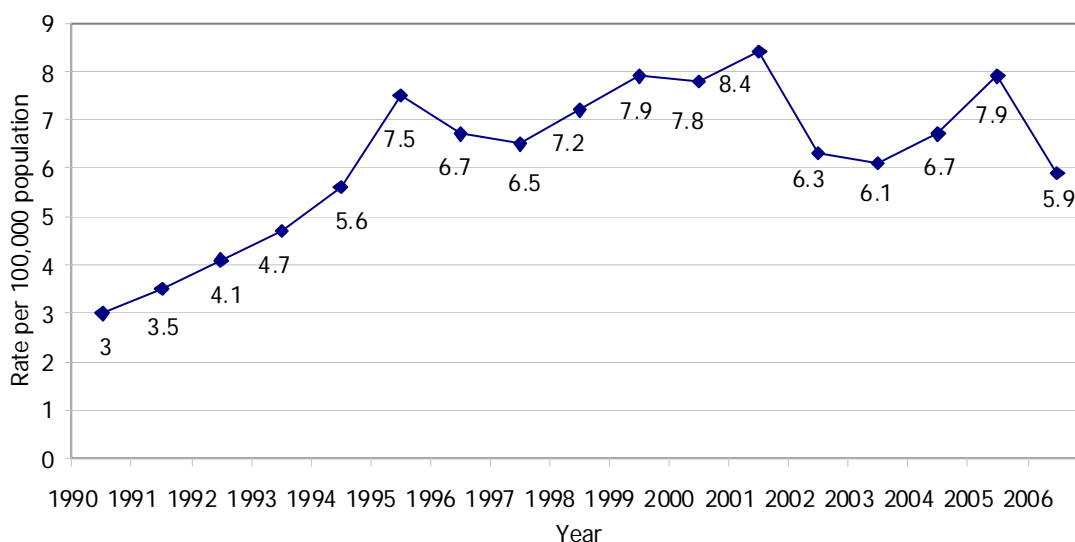
No new information available.

## 6.4 Psychiatric co-morbidity (dual diagnosis)

### 6.4.1 Trends in drug disorders in psychiatric facilities

In 2006, 663 cases were admitted to psychiatric facilities with a **drug disorder**, of whom 250 were treated for the first time (Daly et al 2007). The authors do not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate. Figure 6.4.1 presents the rates of first admission between 1990 and 2006 of cases with a diagnosis of drug disorder, per 100,000 of the population. The rate increased steadily between 1990 and 1995, with a dip in 1996, and further annual increases between 1997 and 2001. The rate was almost three times higher in 2001 than it was in 1990. Notable dips in the rate occur in the census years 1996 and 2002, and can be partly explained by the increased population figure used as the denominator in calculating the rate for those years.

The overall increase in the rate of drug-related first admissions between 1990 and 2001 reflects the increase in problem drug use in Ireland and its burden on the psychiatric services. The overall decrease in the rate since 2001 possibly reflects an increase in community-based specialised addiction services during this period. The increased rate in 2005 may be accounted for by the use of the 2002 census figure in calculating the rate. The decrease to 5.9 in 2006 reflects the new census figure used as denominator. Of the 659 discharges with a drug disorder, just under 48% spent less than one week in hospital and just over 17% spent more than one month in hospital.



**Figure 6.4.1** Rates of psychiatric first admission of cases with a diagnosis of drug disorder (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the National Psychiatric In-patient Reporting System, 1990 to 2006

### 6.4.2 Substance dependence and mental illness among homeless persons

O'Neill and colleagues (2007) reported on a study to determine the proportion of those attending the Mater University Hospital's (in Dublin) psychiatric service, including those presenting to accident and emergency, who were homeless, and to compare the homeless group with the non-homeless, so as to obtain a profile of this group. All

adults over 16 attending A&E, outpatient clinics, liaison consultations and admitted to psychiatric units who were referred for psychiatric assessment in the six-month period from January to June 2003 were included. Excluded were those who were under 16, who refused to participate, who did not speak English, those with a diagnosis of personality disorder and organic brain damage. Questionnaires were completed by psychiatric registrars and a community psychiatric nurse, with an ICD-10 diagnosis recorded on each individual, in consultation with the treating consultant psychiatrist.

A total of 628 patients were seen in the Mater University Hospital during the study period, and 13.8% were homeless. Of the homeless, 56.3% were seen as emergency referrals in the A&E, 23% were inpatients (including the psychiatric unit and consultations in medical/surgical wards) and 20.7% were seen in the outpatient department. Of all the A&E referrals to psychiatry, 34.8% were homeless. The homeless presented most commonly in suicidal crisis (26.6%), compared with 12.5% in the non-homeless group. Substance-abuse disorders were the primary diagnosis in 42.3% of the homeless group, and in 14.2% the housed sample. The outcome for both groups was similar, with slightly more homeless being referred for psychiatric admission (17.8%) compared to 12% in the non-homeless group. The authors concluded that mental illness and the need for psychiatric services remain a serious issue for a significant segment of the homeless population. The homeless are over-represented in accident and emergency departments, with their psychological and medical needs not being met in primary care. According to the authors an integrated multi-disciplinary treatment approach, including outreach work, that addresses their many needs, appears to hold the greatest promise of success in this population.

#### **6.4.3 Mental illness and substance use among children in detention schools**

In May 2007 a report of a study on mental illness and substance use among children in detention schools was published (Hayes and O'Reilly 2007). Researchers interviewed three groups of adolescent males (average age 14.9 years); 30 participants were residing in juvenile detention schools (the offender group), 20 had been referred to an adolescent mental health service in HSE South (the mental health group), and 30 were recruited from a secondary school in County Cork (the control group). The researchers used a number of validated instruments to determine each child's emotional intelligence and mental well-being, and obtained demographic characteristics and history of offending by means of a questionnaire.

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

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

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



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

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

### **6.5.1 Somatic illnesses**

No new information.

### **6.5.2 Non-fatal overdose**

#### **Overdose of known illicit drugs**

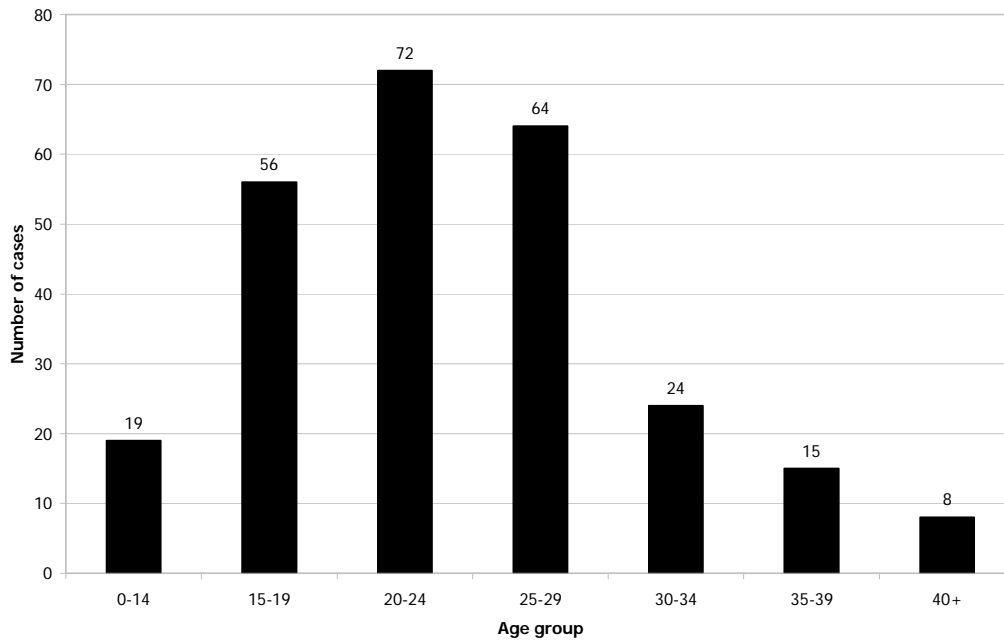
Data used in the following analysis were extracted from the Hospital In-Patient Enquiry (HIPE) scheme. The Economic and Social Research Institute (ESRI) manages the HIPE scheme in Ireland. HIPE is a computer-based health information system designed to collect data on all discharges and deaths from acute general hospitals in Ireland. Each HIPE discharge record represents one episode of care; patients may be admitted to hospital(s) more than once with the same or different diagnoses. The records therefore facilitate analyses of hospital activity rather than of the incidence of disease. HIPE does not record information on cases that attend accident and emergency units and who are not admitted as inpatients. The International Classification of Disease (ICD) codes used by HIPE changed from version 9 to version 10 (fourth edition, Australian Modification ICD-10-AM) in 2005. For this reason only data pertaining to the year 2005 is included in the following analysis.

#### **Number of deaths from overdose**

The total number of overdose cases involving known illicit drugs for 2005 was 264. Six of these cases died and have been excluded from this analysis. Only drugs that are known to be illicit are included. This analysis excludes other opiates and other narcotics where provenance is unknown.

#### **Age group**

Figure 6.5.1 shows that the 20–24-year age group is at highest risk, with the number of overdoses of known illicit drugs decreasing with age. It is important to note the significant number of cases in the 15–19-year age group.



**Figure 6.5.1** Number of overdose cases using illicit drugs by age group, 2005

**Area of residence**

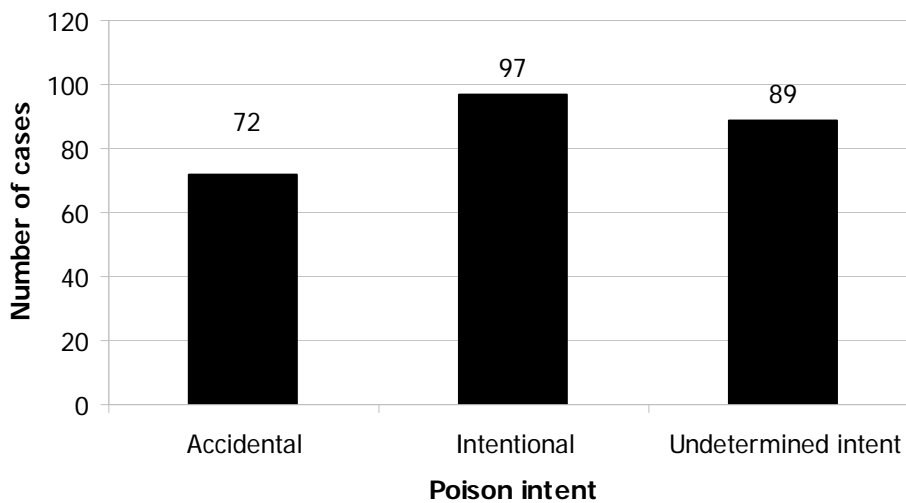
More than one quarter (26.4%, 68) of all overdose cases involving known illicit drugs were among persons resident in Dublin (city and county). Thirty five (13.6%) cases resided in County Tipperary, a predominantly rural area.

**Gender**

Overdose using illicit drugs is more frequent among males than females. Males accounted for 80% (207) of cases.

**Poisoning intent**

The poisoning was intentional in 37.6% (97) of cases. Accidental poisoning accounted for over one quarter of cases (27.9%, 72), while the intent of the remaining cases was undetermined (Figure 6.5.2).



**Figure 6.5.2** Poisoning Intent categories for overdose cases using illicit drugs, 2005

### Most common known illicit drug

The total number of overdoses involving known illicit drugs in 2005 was 264. In 16% (41) of these overdose cases more than one known illicit drug was used. Hallucinogens were the most common, known illicit drug used, occurring in 38.4% (99) of cases, of which 15% had taken at least one other illicit drug. Cocaine occurred in over a quarter of cases (27.5%, 71). Opiates occurred in 29.5% (76) of cases. Cannabis was present in almost one fifth of these overdoses (19.4%, 50). Of note, benzodiazepines were used in conjunction with a known illicit drug in 15% (39) of cases (Figure 6.5.3).

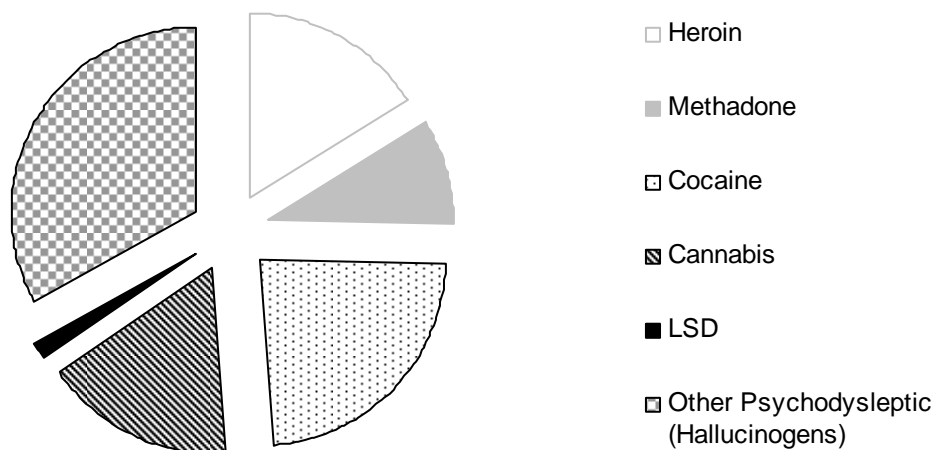


Figure 6.5.3 Type of known illicit drug used in overdose cases, 2005

### National Registry of Deliberate Self Harm – annual report 2006

See section 4.4.1

#### 6.5.3 Driving and other accidents

No new information.

#### 6.5.4 Pregnancy and children born to drug users

No new information.

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

### **7.1 Overview**

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

The introduction of hepatitis B vaccination as part of the National Child Immunisation Programme in August 2008 differs from the majority of interventions, for example those preventing drug-related mortality or dealing with co-morbidity, which are introduced on a once-off or ad hoc basis.

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

#### **Prevention of drug-related deaths among drug users in treatment**

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

The group aimed to examine the number, and suspected causes, of deaths among drug users receiving methadone treatment in Ireland in 2006 and to identify any associated factors that increase the risk of death. Its objectives were:

- To determine the number of deaths among drug users notified to the Central Treatment List (a register of all patients receiving methadone treatment for problem opiate use in Ireland) in 2006
- To provide a descriptive analysis of the circumstances of death of drug users who died while on methadone treatment or within three months of leaving treatment
- To compare the characteristics of drug users currently and previously in treatment who died in 2006 with a sample of drug users in treatment in 2006
- To better inform the drug services by providing them with timely information on deaths among drug users.

Owing to the delay in obtaining a definite cause of death, the group concluded that the study was not feasible and that the best method of obtaining such data in the future would be through the work of the NDRDI.

#### **Drug users' experiences of overdose**

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

The researcher asked participants questions about their own overdose experiences, including: what drugs they had used; their method of drug taking; their actual experience of overdose; whether the overdose was accidental or intentional; their

perceived reasons and/or precipitating factors for accidental overdose; trigger factors for intentional overdose; their knowledge of medical treatment for overdose; and possible strategies to prevent or reduce future overdoses.

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

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

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

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

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

### **7.2.1 Preventing suicide**

#### **Nursing assessment of episodes of deliberate self-harm**

In January 2008 a research study *Accident & Emergency Nursing Assessment of Deliberate Self Harm* was released by the HSE South and the National Suicide Research Foundation Ireland (Lamb *et al.* 2008). It reports on a pilot study exploring 'the impact of introducing a suicide education programme and a suicide intent scale into A&E/MAU [Medical Assessment Unit] nursing practice'. The study was based on the concern that inadequate assessment of deliberate self-harm (DSH) patients may result in failure to diagnose treatable underlying conditions such as alcohol and drug dependence. Key findings of the study were that (a) the provision of training was associated with a significant increase in nurses' confidence in dealing with DSH patients and positive changes in their attitudes towards suicidal behaviour and its

prevention, and (b) the use of a suicide intent scale is potentially valuable in referring DSH patients presenting at A&E/MAU to the appropriate service.

## 7.2.2 Dealing with drug-related deaths

### **Help and advice on coping with the death of someone close**

In its vision statement and guiding principles, the national strategy for action on suicide prevention 2005–2014 (Health Service Executive, National Suicide Review Group, Department of Health and Children 2005) proposed that ‘those affected by a suicide death or deliberate self-harm receive the most caring and helpful response possible’. To assist this process, the strategy proposed a review of the existing information and resources available to the bereaved. In response, the National Office for Suicide Prevention has published the two booklets outlined below.

*You are not alone: help and advice on coping with the death of someone close* provides practical advice and support to those who have been affected by suicide or an unexpected death. The booklet is divided into five sections: immediate reactions; natural responses; events that occur following a death; sorting out your affairs; and getting help for you and your family. Each section deals with the different stages of the bereavement process.

‘Immediate reactions’ and ‘Natural responses’ recognise that the circumstances surrounding suicide can be overwhelming and difficult to understand. The aim of these sections is to guide the bereaved through their feelings of anger, guilt and depression, both in the initial stages and in the months following the death. The second section addresses the behaviour and emotions that can be expected from a child who has lost a parent, sibling or loved one. It provides ways of breaking the news to a child and methods keeping channels of communication open.

When a death occurs by suicide or is unexpected, certain legal procedures must be followed. ‘Events that occur following the death’ introduces and describes the roles of all the parties involved following the death, including the gardai and the coroner. The term and process of a post-mortem and its effect on funeral arrangements are explained. Owing to the nature of a suicide death, an inquest will be held and a brief description of the inquest proceedings is given. This can delay the issuing of a death certificate, but again an explanation is given as to how to obtain an interim certificate from the coroner.

‘Sorting out your affairs’ addresses money matters, such as how to access social welfare entitlements and funds lodged in banks, post offices, or insurance policies. Advice is provided on registering a death, who deals with a will or what do in the absence of a will. The terms ‘intestacy’, ‘probate’, ‘executors’ and ‘administrators’ are explained.

The final section, ‘Getting help for you and your family’, lists the types of support that are available and mentions how people are referred to the mental health services in Ireland.

*You are not alone: directory of bereavement support services 2007* is a guide to bereavement support services available throughout Ireland. Specific support services for those who are bereaved owing to suicide are highlighted. The booklet provides contact details for multi-branch organisations, including Barnardos Bereavement Counselling for Children, Samaritans and Console. The directory includes voluntary, community-based and self-help groups, and private counsellors.

The role of the HSE Resource Officer for Suicide Prevention is to guide bereaved people to the most appropriate support service available, and to support the service providers. Contact details for the resource officers throughout Ireland are listed, as are

key contacts such as ISPC, GROW and Aware.<sup>7</sup> Irish and international websites are also listed, along with suggested reading.

These booklets will be useful to those who are bereaved, particularly by suicide or sudden death. They have been distributed to GPs, funeral directors, gardaí, resource officers and registered counsellors, and can be downloaded from [www.nosp.ie](http://www.nosp.ie).

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

#### **7.3.1 Strategy to deal with hepatitis C**

In January 2007 the HSE established a working group on hepatitis C. The brief of this group is to build on a 2004 unpublished report on hepatitis C carried out by the then Eastern Regional Health Authority. Unlike the 2004 report, the 2007 initiative has a national brief. It is examining how best Ireland can respond to hepatitis C in the areas of surveillance, education and treatment. The working group will comment on how the recommendations of the 2004 report have been progressed. It will bring forward costed and prioritised recommendations. The group has completed its report and is waiting to present it to HSE senior management (J Barry, personal communication, September 2008).

#### **7.3.2 Management of hepatitis C**

Cullen and colleagues published a peer-reviewed study of a report published in 2003 (Cullen *et al.* 2003). Unlike the 2003 report, the findings presented in the 2007 study are validated and the analysis refined.

In Ireland, long-term care for injecting drug users, many of whom are hepatitis C positive, is increasingly being provided by GPs. Cullen and colleagues (2007) describe HCV care among opiate users attending general practice in the greater Dublin area prior to the implementation of the clinical practice guidelines for hepatitis C. The clinical records of 196 out of 200 patients attending 25 general practices in the HSE Eastern Region for methadone maintenance treatment were examined on site, and anonymised data collected on HCV care processes. Half of the patients had been attending general practice for methadone maintenance treatment for more than 28 months; 72% were male and half were under 32 years of age. The average age of first injecting illicit drugs was 20 years. Ninety-nine (51%) tested positive for metabolites of drugs of abuse other than methadone in the previous three months. There was evidence that 77%, 69% and 60% had been screened for HCV, human immunodeficiency virus (HIV) and hepatitis B (HBV) respectively. Among those who had been tested, the prevalence of HCV, HIV and HBV infection was 69%, 10% and 11% respectively. Of those known to be HCV positive, 36 (35%) had been tested for HCV-RNA, 31 (30%) had been referred to a hepatology clinic, 24 (23%) had attended a clinic, 13 (13%) had had a liver biopsy performed and three (3%) had started treatment for HCV. While the majority of patients had been screened for blood-borne viruses, a minority of those infected with HCV had subsequent investigations or treatment by participant GPs. New interventions to facilitate optimum care in this regard were considered. Clinical guidelines for hepatitis C management among current or former drug users attending general practice were developed.

#### **7.3.3 Ballyfermot Drugs Task Force hepatitis C campaign**

The Ballyfermot Hepatitis C Campaign was run in 2007 to raise awareness of hepatitis C and of the options for its investigation and treatment at appropriate services. As part of the campaign, information booklets were published for three different audiences – active drug users, ex-drug users who injected at some time in the past, and GPs caring for people with hepatitis C. The current issue of the local newsletter, *d-Talk*, is a 'Hepatitis C special' and also part of the campaign.

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<sup>7</sup> ISPC (Irish Society for the Prevention of Cruelty to Children) [www.ispcc.ie](http://www.ispcc.ie); GROW (World Community Mental Health Movement) [www.grow.ie](http://www.grow.ie); AWARE (providing support through depression) [www.aware.ie](http://www.aware.ie)

Each booklet covers issues specific to the target group, but all include information on who is at risk of acquiring hepatitis C, facts about the infection, symptoms of acute hepatitis C, blood tests and other investigations for diagnosing the illness, possibilities for and improvements in treatment, side effects of treatment and requirements in order to start treatment. The active drug users' booklet has a section on protecting against infection. The ex-drug users' booklet has an expanded section on personal health. The GPs' booklet contains some common beliefs among drug users about hepatitis C, and more detailed information on investigation and treatment.

These booklets present accurate factual information and are useful not only to the immediate target groups but also to those living or working with drug users. The booklets can be shared with other taskforce areas with a high prevalence of drug users.

### **7.3.4 World Hepatitis Day**

On 19 May 2008, the *Blood Borne Virus Forum* marked *World Hepatitis Day* with an Open Day at Community Response, Carman's Court. The purpose of the open day was to raise awareness about hepatitis and in particular about hepatitis C. Attention was drawn to the fact that almost 20,000 Irish people could be infected with hepatitis C and most do not know that they are infected. Information on the symptoms of hepatitis C, its routes of transmission and testing and treatment procedures was provided using educational posters, leaflets and interactive activities.

Two short films were shown - *Hidden I* and *Hidden II* – both of which were produced by Community Response Drama Group and developed through improvisation and role play. *Hidden I* is an educational drama about drug use, pregnancy and hepatitis C, while *Hidden II* continues the story and educates the viewer about testing and treatment for hepatitis C.

A new hepatitis C awareness board game and DVD were launched at the open day. The board game can be played by up to 10 people and requires players to answer a possible 29 questions about hepatitis C. The questions are divided into three topics:

- Basic Information
- Testing, treatment, sex and pregnancy
- Social, health promotion and support.

There were opportunities for people to play the board game on the day and to test their knowledge of hepatitis C.

Dara Ryan, Roche Products Ireland, launched postcards which provide information on the risk factors for hepatitis C infection. The postcards are soon to be available in cafés nationwide.

Service users and health and social care professionals attended the open day. Nicola Perry, of Community Response, and Olivia Carr, from the Blood Borne Virus Forum, welcomed everyone. Dr Shay Keating, Drug Treatment Centre Board, Trinity Court, applauded the positive work of Community Response and other voluntary agencies over the last ten years in raising awareness about hepatitis C. Antonia Leslie, of the pharmaceutical industry, supported the event and presented members of Ban Og in Tallaght and the Youth Reach Project on Pleasant Street with certificates upon having completed a four-week Health Promotion Course on HIV and hepatitis awareness.

### **7.3.5 MQI safer injecting guide**

On 3 April 2008 Merchants Quay Ireland (MQI) launched the booklet *Safer injecting* at a seminar focused on reducing the harm associated with injecting drug use.

This safer injecting guide is produced for people who inject drugs. The booklet includes advice about safer injecting practices and different types of injecting – into a vein or



muscle, or under the skin (skin popping). The importance of washing one's hands prior to injecting to reduce the risk of infection is a simple and important point highlighted in the guide. Advice is provided about how to look after veins and decrease vein damage. Readers are encouraged to seek medical attention if they experience any health issues associated with injecting. A full description of the necessary injecting equipment is provided, along with the important statement that 'single-use syringes are the safest as water and/or bleach will not destroy all viruses'. Overdose prevention techniques and responses are described, along with information on the increased risk of overdose owing to polydrug use. The necessity for protection against the acquisition and transmission of blood-borne viruses is also discussed.

### **7.3.6 Methadone combined with HIV medications may cause cardiac arrhythmia**

Adverse drug reactions account for approximately 5% of acute medical admissions. Falconer and Molloy (2007) published a case history about a 34-year-old male patient who received antiretroviral therapy, methadone and flurazepam and then presented to the emergency room following collapse with associated loss of consciousness. Cardiac monitoring demonstrated marked Q-T prolongation followed by the cardiac arrhythmia, known as torsade de pointes. The patient made a full recovery following withdrawal of the antiretroviral therapy and a reduction in methadone dose. Methadone is a recognised cause of this potentially fatal cardiac arrhythmia, which is more likely to occur when methadone metabolism is inhibited by drugs such as HIVtease inhibitors. HSE addiction service clinical directors have requested that patients receiving certain therapies are monitored for cardiac arrhythmia prior to and during therapy.

### **7.3.7 Inclusion of hepatitis B vaccine in the Irish Childhood Immunisation Programme**

The National Immunisation Advisory Committee and the Department of Health and Children are recommending significant changes to Ireland's national childhood immunisation programme in 2008. These changes, which were published in the revised *Immunisation guidelines for Ireland* in August 2008, include the addition of hepatitis B vaccine, to the routine childhood programme. The 5-in-1 childhood vaccine will be replaced with a 6-in-1 vaccine which includes hepatitis B vaccine. In the *Immunisation guidelines for Ireland 2002*, hepatitis B vaccine was recommended for several high-risk groups rather than the child population; prisoners and injecting drug users were two of the high-risk groups named.

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

No new information.

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

### **7.5.1 Prevention of somatic illnesses**

No new information.

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

No new information.

### **7.5.3 Prevention and reduction of driving accidents**

An increase in the number of motorists tested for drug driving was announced in January 2007. The agency responsible for testing samples, the Medical Bureau of Road Safety (MBRS), anticipated that the number of drivers tested would 'double or triple' (*Irish Times: Motors supplement*, 10 Jan 2007, p 1). In 2006 the MBRS tested almost 1,000 samples from drivers suspected of drug driving for traces of seven classes of drug. The Department of Transport is funding a specialist post of senior

scientist in drug toxicology. According to the director of the MBRS, 'That senior scientist was asked to head up the expansion of the drugs testing programme both in terms of numbers and in terms of categories of drugs. This is the first phase [of expansion]. There are a number of other phases on which we are in deliberations with the Department of Transport.' The director also said: 'Part of the expansion programme will be to keep an eye on new types of drugs, and new variations on old categories. We will expand into testing for other drugs and illegal drugs as and when the need arises.' The MBRS also has a representative on a national drug monitoring body which monitors changes in the type and composition of illegal drugs coming into the State. The Road Safety Authority (RSA) has published a new road safety strategy which includes a number of provisions in relation to driving under the influence of drugs (Road Safety Authority 2008). *The Road Safety Strategy 2007-2012* notes that the Medical Bureau of Road Safety (MBRS) has commented on the increasing evidence of prescription and non prescription drugs implicated as a cause of impaired driving. However, the strategy document also highlights the limitations of data in this area. It states, 'No reliable data is available beyond the work done by the MBRS in testing selected samples from the specimens submitted to them. This will provide information on the presence of drugs only from this pre-selected sample and will not provide information on the incidence of drug-impaired driving within the driving population as a whole'. The strategy further states that 'the addition of a Field Impairment Test to enforcement activity would improve the available data' (p 82).

The following actions in the road safety strategy relate to driving under the influence of drugs:

- Action 32 aims to expand the forensic analysis programme for driving under the influence of drugs by the first quarter of 2009.
- Action 33 aims to establish drug impairment education programmes for An Garda Síochána, doctors and nurses by the end of 2008.
- Action 78 obliges the Department of Transport to review legislation on the issue of driving under the influence of drugs by the first quarter of 2009 and to consider appropriate enforcement options.
- Action 123 obliges An Garda Síochána to 'develop the testing of impaired drivers based on the incidence of drink/drug driving, record data and plan future interventions to achieve deterrence and better compliance'.

The RSA also proposes the introduction of a new scheme of graduated driver license (GDL). This scheme, which is already in existence in a number of other countries, applies a number of restrictions at different stages of a person's learning to drive. The aim of the GDL system is to reduce the number of accidents involving novice drivers. The RSA states that the GDL is based on 'driving experience being developed in low risk driving practice, keeping the learner out of high risk situations, developing good practice, and having a delayed progressive entry to full license entitlement without any restrictions' (p 47). The proposed GDL system involves a range of measures to be applied to drivers with learner permits. One measure under consideration is to empower the courts to specify that a person convicted of a drink or drugs offence under the Road Traffic Acts may be referred to an appropriate counselling programme. The application of a zero balance alcohol for learner drivers while holding a learner permit licence and during the first two years of holding a driving licence is also suggested as part of the proposed system.

#### **7.5.4 Maternal health and child care**

No new information.

#### **7.5.5 Other health care targeted to drug users**

No new information.

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

### **8.1 Overview**

Research among homeless young people aged 16-25 in the south of Ireland reveals that being in state care, experiencing abusive family situations and family conflict and exhibiting problematic behaviour such as abusing drugs and alcohol can create 'pathways to homelessness' and further exclusion. Substance abuse exacerbated the experience of being homeless. Unemployment and early school leaving have been a problem for a significant proportion of drug users reporting for treatment over the period 2001-2006.

With regard to drug offences under the Misuse of Drugs Acts, there was an overall increase between 2006 and 2008. Relevant legal proceedings (including possession, supply, obstruction, forging prescriptions, cultivation and manufacture) also increased overall. With regard to proceedings for possession, cannabis-type substances accounted for the majority of proceedings, 49.6% (n=6,947) in 2006.

### **8.2 Social exclusion**

#### **8.2.1 Homelessness**

##### **Homelessness among young people**

Research by Mayock and Carr (2008) was designed to generate in-depth knowledge and understanding of the experiences of homelessness among young people in the south of Ireland, particularly in Cork city. It highlighted the nature of the association between substance misuse and homelessness.

Life-history interviews were conducted with 37 young people (20 males and 17 females) between April and October 2006. Participants ranged in age from 16 to 25 years and were recruited from residential settings, emergency hostels, drop-in centres and the street. Aspects of the group profile were:

- 20 reported a history of state care.
- Seven were either parents (3) or expectant parents (4).
- Five reported a learning disability and had attended a special school.
- 10 had left school without formal qualifications.
- 21 described themselves as unemployed.
- Nine were attending a skills training scheme (FÁS).
- 24 reported depression; 20 reported substance misuse; 15 reported stress or anxiety; 13 reported one or more episode of self-harm; and six reported attempted suicide.

The first objective of the study was to identify young people's pathways into homelessness. Four distinct pathways were identified:

- Time spent in state care (13 participants)  
Features of this pathway were multiple care placements in residential and/or foster care, inadequate preparations for leaving the care setting and lack of aftercare.
- Abusive family situation (10 participants)  
Characterised by abuse or violence directed at the respondent, or between other family members, creating an unstable environment.
- Family conflict (10 participants)  
Typically, these accounts described difficult relationships within the family home, often with a parent, and sometimes of long standing.
- Problematic behaviour (4 participants)  
Accounts described patterns of behaviour that led to family relationship problems, including problem substance use, criminal activity, gambling and aggression.

A second objective was to examine participants' experiences of living out of home. The experiences reported were characterised by movement from one insecure setting to another, resulting in instability and insecurity. For example, participants reported running away from home and care placements, difficulties with living in different accommodation settings and problems with tenancy sustainment in private rented accommodation. The majority of participants who accessed adult hostels experienced a sense of stigma, which confirmed a homeless identity for some. Substance misuse issues, mental health issues and learning difficulties often predominated when young people were exposed to this setting. Six participants reported moving between prisons and psychiatric hospitals, and some reported a pattern of movement between Ireland and the UK.

A third objective was to examine the challenges young people experience on becoming homeless. One of the main challenges facing participants was their use of alcohol and illegal substances. All except one of the 37 participants had consumed alcohol at some point. Thirty-one had used an illegal drug at some point, of whom two-thirds reported the use of four or more substances in their lifetime. Nine had used heroin but only two were current users. The early- to mid-teenage years was the peak period of initiation of both alcohol and illegal drug use. Substance use was associated with coping mechanisms: some participants, particularly those in hostels, tended to drink and use drugs to 'pass the time'; and many used substances to counteract anxiety and depression. Some reported using substances to 'chill out' with peers, and stated that managing their use of alcohol and drugs was important as they did not want to develop the kind of negative relations with these substances that they had often seen in their parents. A total of 22 reported either past or ongoing problems with their use of alcohol and/or drugs.

In general, substance use did not emerge as a factor leading to homelessness for the majority of the young people. However, it did exacerbate the challenges faced by some participants in their efforts to secure and sustain accommodation, and often caused crises with regard to their tenancies.

### **Reporting homelessness among the drug treatment population: 2001-2006**

Reynolds *et al.* (2008) analysed data from cases reporting for treatment for problematic drug use between 2001 and 2006. They reported that, though small, the proportion of cases who reported being homeless and the proportion not born in Ireland increased steadily during the reporting period. The increase in the proportion of other nationalities seeking treatment may have implications for service provision as drug treatment interventions rely heavily on verbal communication.

### **8.2.2 Unemployment**

Reynolds *et al.* (2008) analysed data from cases reporting for treatment for problematic drug use between 2001 and 2006. They reported that in general, problem drug users are young and male, have low levels of education and are unlikely to be employed, indicating the importance of personal development and educational and employment opportunities as part of the drug treatment and reintegration process. In addition, data in Table 8.2.1 below shows a reduction in the percentage of treatment contacts in employment over the reporting period.

**Table 8.2.1 Drug treatment contacts in employment, 2001 and 2006**

All contacts	2001	26.7%
	2006	21.2%
Previously treated contacts	2001	22.7%
	2006	16.2%
New contacts	2001	32.3%
	2006	28.0%

Source: Adapted from Reynolds *et al.* (2008)

### 8.2.3 Early school leaving

Reynolds *et al.* (2008) analysed data from cases reporting for treatment for problematic drug use between 2001 and 2006. This analysis (Table 8.2.2) revealed very little change in the proportion of treatment contacts reporting to be early school leavers over the reporting period.

**Table 8.2.2 Drug treatment contacts reporting early school leaving, 2001 and 2006**

All contacts	2001	19.5%
	2006	20.0%
Previously treated contacts	2001	22.3%
	2006	23.7%
New contacts	2001	16.4%
	2006	15.2%

Source: Adapted from Reynolds *et al.* (2008)

### 8.2.4 Financial problems

No new information available.

### 8.2.5 Social networks

No new information available.

## 8.3 Drug-related crime

Until 2006, the principal source of information on drug offences was the annual reports of the Garda Síochána. In 2006, responsibility for reporting crime statistics was transferred to the Central Statistics Office (CSO). In January 2008 the CSO issued *Headline crime statistics: quarter 4 2007* (2008a). This quarterly report compared the headline crime statistics for quarter four of 2006 and of 2007, using the old Garda headline crime classification system. It also compared the annual figures for the years 2004 to 2007. In April the CSO (2008b) introduced a new Irish Crime Classification System (ICCS), together with an overview summarising the history of the former headline classification system and the rationale behind the new system. The CSO (2008c) also published *Garda recorded crime statistics 2003–2006*, based on the new ICCS. A fourth CSO publication (2008d), entitled *Recorded crime: quarter 1 2008*, was published in May 2008. This report was based on the new ICCS, thereby including the recorded incidents of driving/in charge of a vehicle under the influence of drugs. These figures are reported for the years 2004 to quarter 1 of 2008. The figures for quarter 1 of 2007 and of 2008 are also compared.

### 8.3.1 Drug offences

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

Table 8.3.1 displays total headline offences in the drugs category for the years 2006 and 2007. Increases were recorded in all such offences in 2007, with an overall increase of 791 (21.8%). The offence of cultivation, manufacture or importation of drugs, while the lowest in the category, showed the largest percentage increase (58.5%) in 2007. Possession of drugs for sale or supply, representing the largest offence type in this category, increased by 595 (19.7%).

**Table 8.3.1 Total headline drug offences, 2006 and 2007**

	Possession for sale or supply	Offence type Cultivation, manufacture or importation	Obstruction
2006	3,025	135	472
2007	3,620	214	589
% Increase	19.7	58.5	24.8

Source: CSO (2008a)

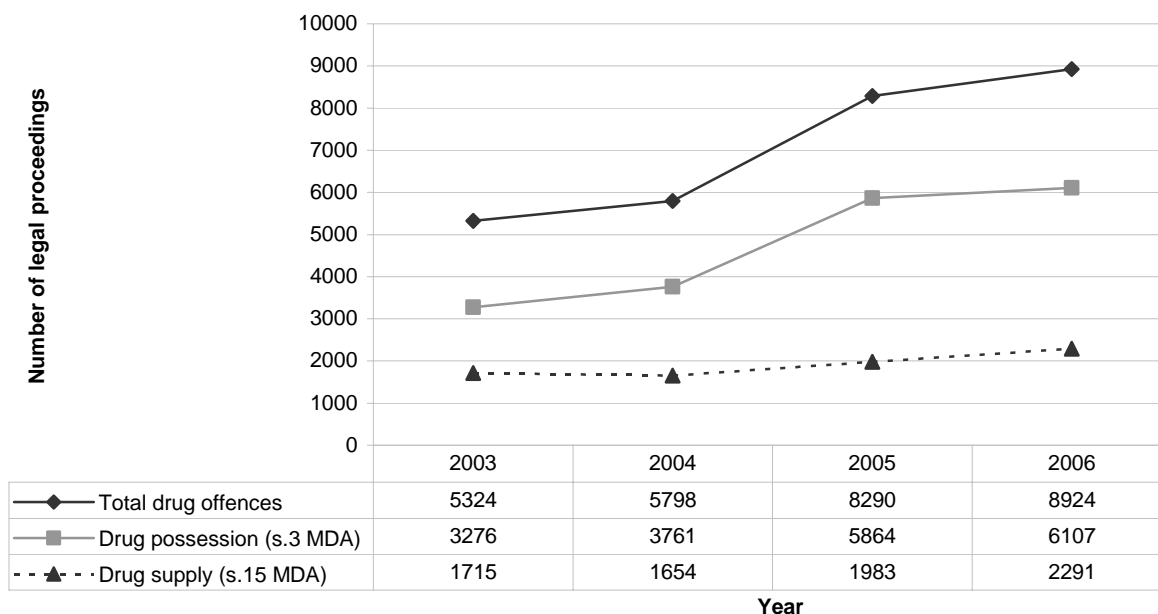
Table 8.3.2 displays controlled drug offences for quarter 1 of 2007 and of 2008. Increases were recorded in all categories in 2008, with the exception of other drug offences. An overall increase of 28.1% (1,118) was recorded, with possession of drugs for personal use marginally representing the largest increase (33.4%).

**Table 8.3.2 Quarter 1 total controlled drug offences, 2007 and 2008**

	Importation	Cultivation or manufacture	Offence type Possession for sale or supply	Possession for personal use	Other drug offences
2007	15	25	898	2,856	179
2008	20	29	1,061	3,811	170
% Increase	33.3	16.0	18.2	33.4	-5.0

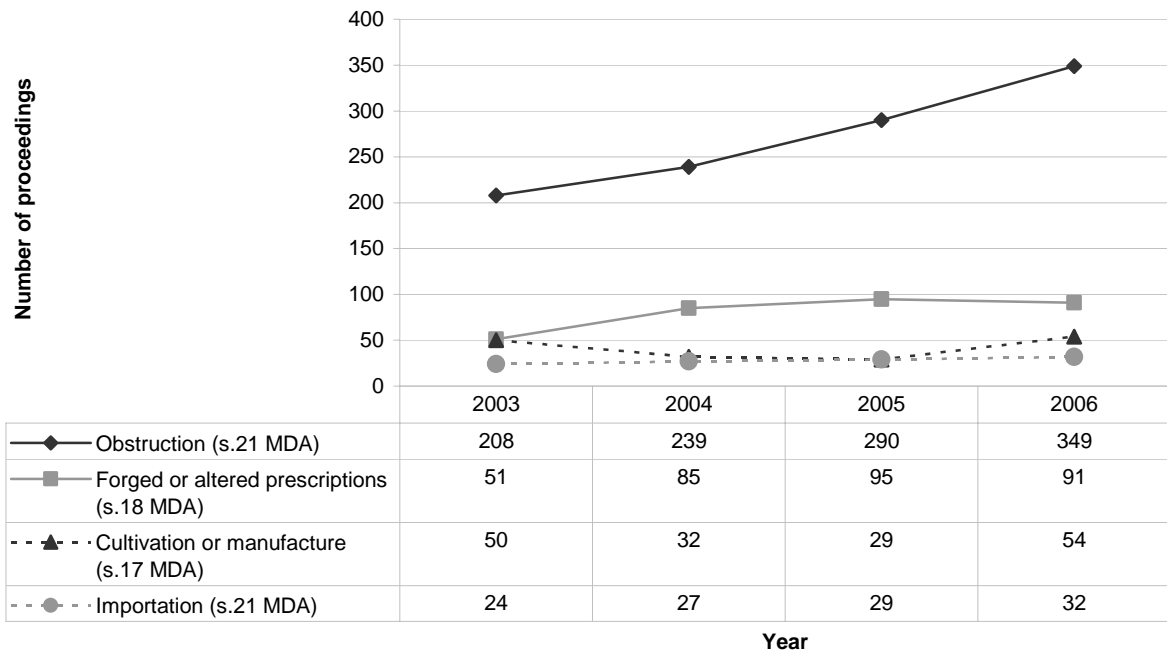
Source: CSO (2008d)

Figure 8.3.1 shows trends in relevant legal proceedings for possession and supply between 2003 and 2006. The report uses the term ‘relevant proceedings’, which refers to the legal proceedings, such as prosecution, taken in relation to the offence as it was originally recorded in the Garda Síochána IT system PULSE. The majority of these proceedings are for drug possession, which have risen since 2003 and accounted for 68.4% of drug offence proceedings in 2006. The number of relevant legal proceedings for supply offences in 2006 was 2,291, representing 25.7% of total drug offence proceedings.



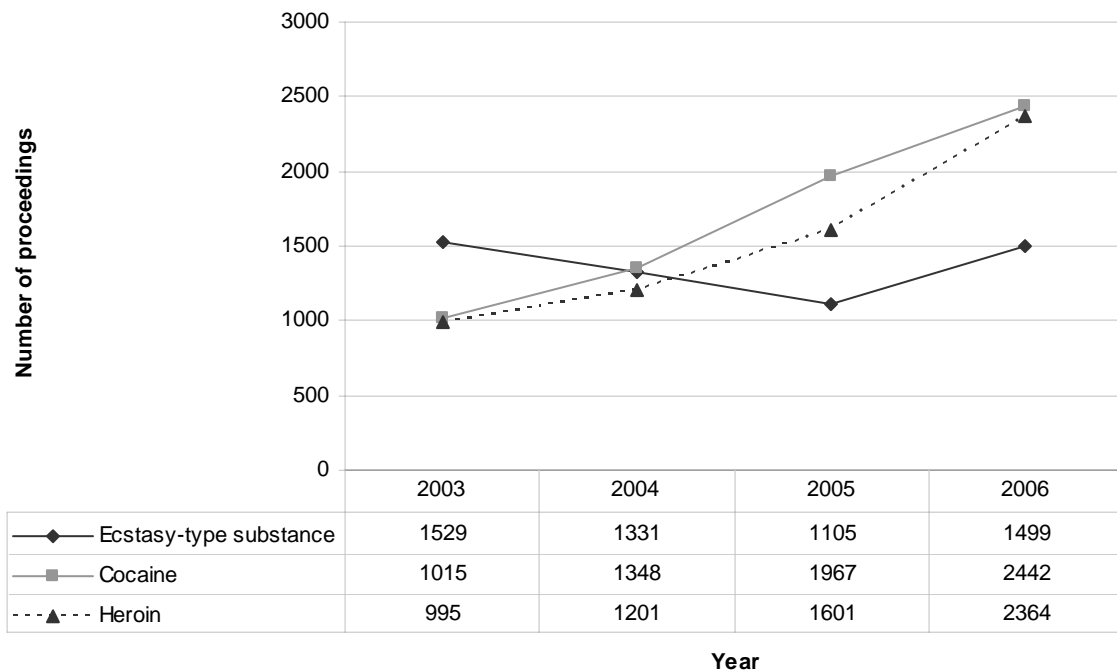
**Figure 8.3.1** Trends in relevant legal proceedings for possession (s.3 MDA), supply (s.15 MDA) and total drug offences, 2003–2006, reported by the CSO (2008c)

Figure 8.3.2 shows trends in relevant legal proceedings for a selection of other drug offences between 2003 and 2006. Obstruction offences increased steadily from 208 in 2003 to 349 in 2006. Following a two-year decline, relevant legal proceedings for cultivation or manufacture of drugs increased during 2006 to slightly above the figure for 2003.



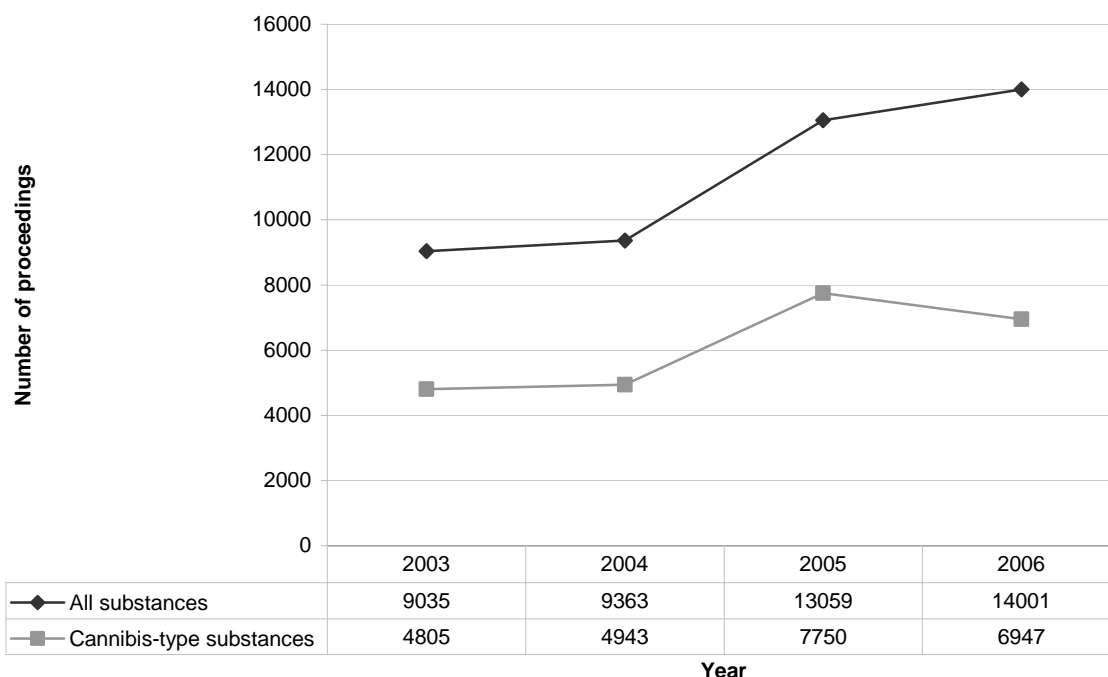
**Figure 8.3.2** Trends in relevant legal proceedings for selected MDA offences, 2003–2006, reported by the CSO (2008c)

Figure 8.3.3 shows trends in proceedings for possession of drugs, by drug type, for a selection of substances between 2003 and 2006. ‘Proceedings’ is a list of charges and proceedings which do not necessarily relate to the offence as it was originally recorded in the PULSE system. Both heroin-related and cocaine-related possession offences show steady increases since 2003, with heroin increasing by 47.7% between 2005 and 2006. Following a 27.7% decline over two years, proceedings for possession of ecstasy-type substances increased by 35.6% between 2005 and 2006, almost reaching their 2003 level.



**Figure 8.3.3** Trends in proceedings for possession of drugs, by selected drug types, 2003–2006, reported by the CSO (2008c)

Figure 8.3.4 shows trends in total proceedings for possession and those for cannabis-type substances between 2003 and 2006. Although cannabis as a proportion of possession offences decreased in 2006, cannabis-type substances have consistently accounted for the majority of these proceedings, representing 6,947 (49.6%) of the total in 2006.



**Figure 8.3.4** Trends in total proceedings for possession and those for cannabis-type substances, 2003–2006, reported by the CSO (2008c)

### 8.3.2 Drug-related crime

The main evidence in relation to drugs and driving in Ireland comes from a nationwide survey conducted by the Medical Bureau of Road Safety in 2000–2001 (Cusack *et al.* 2004). This survey found that although 68% of drivers tested had zero levels of alcohol, they were positive for more than one drug.

The number of offences with relevant legal proceedings for driving/in charge of a vehicle while under the influence of drugs increased by 19 between 2004 and 2005 (Table 8.3.3).

**Table 8.3.3** Relevant legal proceedings for driving/in charge of a vehicle under the influence of drugs, 2003 to 2006

	2003	2004	2005	2006
	51	51	70	70

Source: CSO (2008c)

The annual total recorded incidents of driving/in charge of a vehicle under the influence of drugs have increased since 2004 (Table 8.3.4). The largest increase was recorded between 2006 and 2007, when these incidents doubled. This was followed by an increase of 140% (49) between quarter 1 of 2007 and of 2008.

**Table 8.3.4** Annual total recorded incidents of driving/in charge of a vehicle under the influence of drugs, 2004 to 2007

	2004	2005	2006	2007
	77	107	113	226

Source: CSO (2008d)

A study *Recidivism in the Republic of Ireland*, by O'Donnell *et al.* (2008), analysed the level and pattern of recidivism in an Irish context, while also exploring the implications of the patterns of recidivism observed. The objectives were to estimate the recidivism rate for persons exposed to a prison term and to investigate whether these rates varied by the characteristics of offenders, the offence for which they were punished and the duration of the punishment. It is recognised that the data do not facilitate a cross-national analysis owing to the ways in which they were recorded.

The sample for this study consisted of all prisoners released from Irish prisons between 1 January 2001 and 30 November 2004. There were 19,955 unique releases from



prison, representing 14,485 different persons. Recidivism can be measured as reoffending, re-arrest, reconviction or re-imprisonment, with data provided by offender self-reports or official records. Recidivism is, most often, based on reconviction or re-imprisonment. This relates to a new offence committed within a specified follow-up period. Survival regression analysis was the statistical technique used, as it accounted for differences across persons in release dates and follow-up duration (O'Donnell *et al.* 2008). The social and demographic characteristics of persons released from Irish prisons were specified. The vast majority were male (93%), unmarried (82%) and relatively young. Drug offences represented 13% of the crime types these participants were most likely to have been imprisoned for.

For the first few months subsequent to release, re-imprisonment rates accelerated steadily, with 27.4% re-imprisoned within one year. Just over 45% were re-imprisoned within three years, and almost half (49.2%) were re-imprisoned within four years, by which time it appears that the trend line has begun to flatten.

A previous sentence is one of the strongest predictors of recidivism in Ireland. This is in line with observations in other nations. Drug offenders represented 42.1% of the total sample who were re-imprisoned within 36 months following the completion of a sentence. This study has highlighted the fact that the recidivism rate in Ireland is lower than was previously assumed by many policy makers and other commentators. The assumption that this rate was exceptionally high, approximately 70%, was proved to be inaccurate. Approximately 50% of those released from Irish prisons were re-imprisoned within four years.

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

The Irish Prison Service (IPS) 2006 annual report is the most recent report currently available from the IPS.

According to the 2006 annual report, a number of specific measures have been taken in order to combat the supply of drugs into prisons. There are new prison visiting arrangements, involving greater control over the number and identity of visitors. In addition, there is enhanced supervision of such visits. Prisoners may only receive visits from identified and known persons, reducing the likelihood of visitors attempting to pass drugs on. It also reduces the likelihood of prisoners being coerced into receiving visits from persons not known to them in order to facilitate the transmission of drugs. Perimeter security was enhanced, with improved netting and closer cooperation with the Garda Síochána to arrest and prosecute persons attempting to transmit drugs into prisons. This has resulted in arrest, prosecution and imprisonment of persons attempting such activity.

Improved technology for searching cells and prison property was also introduced. This resulted in enhanced detection and seizure of contraband. Prison design was also improved, aimed at ensuring greater security. It was reported that new prisons are designed to be impervious to attempts to propel drugs into prison yards. Drug detection dogs were also introduced to monitor persons entering prisons and to aid searches within prisons.

Information on drug testing in prisons from 2005 to 2007 was obtained from the IPS by *The Irish Times* under the Freedom of Information Act (Long 2008). According to this data, more than 20,000 voluntary tests were carried out each year to monitor drug use and responses to treatment. These tests included those carried out on committals (new entries) as well as on existing inmates. It may be assumed, therefore, that some of the positive test results relate to drugs or alcohol consumed outside the prison. Between one-third and one-half of those screened tested positive for at least one drug. The common metabolites detected indicated use of cannabis, benzodiazepines and opiates (Table 8.4.1). It is not clear whether the numbers of positive cases excluded prisoners

who were prescribed benzodiazepines; if they do not, these figures overstate the extent of unregulated use of benzodiazepine in prisons. Cocaine and alcohol were detected in a small number of tests. The profile of positive drug tests was similar among prisoners tested in Mountjoy, Wheatfield, Limerick, Midland and Cloverhill prisons. The proportion of positive tests was low in St Patrick's Institution and in Castlereagh and Cork prisons.

**Table 8.4.1 Number of tests, by prison, and number (%) of positive tests, by prison and by drug type, 2007**

Prison	No. of tests	Cannabis	Benzodiazepines	Opiates	Cocaine	Alcohol	Amphetamines
Mountjoy Main	3,680	1,860 (51%)	1, 871 (51%)	2,112 (57%)	78 (2%)	23 (0.6%)	29 (0.8%)
Dochas Centre	2,464	844(34%)	1,294 (50%)	751 (46%)	85(11%)	55 (3%)	14 (1%)
Wheatfield	4,369	2,122 (49%)	1,572 (36%)	1,842 (44%)	51 (1%)	31 (0.7%)	35 (0.8%)
Cloverhill	3,301	833 (25%)	1,206 (37%)	1,141 (35%)	267 (8%)	79 (2%)	31 (0.9%)
St Patrick's Inst.	3,489	245 (7%)	179 (5%)	86 (3%)	12 (0.3%)	14 (0.4%)	20 (0.6%)
Castlereagh	92	14 (15%)	17 (19%)	9 (10%)	0 (0%)	0 (0%)	2 (2%)
Loughan House	407	128 (32%)	55 (14%)	16 (4%)	7 (2%)	9 (2%)	8 (2%)
Shelton Abbey	382	97 (25%)	45 (12%)	22 (6%)	19 (5%)	12 (3%)	10 (3%)
Limerick	518	189 (37%)	223 (43%)	228 (44%)	3 (0.6%)	18 (3%)	5 (1%)
Cork	97	3 (3%)	8 (8%)	1 (1%)	0 (0%)	1 (1%)	0 (0%)
Midland	1,694	263 (16%)	422 (25%)	871 (51%)	18 (1%)	9 (0.5%)	9 (0.5%)
Portlaoise	20	3 (15%)	4 (20%)	4 (20%)	0 (0%)	1 (5%)	0 (0%)

Source: Data received from the Irish Prison Service

The IPS annual report for 2006 states that of the twelve deaths in custody in 2006, five were suspected drug overdoses.

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

No new information available.

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

### **9.1 Overview**

Measures tackling vocational training, employment and educational opportunities for drug users are being planned and developed on foot of recommendations made in the Report of the Working Group on Drugs Rehabilitation. An evaluation of the Georges Hill Step-Down facility shows the merits of inter-agency collaboration in improving accommodation outcomes for individuals who have been in residential drug treatment. The provision of methadone to hostel-dwelling heroin users reduces chaotic drug use and improves their health and social functioning. An evaluation of the Bridge to Workplace Initiative shows the benefits of an inter-agency response to improving the employability of drug users by successful work placements. Participants on the Keltoi Residential Drug Treatment programme achieved paid employment 1-3 years after treatment. Research shows that for some drug users, difficulties persist in obtaining medical cards which has implications for accessing basic healthcare. An innovative programme of intra-agency community-based methadone detoxification protocols have been introduced and these may benefit methadone clients who are in employment.

### **9.2 Social reintegration**

#### **Social reintegration and rehabilitation in the Irish drug strategy**

The Report of the Working Group on Drugs Rehabilitation made a series of recommendations for the development of a comprehensive rehabilitation pillar under the National Drugs Strategy (Report of the Working Group on Drugs Rehabilitation 2007). The recently-appointed new Minister of State with Responsibility for Drugs, Deputy John Curran, in a written answer to a Parliamentary Question, reported on progress regarding these recommendations (Curran 2008, 20 May). The salient points of the Minister's response are summarised below.

Progress in implementing the recommendations has been slow, but further action is being actively considered. The HSE is taking the lead role and the post of Senior Rehabilitation Co-ordinator is to be advertised and filled by September. The National Drugs Rehabilitation Implementation Committee, which was recommended in the Report of the Working Group, will also be in place by September and this will be chaired by the Senior Rehabilitation Co-ordinator.

Other recommendations contained in the report of the Working Group that are being progressed include:

- Steps are being taken to increase the number of stabilised drug users on drug-specific Community Employment Schemes from 1,000 to 1,300. These schemes are designed to provide educational and training opportunities for stabilised drug users, to improve their employability and social functioning.
- The Department of Education and Science is developing proposals for an Education Fund to support recovering drug users to access further educational opportunities.
- The Department of the Environment, Heritage and Local Government is establishing a Working Group to progress the recommendations in regard to accommodation issues for drug misusers.
- The Irish Prison Service is working to improve the operation of the Local Prison Liaison Groups and to ensure a continuum of care for problem drug users when they leave prison.
- Increased funding has been provided to support the Family Support Network, in order to prioritise the role of families in the rehabilitation process.

## 9.2.1 Housing

### **George's Hill Step-Down programme**

In 2004, the Health Service Executive Rehabilitation/Integration Service (RIS) and the Keltoi residential drug rehabilitation service recognised that some people who had taken part in drug rehabilitation in Keltoi did not have a secure and safe living environment to return to and were exposed to the risk of relapse. Also, some were not ready to move to independent living after rehab and needed the help of supported accommodation. Keltoi clients reported difficulties in sustaining accommodation, and at least two-thirds experienced episodes of homelessness. In response, the RIS and Keltoi, in conjunction with Focus Ireland, a voluntary service provider to the homeless, developed an inter-agency response, known as the George's Hill Step-Down programme, providing six months' supported accommodation.

The Step-Down programme has seven self-contained apartments. Clients are responsible for payment of rent and other domestic services such as electricity and phone bills. A tenancy support worker is available to clients for six months after they leave George's Hill. The RIS continues to work with individuals for at least one year, to assist them to access further education, training or employment. Support is provided by a key worker and a caseworker, and through aftercare sessions and monthly review meetings. Day-time vocational programmes and facilitated group sessions are also provided. The latter include modules on practical skills, education, and stress management, managing accommodation, communication and health care.

The results of an external evaluation of the programme in 2007 have now been published (Juniper Consulting 2008). Data were collected from 10 former and current clients, and from staff members of the three partner agencies, using semi-structured interviews.

Between the time of its launch in September 2005 and August 2007, 15 clients participated in the programme, of whom 12 completed and three left before the end of the six months. A further seven clients were on the programme during the evaluation period in 2007. Of the 22 former and current clients, 15 (68%) were male, 15 (68%) were in the 26–40 age group, and the majority (18) were single.

Of the 12 clients who had completed the programme, six were living independently, two were living with a family member or a partner, and four were living in transitional housing. In addition, the evaluation reported that anecdotal information gathered by Focus Ireland key workers, either through direct contact with former clients or through RIS and Keltoi sources, suggested that all former clients remained drug free and all were in education, training, employment or travelling.

### **Coolmine Therapeutic Community: The development of integration and aftercare services**

The Coolmine Therapeutic Community (CTC) provides dedicated residential treatment services to 30 men in Coolmine Lodge and 8 women in Ashleigh House. Coolmine TC now provides an integration and aftercare service for those individuals that have completed residential treatment. With the support of Dublin City Council and Fingal County Council, the integration service has established four community-based houses in suburban Dublin to provide transitional support following residential treatment. The overall aim of the integration and aftercare service is to support clients as they negotiate the transition to living in the wider community while also remaining drug and alcohol free. It provides step-down, community-based housing for a minimum of six months. In 2006, the programme provided services to 36 clients (Coolmine Therapeutic Community 2007).

### **Safetynet Methadone Pilot in Hostel for homeless heroin users**

The Dublin Simon Emergency Shelter provides up to six months' accommodation to 30 residents. Hostel admission is largely restricted to persons living on the streets and most of the homeless persons accepted are high-risk intravenous heroin users who are

not in treatment. During the six-month period from December 2007 to May 2008, the Safetynet Service, a mix of statutory and voluntary health care professionals, piloted a methadone programme in the hostel. The rationale for this pilot intervention was to reduce the level of heroin use and the high level of hospital admissions among homeless heroin-using residents of the hostel. During this six-month period, 14 residents were initiated onto the programme. At the end of the period, 10 patients remained in treatment, 2 patients had been transferred to another GP within the Safetynet service, and two had left the hostel without further contact.

An internal evaluation of the Safetynet methadone programme in the Dublin Simon Emergency Shelter was undertaken after six months (Geraghty *et al* 2008). Data collection methods included interviews with staff and clients of the shelter. Drug use and social functioning before and after commencing treatment were assessed and data relating to participants' shelter and nursing were analysed.

Of the 10 patients on the programme at the end of six months, two had opiate- and cocaine-free urines and the remainder reported marked reductions in drug use. This reflected a reduction from an average pre-treatment six 'bags' of heroin daily to 1–2 'bags' of heroin per week. This reduction is self-reported but is supported by key workers' estimates and clinical impressions. Four patients who left the programme reported marked reduction in drug use prior to exiting.

There was a marked reduction in abscesses and skin conditions in the first five months of 2008 compared to 2007, a reduction largely attributed to the decrease in injecting by clients.

There were no evictions or 'barring' from the hostel for unsafe drug use in the first four months of 2008 compared to eight for the same period in 2007, a reduction largely attributed to the methadone programme. In addition, there has been a reduction in the residents' involvement in crime, improvements in level of contact with family, in motivation to attend stabilisation programmes and to source longer-term accommodation. Some have started to attend hospital outpatient appointments and re-engage in education.

### **9.2.2 Education and training**

The Bridge to Workplace Initiative is a multi-agency approach to accessing work-placement options as a mode of progression for individuals with a history of problem drug use. The Health Service Executive Rehabilitation/Integration Service (HSE/RIS) and the Local Employment Services Network (LESN), supported by a number of Local Drugs Task Forces and associated agencies, are responsible for operating the initiative.

Potential clients are referred to the initiative when they have been assessed as stable, motivated, committed and drug-free; however, clients on methadone maintenance are also referred. Protocols governing confidentiality and release of information to the different agencies are agreed between the referral officers and clients. When clients present and are assessed as being suitable for the initiative, the initial aim is to establish an individualised client progression plan that is regularly monitored and reviewed. This is done by way of a three-way meeting between the client and workers from the RIS and the LESN.

The provision of baseline knowledge to frontline workers on the role of each agency and the formation of agreed lines of communication has been crucial in facilitating compromise between the agencies. In addition, securing work placements for clients remains an ongoing challenge for the programme, with potential employers showing a lack of understanding around issues such as methadone maintenance, stability and social skills deficits.

An evaluation (Bridge-to-Workplace, 2008) reported that a total of 74 clients had engaged with the initiative between its commencement in August 2005 and the end of December 2006. Of the total 41.9% are presently engaged, 21.3% have completed and 29.7% have disengaged for a period but remain in general contact with the service providers of the initiative. The majority are male, fall within the 26–32 year-old age range and are deemed to be drug-free. The non-completion of secondary-level education was particularly acute among clients. Eighty per cent of workplacements to date have been within the commercial private sector, with the remainder in the public/social sector. The duration of placements ranges from 2 to 25 weeks with the average 12 weeks.

It is reported in the evaluation that many participants referred to the positive experience of the placement in terms of respect, routine, motivation and increased levels of confidence, as well as the placement being a catalyst for progression.

An employer is reported as saying that:

The clients are incredibly motivated in the workplace. They have clear goals about getting their lives back on track and they work hard to prove it. All clients are integrated with our team, working side-by-side and on the same projects as professionals. (p 24)

The Bridge-to-Workplace pilot phase continued until December 2007, at which stage the partner organisations committed to a further two years of collaborative work with a final date of May 2009. The next phase will continue, using the inter-agency protocols, and will include an expanded programme with potential employers to build up a work placement programme. The funding for the initiative incorporates important costs such as childcare, insurance for workplace indemnity, work placement equipment, uniform/clothing and a participant allowance to cover costs such as travel, food and phone.

### **9.2.3 Employment**

An evaluation of the Keltoi Therapeutic Residential programme was completed in 2007. Keltoi's model is based on the premise that rehabilitation with a focus on developing living skills rather than procuring insight produces more favourable outcomes where clients develop and successfully maintain a drug-free lifestyle (Miller and Wilbourne 2002). The main therapeutic work in the programme focuses on addressing cognitive, affective and external stimuli that can trigger substance misuse episodes. The programme is run over an eight-week period with a strong emphasis on occupational work, advocating respect, life management and negotiating around interpersonal relationships. Prior to admission, clients need to be drug-free, physically stable and committed to remaining drug-free while resident at Keltoi. The overwhelming majority of clients admitted to Keltoi report acute opiate dependence and related problems with a small proportion reporting acute cocaine dependence.

Prospective clients for the evaluation were recruited between November 2002 and August 2004. The evaluation followed up a non-random cross-sectional cohort of clients (n=94) who were 1–3 years post-discharge from the programme. This cohort represented approximately 67% of the total number of clients admitted to the programme from November 2002 to August 2004. The interview process began in May 2004 and the final interview took place in July 2006.

Of the 485 clients referred to Keltoi between 2002 and 2004, 149 (31%) were treated. Ninety-five per cent of clients admitted to the treatment programme had severe opiate dependence problems, and a small proportion had severe cocaine dependence. To be admitted to the programme, clients had to have been drug-free for two to six weeks, depending on the individual case and the assessment of the team. Ninety-two participants (62%) agreed to be interviewed, two of whom died prior to the interview

date. Eighty questionnaires were completed. The final sample comprised 52 (74%) men, 18 (26%) women and 10 individuals whose gender was not recorded.

The study reported that a large proportion of those who started treatment completed it (83%, 58/70). Half (29/58) of those who completed treatment were drug-free in the month prior to this study interview. The abstinence rate for men (50%) was higher than that for women (39%). Five of the 29 who had used at least one drug in the last month had injected it.

The proportion who committed at least one crime during the 30 days prior to interview was lower among those who had not used drugs in that time than among those who had, 15% compared to 30%. Physically and psychologically, abstinent individuals reported higher levels of wellbeing than those who were not abstinent. Men reported marginally better levels of wellbeing than women.

Of the 40 clients (50%) who had paid work in the 30 days prior to interview, 23 (57.5%) did not miss any days work during that period while eight (20%) reported that they were formally unemployed. Within the entirely abstinent cohort (n=41), 18 individuals (44%) had had paid work in the last 30 days, and 13 (72%) of those did not miss any days owing to sickness or unauthorised absence.

The evaluation acknowledged that the lack of baseline data and any form of independent verification of the self-report methodology meant that the findings needed to be treated with caution. It is possible that other treatment interventions may have taken place between discharge from Keltoi and the study interview and these may have accounted for some of the positive findings. Nevertheless, these findings indicate that the Keltoi approach can contribute to favourable outcomes both in treating drug use and improving indicators of social reintegration such as employment.

#### **9.2.4 Basic social assistance**

Difficulties experienced by drug users, particularly homeless drug users, in accessing medical cards persist. Feedback from primary health care providers (O'Sullivan 2008), cited in the recent submission by Merchants Quay Ireland to the review on the National Drug Strategy (2008), highlights how difficulties accessing medical cards have negative knock-on effects in terms of limiting access to a range of health services, not only GP services. It was suggested that, as a group that experiences a high rate of ill-health, drug users should not be confronted by unnecessary systemic barriers to health care: a system of medical card service access that is not dependent on being registered with a general practitioner should be considered, and especially for homeless drug users.

A series of seminars was held in Dublin on 8 April 2008 with health-care professionals and community and voluntary groups to introduce intra-agency community methadone detoxification protocols. The protocols will be piloted in the North Inner City Drugs Task Force (NICDTF) area over the next 18 months. They aim to provide an option for people who find it difficult to take up a residential detoxification bed owing to family or work commitments and to benefit individuals who want to reduce their methadone dosage in order to access a residential programme. The protocols are in response to concerns voiced by the community and by drug users that individuals were being 'parked' on long-term methadone maintenance. The protocols are designed to address the concerns of GPs about the risk factors associated with the process of detoxification, including integrating the necessary social support for their patient for a successful and safe detoxification. The protocols emphasise empowerment – drug users are empowered to choose what treatment option best suits them, but also to take responsibility for their treatment. Clients will be primarily managed by a case manager, who, in conjunction with the GP, is responsible for assessing the client's suitability for the programme and for ensuring that the correct protocols are followed. He/she has primary responsibility for the client's care plan. In consultation with the client, the case manager will develop a relapse-prevention and aftercare plan, and will work with the client during and after the detoxification (for a minimum of six months). Under the pilot

scheme, clients will also be supported to reduce and ultimately cease their use of benzodiazepines. In this case, the client shows their commitment by attending four care-planning meetings over a period of two to six weeks. They are also required to fill out weekly drug diaries (Department of Health and Children 2002). The protocols have the potential to support people who are in employment to access treatment and medical care in the community, without this adversely impacting on their employment. In addition, the protocols can contribute to a reduction in methadone dosage, when the client requests this. This was identified as a barrier to pursuing further education and training/employment (Lawless 2006), and in progressing individuals on from existing vocational training programmes.

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

#### **9.3.1 Assistance to drug users in prison**

The Irish Prison Service (IPS) *Annual Report 2006 (2007)* details the enhancement of treatment services to prisoners during 2006. This was achieved by the development of new services and programmes for prisoners with an addiction. These services are being delivered by the IPS in partnership with community-based services, including the Health Service Executive and contracted private services.

Specific developments during 2006:

- A contract was awarded to Merchants Quay Ireland for 24 addiction counsellors to cover all prisons. This would, in conjunction with other developments, lead to an increase of nearly 1,000 hours per week of prisoner access to addiction counselling.
- Seven nurse officers and five prison officers were allocated to dedicated drug treatment teams in prisons with significant needs. This was reported as supporting and improving service quality in prisons that receive a large number of prisoners with addictions.
- Funding was provided for four community groups to provide addiction counselling and other supports to prisoners while in prison and on release in the community. This would build on prisoners' success in becoming drug-free in prison by supporting their return to the community.
- Additional prison sessions with consultants in addiction and registrars were established and resourced, significantly improving the quality, coordination and availability of drug treatment in prisons.
- A consultant-led infectious disease service was contracted from St. James' Hospital to provide new treatments to prisoners with an infectious disease. It was hoped this service would be expanded to other sites.
- A tender for dedicated drug treatment pharmacy services was developed. This service was to contribute significantly to supporting improved quality and availability of treatment services.

It was noted in the annual report that these services would continue to be provided on the basis of clinical need. They would be supported by '...the implementation of a system of mandatory drug testing (provided for in the Prisons Act 2007) upon the coming into force of the new Prison Rules' (p. 24).

Links with community-based services and communities affected by drug addiction continued in 2006. The Probation Service maintained its contribution by assisting with the implementation of programmes such as Drug Treatment and Alcohol and Drug Awareness. In addition, through this service, the Department of Justice, Equality and Law Reform provided funding to over 70 community and voluntary agencies. These agencies work with prisoners at a local level in areas such as accommodation, work and education, drug treatment and reintegration projects.



As can be seen from Table 9.3.1, nine prisons provided methadone treatment to 1,579 prisoners in 2006, of which 162 were receiving methadone for the first time. It is noteworthy that methadone treatment was not provided in two large prisons, namely Cork and Castlereagh.

**Table 9.3.1 Numbers of individuals receiving methadone treatment\* in Irish prisons in 2006**

Prisons	Total patients during 2006	New patients in 2006	Patients as of 31 December 2006
Cloverhill Prison	678	107	175
Dochas Centre	216	20	32
Limerick Prison	8	0	6
Midlands Prison	19	2	12
Mountjoy Main Prison	416	13	145
Mountjoy Prison Medical Unit	48	2	12
Portlaoise Prison	2	1	2
St Patrick's Institution	8	1	6
Wheatfield Prison	184	16	82
<b>Total</b>	<b>1579</b>	<b>162</b>	<b>472</b>

\*Methadone treatment in this context is either substitution or detoxification.

Source: 2006 Annual Report of the Irish Prison Service (2007)

### 9.3.2 Prevention of drug-related crime in urban societies

Pilot Joint Policing Committees (JPCs) have been established under the provisions of the Garda Síochána Act 2005 (see National Report 2007). JPCs bring together public representatives, representatives of local authorities, the Garda Síochána and representatives of the voluntary and community sector to assess levels of crime and anti-social behaviour, including that related to alcohol use and illicit drug use, and to make recommendations as to how to prevent and address such problems. According to the *Annual Report of An Garda Síochána 2007*, community policing was supported through a number of developments in 2007:

- A Joint Policing Committee (JPC) office was set up in May 2007. The main role of the JPC office is to monitor garda involvement in JPCs and make recommendations on how participation and effectiveness can be improved.
- A Superintendent was appointed to the new position of Family Liaison Officer in March 2007 to improve victim-related services.
- The pilot phase of An Garda Síochána National Model of Community Policing was approved and work is progressing to implement same.
- At year end 2007, 1,250 Community Alert and 2,601 Neighbourhood Watch schemes were active throughout the country.

The JPC pilot was evaluated in early 2008 and final guidelines will be issued before the end of 2008 to ensure the establishment of JPCs in all local authority areas throughout the state. Further guidelines are due to be issued establishing Local Policing Fora in local drug task force areas as provided for in Action 11 of the National Drugs Strategy 2001 – 2008.

The Local/Regional Drugs Task Force Community Representatives Conference, facilitated by the CityWide Drugs Crisis Campaign and hosted by the National Drugs Strategy Team (NDST) and the Inter-Departmental Group on the National Drugs Strategy (IDG), took place at the Killeeshin Hotel in Portlaoise from 4 to 6 April. In light of the development of the new National Drugs Strategy 2009–2016, the main objective of this conference was to consult with community representatives so as to identify priority actions needed to address drug misuse in communities. A further objective included establishing how communities can play a lead role in developing, planning and delivering the new National Drugs Strategy.

Criminologist, Johnny Connolly of the Health Research Board, highlighted the significant gaps in our understanding of how illicit drug markets operate. He pointed out that, despite the major anxiety within society about drug-related crime and the huge resources invested in drug law enforcement, we have very limited information on how these resources are used or what sort of impact they have. He suggested that there is

growing evidence internationally that partnership between stakeholders including local communities, law enforcement, local authorities and health workers offers the most sustainable method of responding to many drug problems. He suggested that the joint policing committees and, in particular, the local policing fora being rolled out in line with the National Drugs Strategy and An Garda Síochána Act, 2005, have the potential to provide the necessary infrastructure through which such partnership approaches can be delivered at local level.

Priority actions from the supply control workshop included:

- Put community policing fora in place in all LDTF areas as a matter of urgency and facilitate discussion as to how the model can be adapted to RDTF areas.
- Develop a more intensive and targeted response to drug 'hotspots' identified at local level.
- Implement a national programme of arrest referral schemes.
- Encourage liaison between the Courts Service, the NDST and drugs task forces to progress Action 72 of the strategy relating to the training of members of the judiciary.
- Expand the means by which people can safely and anonymously contact the garda in relation to drug dealing.
- Ring-fence money obtained through the Criminal Assets Bureau for re-investment in local communities most affected by drugs.
- Address drug supply within the Traveller community in local and regional policing plans.

## 10. Drug Markets

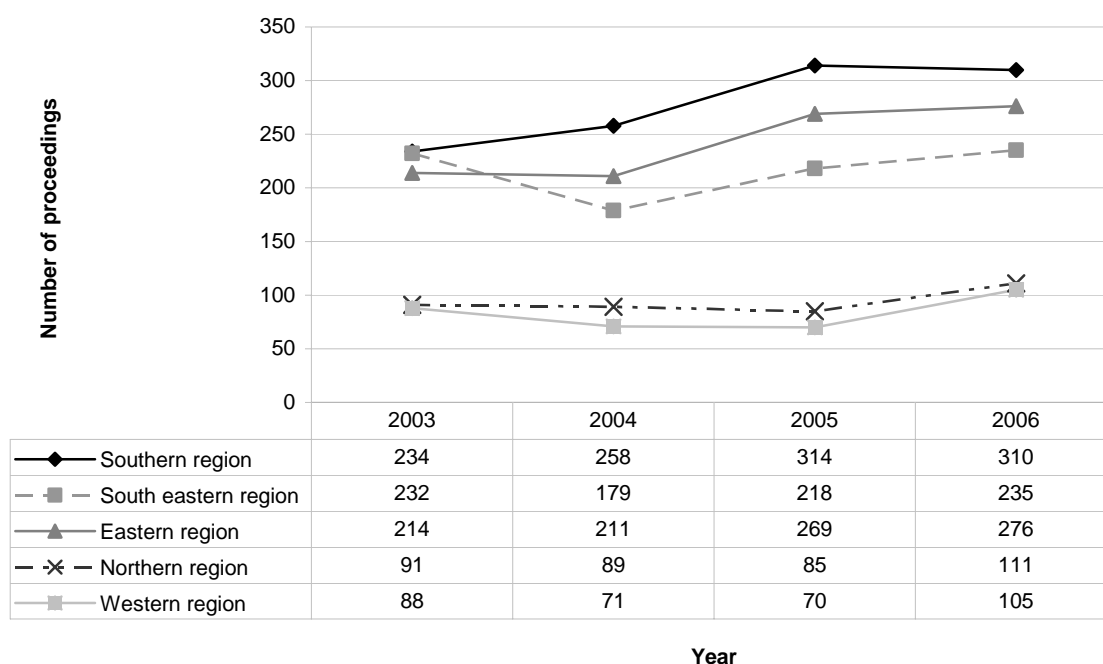
### 10.1 Overview

There is no systematic, comprehensive information available on illicit drug markets in Ireland. However, new developments in research relating to Irish drug markets are described at the end of this chapter.

The report *Garda recorded crime statistics 2003–2006*, published by the Central Statistics Office (CSO) (2008c), provides data which can assist us in understanding aspects of the operation of the illicit drug market in Ireland. With regard to the so-called middle market level, which involves the importation and internal distribution of drugs, data on drug supply offence prosecutions by Garda division are a possible indicator of national drug distribution patterns. While these data primarily reflect law enforcement activities and the relative ease of detection of different drugs, they may also provide an indicator of national drug distribution trends. These data can be compared with other sources such as drug treatment data, for example, to show us trends in market developments throughout the State. Such data can also provide an indicator of trafficking patterns by showing, for example, whether there is a concentration of prosecutions along specific routes.

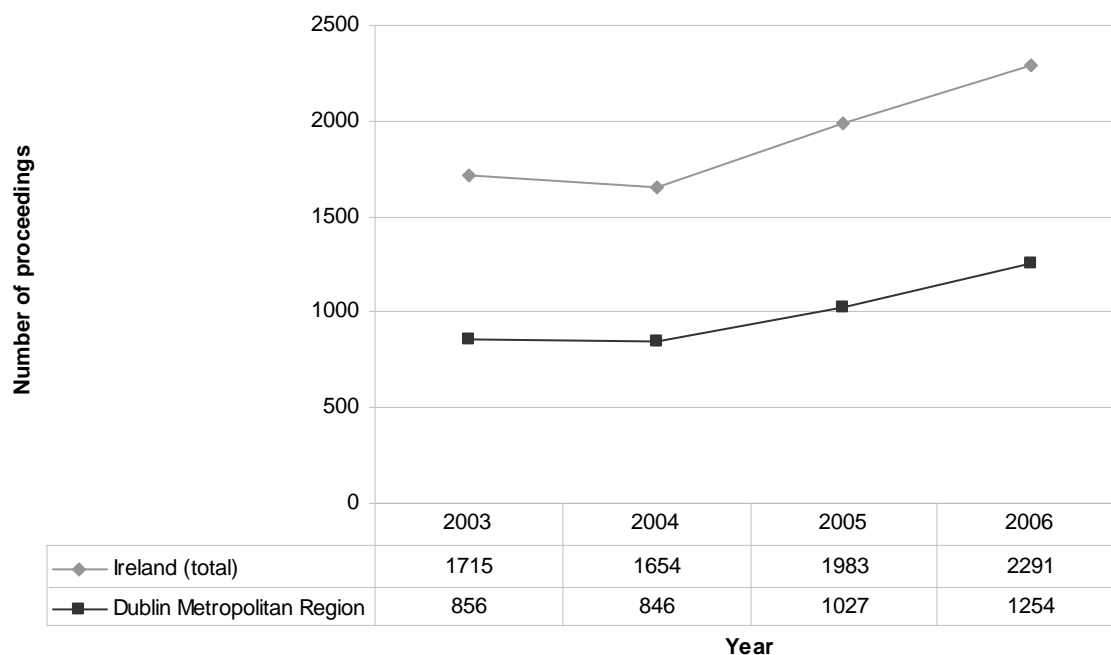
### 10.2 Availability and supply

Figure 10.2.1 shows the number of relevant legal proceedings for drug supply offences by Garda region outside the Dublin Metropolitan Region.



**Figure 10.2.1** Drug supply (s.15 MDA) offences outside the Dublin Metropolitan Region 2003–2006 where relevant legal proceedings commenced, reported by the CSO (2008c)

The upward trend since 2004 in relevant legal proceedings for drug supply continued in 2006 (Figures 10.2.1 and 10.2.2). Although the majority of such proceedings still take place in the Dublin Metropolitan Region, the number of proceedings taking place outside Dublin has increased from 859 in 2003 to 1,037 in 2006 (Figure 10.2.2).



**Figure 10.2.2** Trends in total number of relevant legal proceedings for supply offences and those in the DMR, 2003–2006, reported by the CSO (2008c)

## Drug importation

### *Cocaine*

Customs Drug Law Enforcement (CDLE) reports an ongoing trend of import by air passengers and by express mail service post (EMS). According to CDLE

Recent importation attempts have tended to involve European-type females and older retired males with multi kilo quantities being smuggled in carry-on baggage. A number of these have been detected in Germany and France. Countries of origin appear to be South and West African or South American. (CDLE, personal communication, July 2008)

CDLE also reported the continued involvement of West African organised crime groups (OCGs) in organising importations of cocaine.

### *Heroin*

CDLE reported the use of both commercial vehicles and groupage loads for drug concealments. According to CDLE, there is also evidence to suggest that some OCGs may be sourcing their heroin directly from the Balkan Route, involving significant movements of drugs via Italy (CDLE, personal communication, July 2008).

### *Cannabis*

The primary trends reported are importation by air passengers with checked-in baggage and by EMS post. According to CDLE, air passenger importations typically involve quantities of between 5 and 30 kg of herbal cannabis, while EMS detections typically range from 1 to 40 kg. Recent detections have involved Irish, West African and Eastern European OCGs in both organisational and distribution roles.

### *Amphetamine-type substances / Synthetics*

There have been media reports that methamphetamine has become available on the Irish illicit drug market. To date very few seizures have been made. However, CDLE reported there have been a number of detections of ephedrine tablets in the post since January 2008. This indicates the possible production of methamphetamine within the State.

### Khat

CDLE reported that 'while there is no change in the methods and routes, there has been an overall decrease in the volume of khat being seized' (CDLE, personal communication, July 2008).

### Organised crime

CDLE reported continuing evidence of the involvement of indigenous Irish OCGs in the importation and distribution of heroin and cannabis resin. West African OCGs are, it is suggested, involved in the importation and distribution of cocaine and herbal cannabis. According to CDLE, 'they have now formed strategic links with Eastern European (predominantly Lithuanian) organised crime groups. The Eastern European groups are also active on their own behalf in relation to cocaine and amphetamine type stimulants.' (CDLE, personal communication, July 2008)

### Supply control

CDLE reported a range of activities over the previous year in terms of its supply control activity. This included:

- Participation in MAOC-N, the maritime analysis and operation centre based in Lisbon, and the appointment of a Customs Officer to MAOC-N in 2008
- Four new dog handlers and two new detector dogs trained and deployed
- Appointment of a Customs Officer as Europol Liaison Officer to Europol in Den Haag in 2008
- Operation Resolute: This is a joint Customs/Garda operation which is in pilot phase at present in four regional locations. The operation aims to extend the principles of joint working and intelligence-based targeting.

## 10.3 Seizures

Cannabis seizures account for the majority of all drugs seized. Of the 8,417 reported drug seizures in 2006, 4,243 (50.4%) were cannabis-related. Figure 10.3.1 shows trends in seizures for a selection of drugs, excluding cannabis, between 2003 and 2006. We can see a continuous steady rise in cocaine seizures since 2003. Heroin seizures rose sharply during 2006, increasing from 763 in 2005 to 1,254 in 2006. The number of seizures of ecstasy-type substances also rose in 2006, following a steady decline since 2003.

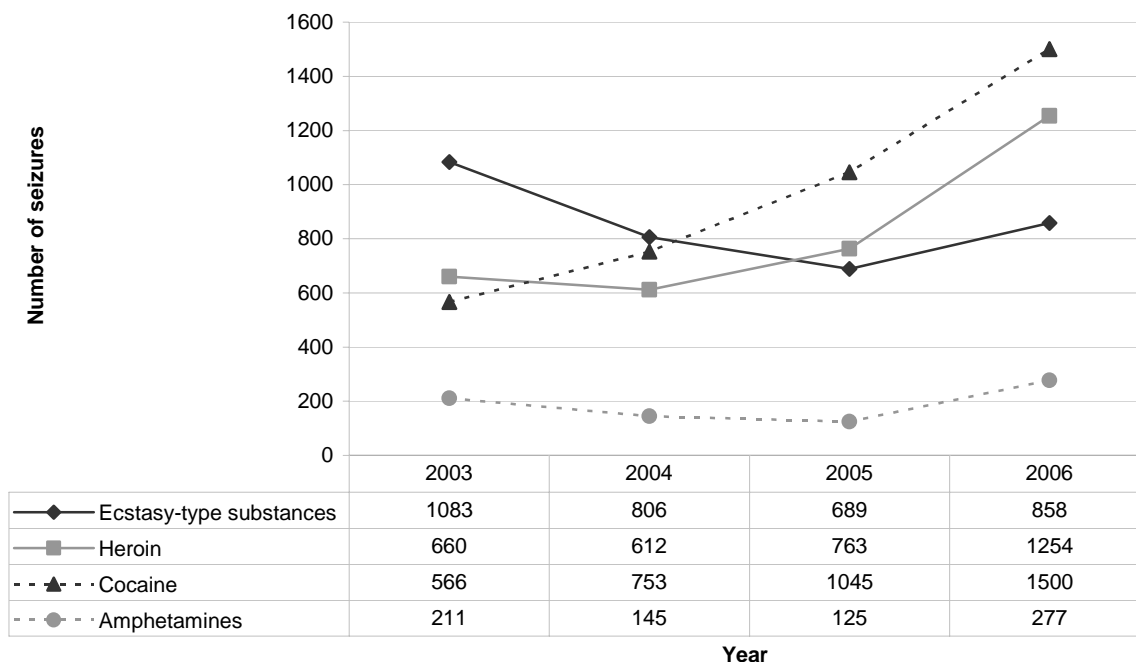


Figure 10.3.1 Trends in the number of seizures of selected drugs, excluding cannabis, 2003–2006, reported by the CSO (2008c)

Table 10.3.1 details the quantity and number of seizures for all illicit drugs during 2006, the most recent data available. As can be seen, LSD only accounted for one seizure in this year. Psilocybin/psilocin (4), Khat (7) and Dimethyltryptamine (4) were also among the lowest number of seizures.

**Table 10.3.1 Particulars of drugs seized during 2006**

Drug Type	Quantity	Cases
Cannabis	314,848 grams	609
Cannabis resin	6,971,699 grams	3,587
Cannabis plants	633 plants	47
Heroin (Diamorphine)	129,640 grams	1,254
LSD	1,528 units	1
Ecstasy MDMA	156,124 tablets, 197 grams, 1,500 ml	856
Ecstasy MDEA	9 tablets	2
Amphetamine	41,397 grams, 7,743 tablets	277
Cocaine	195,343 grams	1,500
Methylamphetamine	144 grams	22
Psilocybin/psilocin	Mushroom samples	4
Khat	Plant samples	7
Dimethyltryptamine	2,000 ml, 37 grams	4

Source: CSO (2008c)

Table 10.3.2 shows drug seizures by the Customs Service in 2007 and up until June 2008. The data for 2007 includes the largest ever seizure of cocaine in Ireland when 1,550 kg of cocaine were recovered from Dunlough Bay in County Cork after drug smugglers ran into difficulties in stormy weather conditions. Evidence from their subsequent trial suggests that the cocaine may not have been destined for Ireland. However, according to Customs Drug Law Enforcement, the smuggling operation may represent a 're-emergence of the threat from the maritime sector' (CDLE, personal communication, July 2008).

**Table 10.3.2 Particulars of drugs seized by customs drug law enforcement 2007 and January– June 2008**

Drug Type	January to December 2007		January to June 2008	
	Number of Seizures	Volume Seized (kg)	Number of Seizures	Volume Seized (kg)
Cannabis (Herbal)	1,490	1,386.341	1,037	272.59
Cannabis (Resin)	558	414.516	362	1,462.26
Heroin	11	22.829	2	20
Cocaine	55	1,617.879*	34	18.29
Amphetamine	39	1.879	11	0.023
Other	604	899.548	1,915	120.946
Total	2,757	4,342.99	3,361	1894.109

Source: CDLE, personal communication July 2008

\*This includes seizure of 1,550 kg of cocaine in 2007

## 10.4 Price/purity

### Price

There are no regular data available on drug prices. The Garda Síochána are currently developing a more robust method to ascertain drug prices (GNLU, personal communication, May 2008). The *Annual Report of An Garda Síochána 2007* noted that 120 searches were conducted by the Organised Crime Unit in that year, leading to seizures of drugs worth an estimated €7 million.

### Purity

The Forensic Science Laboratory (FSL) reported that the average wholesale purity of heroin in 2007 was 41% while the average retail purity was 40%. The average wholesale purity of cocaine was reported as 27% with the average retail purity 10% (Forensic Science Laboratory, personal communication, September 2008).

A review of the FSL by Professor Ingvar Kopp (2007), former director of the Swedish National Forensic Science Laboratory and founding member of the European Network of Forensic Science Institutes, found that approximately one-third of drug samples submitted by the Garda Síochána for analysis between 2000 and 2006 were not

processed because of resource limitations. As a consequence he concluded that, 'the detection and prosecution of crime is weakened ... particularly so in drug analysis cases, where a certificate is required for prosecution' (Kopp 2007, p. 19).

Suspected drugs seized by the gardaí and by customs are submitted to the FSL for analysis to determine whether an illicit substance is present. Samples are submitted in tamper-evident bags, with a Garda form which lists the items being submitted. The Kopp report pointed to unnecessary bureaucratic obstacles, stating that 'in relation to drug cases, there is a lot of manual handling and duplication of data entry' (p. 16). The process by which items are received is, according to the report, 'very cumbersome', owing in part to legal constraints and in part 'to practices grown with the development of the Laboratory' (p. 16). A time-consuming practice has developed whereby labels on the packing and detailed descriptions of the contents form part of the laboratory report. The report recommended that this practice be rationalised by means of an FSL/Garda review of case management procedures and by the automation of procedures and minimisation of manual data entry.

The report also noted, however, that legal constraints require rigorous procedures to be in place. It is not unusual, according to the report, 'for the questioning in court to focus more on the physical appearance of the item rather than analytical results' (p. 16). This can occur even in drug cases, as the court may want to probe 'what the Garda recorded or saw prior to submitting the sample to the Laboratory' (p. 16). Furthermore, beyond the focus on the appearance of evidence, 'enormous and disproportionate demands' are placed on the laboratory arising from the need to certify the chain of evidence. The report recommended that the Law Reform Commission or another suitable expert body be commissioned to conduct a study in order to 'evaluate the scope for a more efficient means of approaching the management of physical evidence' (p.17).

Table 10.4.1 shows the number of drug cases received by the FSL from the Garda Síochána and the number of cases reported (i.e. processed). Of the 61,639 drug cases submitted for analysis between 2000 and 2006, 41,230 were analysed, leaving a shortfall of 20,409, or just over 33%.

**Table 10.4.1 Number of drug cases received and reported by the Forensic Science Laboratory 2000 to 2006**

	2000	2001	2002	2003	2004	2005	2006	Total
Cases received	8658	10715	8673	8470	8192	8079	8852	61639
Cases reported	5111	5813	4764	5653	6251	6390	7248	41230
Shortfall	3547	4902	3909	2817	1941	1689	1604	20409

Source: Kopp (2007)

The report also pointed to the need for resources to cover an additional service, in connection with drug-related sexual assaults. The FSL has carried out alcohol determinations on biological samples submitted relating to victims of sexual assault. In more recent years, requests have been expanded to test for the presence of controlled drugs. However, the report pointed out that the FSL has not been able to meet this demand and estimated that, were it to provide such a service, approximately 150 such cases would arise annually.

Professor Kopp emphasised the importance of the FSL engaging with academic and research institutions, and recommended that the Department of Justice, Equality and Law Reform fund and support the FSL so that it could participate in joint research projects with other institutions, such as the Health Research Board (p. 41). In relation to drug purity, for example, this approach could enhance our understanding of the operation of illicit drug markets. Systematic purity testing of drugs seized at all market levels can provide useful information on market dynamics and profit margins (Connolly

2005). Forensic analysis of seized drugs can also provide us with information on the types of dilutants used to bulk up drugs for street sale, a practice which can have important health consequences for drug users.

Although the FSL sometimes conducts ad hoc studies, only a very small proportion of drugs seized are tested to ascertain their purity. For example, in 2003, the laboratory received over 600 suspected heroin cases, of which 11 were analysed to determine their percentage purity (Connolly 2005). Further research such as that recommended in this report would assist in providing an evidence-base upon which to develop criminal justice interventions.

Kopp's study concluded that the current resource limitations have implications for crime control and law enforcement:

The consequences of the current inability to meet actual and suppressed demands are serious. Investigations and prosecutions which could benefit from forensic analysis are deprived of additional insight and this has inevitable consequences in the fight against crime. (p. 8)

## **10.5 Research on illicit drug markets**

### **Crack cocaine in the greater Dublin region**

A report was published by the Health Research Board in October 2008 using a Rapid Situation Assessment technique to determine the nature and extent of the crack cocaine market in the Dublin region. This study, funded by the Department of Justice, Equality and Law Reform, was commissioned following a number of seizures of crack cocaine in Dublin's north inner city in 2005. The findings of the research will inform the development of a crack cocaine strategy.

### **The illicit drug market in Ireland**

Despite widespread concern about the societal impact of illicit drug markets and related crime, there has been an almost total absence of in-depth research and analysis of the organisation and operation of illicit drug markets in Ireland. A study currently being undertaken by the Alcohol and Drug Research Unit of the Health Research Board seeks to fill this gap. The study was commissioned by the National Advisory Committee on Drugs (NACD). The research objectives are

- to examine the nature, organisation and structure of Irish drug markets
- to examine the various factors which can influence the development of local drug markets
- to examine the impact of drug dealing and drug markets in local communities
- to describe and assess interventions in drug markets with a view to identifying what further interventions are needed

The study employs methodological triangulation, using both qualitative and quantitative methods, to obtain a clear and accurate picture of illicit drug markets and their impact at four different research locations in Ireland. Data collection methods include in-depth semi-structured interviews with individuals involved in the illicit drug market in Ireland, a survey of local residents in each of the four research locations, and the collection and analysis of criminal justice data on drug law enforcement and drug-related crime in the areas under study. The study is due to be published in early 2010.



## Part B: Selected Issues

### Summary of selected issue

- The Courts Service, the Central Statistics Office (CSO) and the Irish Prison Service (IPS) are the three bodies which provide statistical information in relation to sentencing in Ireland. Recent improvements in data automation throughout the criminal justice system have enhanced our understanding of the operation of the system. However, there remain a number of limitations in the available information on sentencing practices throughout the criminal justice system. A recent study examined both levels and predictors of recidivism, and highlighted the data limitations within the criminal justice system. For example, the sharing of information on offences or offenders between the police, courts, prisons and probation data systems is not possible. This is despite the fact that recidivism rates are integral to evaluations of the efficacy of different judicial sentences and punishments.
- There is also limited evidence of a coherent sentencing policy in Ireland, although there have been a number of pronouncements on the issue over time, particularly in support of the use of alternatives to custody and the introduction of mandatory minimum sentences for certain drug supply offences. A complication which arises in the context of sentencing policy in Ireland relates to the role of judicial discretion in the determination of an appropriate sentence. The separation of powers ensures that judges ultimately have discretion when it comes to sentencing. On occasion, the judiciary has come under scrutiny by policy makers as the latter have suggested that judicial discretion is not being exercised in a manner consistent with policy as determined by the legislature, particularly in relation to the reluctance to implement mandatory minimum sentences in drug cases. The Criminal Justice Act 2007 has introduced new provisions to address this issue.
- With regard to disposing of offences, the Garda Síochána have a range of options available, including confiscation and informal warning, caution, juvenile diversion, arrest referral or prosecuting in the District Court. The courts have extensive discretion and a range of options at their disposal: community service orders, entering into recognisance, detention, suspended detention, dismissal, fines, imprisonment, suspended imprisonment, peace bond, contributing to the poor box, probation, acquittal, intensive community supervision and supervision during deferment of penalty. Offenders can also be referred to the drug treatment court.
- Fines continued to be the most common response to drug offences in 2006, accounting for 27% (2,418) of such offences. This was followed by cases struck out (21%) owing to insufficient evidence, imprisonment/detention (10%) and community service (2%). In general, convictions were by far the most common outcome for possession of drugs for sale or supply and possession for personal use offences between 2003 and 2006. Cases pending increased steadily, representing the most common outcome in 2006 for summary drug offences. A recent review of the drug treatment court reported that 22 participants graduated between January 2001 and July 2008, implying that one in five entries (23%) to the Drugs Court is successful.

## 11. Sentencing statistics

### 11.1 Overview

This section introduces a series of issues that arise when seeking to understand and interpret sentencing statistics in Ireland. They include:

- The lack of data and information
- The absence of a coherent sentencing policy
- The discrepancy between legislative enactments and judicial sentencing decisions, illustrated with reference to alternatives to custody and mandatory minimum sentences for drug supply offences

#### **Data limitations**

It has been suggested that of all the decisions made throughout the criminal justice system, those made in the courtroom are the most important as a person's liberty is at stake (Hedderman and Hough 2006). There is, however, a lack of information and data on sentencing and sentencing practices in Irish courts and therefore it is extremely difficult to assess how these important decisions are made (O'Donnell *et al.* 2008, O'Mahony 2002, Bacik 2002). Furthermore, the data that are available are not integrated. A difficulty which arises here, as O'Donnell *et al.* (2008, p. 124) point out, is that 'the computer systems of police, courts, prisons and probation stand alone and are not configured to share details of offences or offenders'. The data presented below are derived from the Courts Service, Central Statistics Office and the Irish Prison Service. The data presented in this section should therefore be regarded as providing an incomplete picture of the operation of the criminal justice system.

#### **The absence of a coherent sentencing policy**

According to O'Malley (2000), Irish sentencing law is skeletal compared to other common-law countries. He mainly attributes this to the fact that crime has only really become a problem since the 1980s and therefore a sentencing structure was not required until that time. The main principles underlying punishment in common-law countries are generally regarded as retribution (just desserts), individual or general deterrence, reform or rehabilitation, incapacitation and denunciation. O'Malley argues that what is needed is a consistency of approach, which reflects the principles being articulated through the criminal justice system (O'Malley 2000). In practice, however, he suggests that the Irish process of sentencing often appears to be intuitive as opposed to being based on the application of common principles. The 1996 Law Reform Commission recommended that sentencing policy should be founded upon the just desserts model (Bacik 2002). This entails matching the severity of the sentence with the seriousness of the crime. The latter would be measured by the degree of harm caused or risked by the offender and their level of culpability. O'Malley (2000) recommended an approach based on limited statutory intervention and appellate court guidance, the latter to be provided by the Court of Criminal Appeal. He also proposed that a sentencing information system be developed which would provide descriptive guidance to judges. This would involve the provision of case histories or summaries highlighting how sentencing occurred in similar cases.

#### **The link between policy and practice – alternatives to custody and mandatory minimum sentences**

Even if a clear sentencing policy based on a common set of principles were identified, it is a matter of some debate as to how this might be applied in practice in Irish courts. The experience of the sentencing process in Irish courts suggests that the connection between criminal justice policy as it is enunciated in parliament, for example, and how it is practised throughout the criminal justice system is a complex one. Although there is limited evidence of a coherent sentencing policy in Ireland in relation to minor crime,

including some drug-related crime, there have been a number of pronouncements in support of the use of alternatives to custody (Connolly 2006b). Over the past twenty years, numerous studies and reports, both government sponsored and non-governmental, have advocated the use of alternatives to prison. There is also broad public support for the proposition that imprisonment should be used sparingly. However, Connolly concludes that 'despite this overwhelming political and public consensus that alternatives to prison should be used where possible, there is no evidence that their use is displacing the use of imprisonment in Ireland' (p. 25). According to O'Malley (2000), a '...good range of appropriate custodial and non-custodial facilities is crucial to the development and maintenance of a just and effective sentencing system' (p. 452). According to Bacik (2002), guidelines need to be introduced alongside greater resources to ensure the availability of alternatives to custody.

Along with these broader policy and resource issues, another complication in connection to implementing sentencing policy in Ireland is the role of judicial discretion in determining the appropriate sentence. The separation of powers ensures that judges have discretion when it comes to sentencing, but on occasion the judiciary has been accused by policy makers of not exercising their discretion in a manner consistent with policy as determined by the legislature. This issue has arisen in relation to mandatory minimum sentences in drug cases.

A mandatory minimum ten-year sentence has been introduced through provisions introduced under s.15A of the Misuse of Drugs Act 1977 (as inserted by ss. 4 and 5 of the Criminal Justice Act 1999). The Criminal Justice Act, 1999 introduced the offence of the illegal possession of drugs with a market value of over €13,000, with the intent to sell or supply. The law stipulates a minimum mandatory sentence of ten years for this offence. It does, however, make provision for 'exceptional and specific circumstances'. The judge can assess whether or not these exist, for example, if the offender has pleaded guilty. The main purpose of these provisions is to ensure that mandatory sentencing for supplying drugs should be imposed in all but the most exceptional circumstances.

Two reviews of the application of the mandatory minimum sentence in s.15a drug cases highlight that, in the majority of cases, the minimum sentence was not applied. The first review (Ennis 2003) focused on decisions made in the Court of Criminal Appeal. The objective was to ascertain how the '...legislation has been applied by the courts and whether any clear patterns have emerged in this area' (p. 30). It was suggested that the interpretation of the section had caused confusion, particularly in relation to the nature of 'exceptional and specific circumstances'. A number of the decisions made in the Court of Criminal Appeal were reviewed and it was found that the minimum sentence was viewed by judges as only one of a number of options rather than as a benchmark. It was also noted that, even though the role of drug couriers was considered to be a serious offence, '...in practice the court does not seem keen to impose the mandatory minimum in such cases' (p. 33). In these cases 'exceptional and specific circumstances' were usually taken into account. The courts adopted a more rigid approach, however, when it came to the 'bigger players'. In such cases it was sometimes deemed inappropriate to use the minimum sentence as a benchmark, where to do so would be to ignore the maximum sentence of life imprisonment. Ennis concluded that, in accounting for judicial practice, 'the key factor is that the seriousness of the offence is reflected in the sentence' (p. 35).

McEvoy (2005) carried out the second review, which focused on the criteria applied by the courts when sentencing in relation to s.15a. This research was based on 55 sentencing transcripts of Circuit Court cases from November 1999 to May 2001. Decisions of the Court of Criminal Appeal were referred to where relevant. Where 'exceptional and specific circumstances' were deemed to exist, the main reasons cited were a guilty plea and material assistance in the investigation of the offence. It was found, nonetheless, that the minimum sentence was successful in its operation, as it

functioned as a positive disincentive to ‘...accused persons to “test” the prosecution case in a criminal trial’ (p. 11). Reluctance to impose the minimum sentence appears to stem from a fear of awarding a disproportionate sentence. However, it was deemed useful as its existence served as a benchmark to the seriousness of the offence, which helped in the process of determining the appropriate sentence.

Part 5 of the Criminal Justice Act 2007 proposes amendments to the Misuse of Drugs Act 1977, specifically in relation to the area of sentencing of those in possession of drugs with intent to supply. The key provisions contained in this section of the Act include the following:

- The minimum period of imprisonment for those convicted under Section 15A or 15B of the Misuse of Drugs Act 1977 is to be 10 years, aside from some exceptional circumstances whereby the court determines that it would be unjust to impose such a sentence
- The minimum period of imprisonment for those convicted of a second or subsequent offence under Section 15A or 15B of the Misuse of Drugs Act 1977 is to be 10 years

The main purpose of these provisions is to ensure that mandatory sentencing for supplying drugs should be imposed in all but the most exceptional circumstances. It is too early to determine whether these changes will have any impact in terms of judicial practice in the courts.

## **11.2 Sentencing options available**

There are a range of sentencing options available at different stages of the criminal justice process. These can vary according to the perceived seriousness of the offence.

### **Personal possession or use**

The gardaí have the options of confiscation and informal warning, caution, juvenile diversion, arrest referral or prosecuting in the District Court. All criminal prosecutions are taken under the authority of the Director of Public Prosecutions (DPP). In practice, the majority of prosecutions for lesser offences are brought by the gardaí without specific reference to the DPP’s office.

The court has a range of options at its disposal including community service orders, entering into recognisance, detention, suspended detention, dismissal, fines, imprisonment, suspended imprisonment, peace bond, contributing to the poor box, probation, acquittal, intensive community supervision and supervision during deferment of penalty. Cases can also be adjourned, permanently stayed, struck out, withdrawn or taken into consideration. Taken into consideration refers to a person, on being convicted of an offence, admitting guilt to another offence and requesting this to be taken into consideration in awarding punishment. When deciding the punishment, if the court takes this fact into consideration, it is noted and filed with the record of the sentence. The accused will not be prosecuted for the additional offence, unless the conviction is reversed on appeal.

### **Production, dealing or trafficking**

The gardaí generally refer charges relating to such offences to the DPP to be either prosecuted in the Circuit Criminal Court or disposed of summarily in the District Court. The courts have the options listed above. In addition, the mandatory minimum ten-year sentence, as discussed in section 11.1, is available. Certain offenders can also be diverted to the Drug Treatment Court, as outlined in section 11.5.

### **Driving after taking drugs**

Driving under the influence of drugs has been a statutory offence in Ireland since the introduction of the 1961 Road Traffic Act. The principal legislation in this area is

contained in the Road Traffic Acts 1961 to 2002. Section 10 of the Road Traffic Act 1994 prohibits driving in a public place while a person 'is under the influence of an intoxicant to such an extent as to be incapable of having proper control of the vehicle'. Intoxicants are defined to include alcohol, drugs, any combination of drugs, or drugs and alcohol. Although penalties for driving under the influence of alcohol are graded according to the concentration of alcohol detected, the law does not set prohibited concentrations for drugs. Neither does it distinguish between legal and illegal drugs. Tests to identify level of impairment can only take place where there is a reasonable suspicion that an offence is being committed. The responses available for this offence consist of licence suspension, a fine or imprisonment. Sentences are imposed at the discretion of the court.

### **11.3 Data collection systems**

The Courts Service, the Central Statistics Office (CSO) and the Irish Prison Service (IPS) provide statistical information in relation to sentencing in Ireland. This information is published in the annual reports of the Courts Service, the CSO and the IPS. Until 2006, the annual reports of the Garda Síochána also provided this information. In 2006, responsibility for reporting crime statistics was transferred to the CSO. In April 2008 the CSO published a comprehensive report which details the Garda recorded crime statistics for the years 2003 to 2006 (CSO 2008c). These systems of data collection operate within different frameworks and are not linked to each other.

#### **The Courts Service**

The Courts Service has published an annual report since 2000.<sup>8</sup> The reporting period is 1 January to 31 December. The first annual report provided overall sentencing statistics for the Supreme Court, the Court of Criminal Appeal, the High Court, the Central Criminal Court, the Special Criminal Court, the District Court and the Circuit Court. While sentences relating to certain categories such as rape and murder were distinguished, a breakdown of drug offence categories was not provided. Outcomes were reported for both the number of offences and offenders. The 'counting rules' dictate that the primary offence only counts for statistical purposes, i.e the most serious offence in terms of severest potential penalty. In general, one offence counts per victim. Multiple sanctions are not addressed.

#### **Central Statistics Office (CSO)**

The Garda Síochána PULSE (Police Using Leading Systems Effectively) system has recorded data in relation to drug offences since its inception in 1999. The gardaí send these data to the CSO who compile the information for their annual reports. It is proposed that the report for 2007 will be published in December 2008, based on data as it exists in early October 2008. To date, the CSO has published the Garda recorded crime statistics report for the years 2003 to 2006 (2008c), using data recorded up to and including 31 December 2006, as it existed in early October 2007. The crime statistics report uses the newly devised *Irish Crime Classification System (ICCS)*, which was published at the same time as the report (2008b). Data from the PULSE system were used for most of this publication. The controlled drug offence category comprises importation/manufacture of drugs and possession of drugs and these categories are further broken down into importation of drugs, cultivation or manufacture of drugs, possession of drugs for sale, and supply, and possession of drugs for personal use. There is a further controlled drug sub-category which relates to other drug offences such as forged or altered prescriptions and obstruction under the Misuse of Drugs Act, 1977. Statistics are provided concerning the specific outcomes for offences recorded in these categories. Drug driving statistics are reported separately and do not provide the same level of detail. The main offence 'counting rule' applies here and multiple sanctions are not addressed.

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<sup>8</sup> The courts services annual reports are available at <http://www.courts.ie/Library3.nsf/16c93c36d3635d5180256e3f003a4580/63c9da3620c14c5a80256f2a006732ad?OpenDocument>

### **Irish Prison Service**

The Irish Prison Service annual reports present figures on committals for drug offences.<sup>9</sup> The reporting period is 1 January to 31 December. The outcomes are reported for the number of offenders. The 'counting rules' apply and multiple sanctions are not addressed.

## **11.4 Data collected and results**

### **The Courts Service**

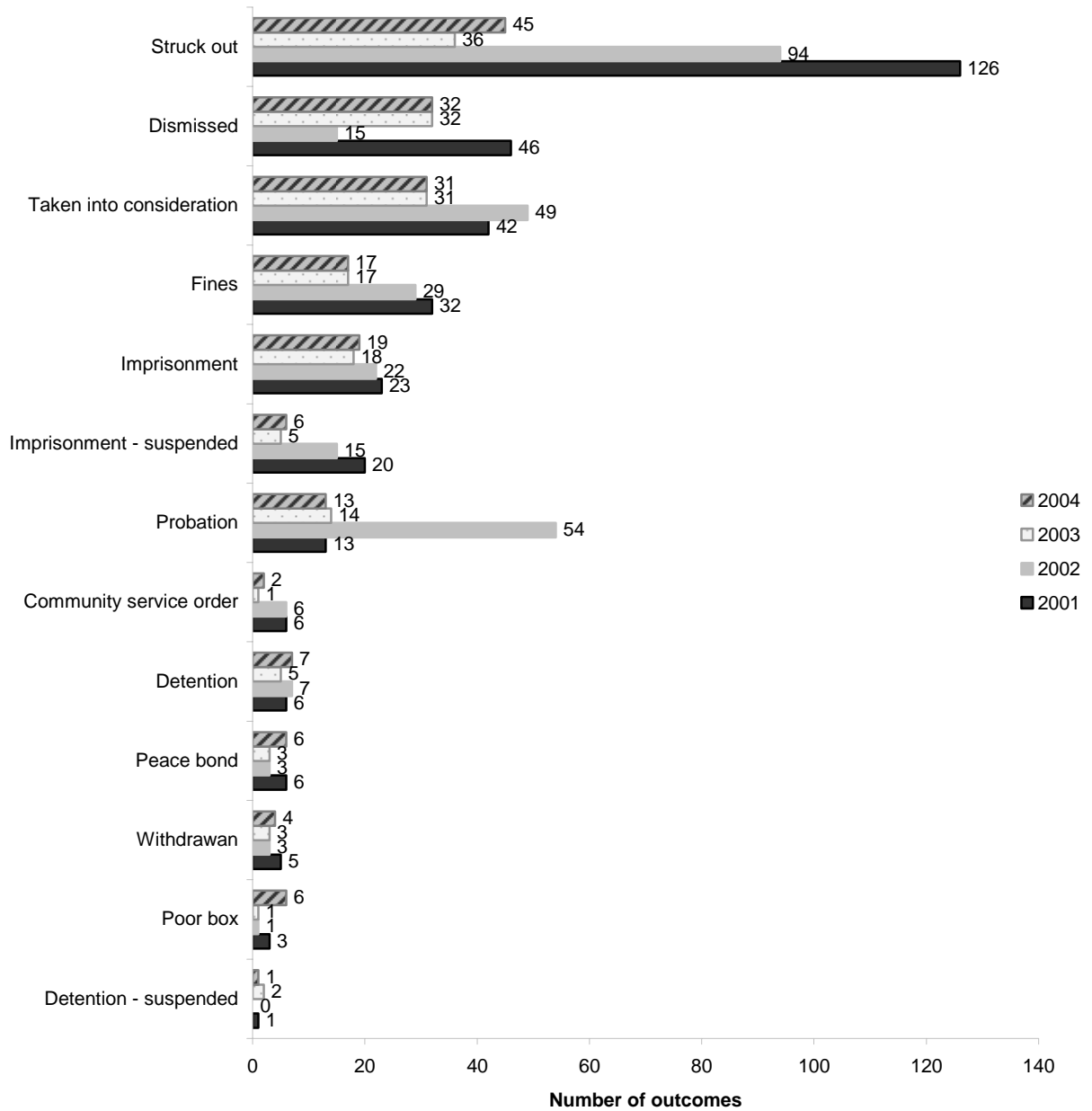
Outcomes are reported for drug offences as a general category, with individual offence types not distinguished. Cases which are closed and assigned a status 'no further action required' are not reported. Prosecutions started and then suspended owing to the offender voluntarily starting treatment are not reported. The Probation Service records data on treatment orders but these are on a case-by-case basis and these data are not collated. The 2001, 2002 and 2004 annual reports also provide a brief discussion of the cases that were referred from the Dublin District Court to the Drug Treatment Court. In the Courts Service the offences are divided into summary and indictable offences. Use and possession and driving under the influence of drugs, if dealt with by the courts, are processed summarily. The production and trafficking of drugs are indictable offences, although many of these offences will also be tried summarily. The outcomes for these offences are not broken down by substance type.

Figures 11.5.1 and 11.5.2 represent the Dublin Metropolitan Region (DMR) areas of Dun Laoghaire, Swords, Richmond and Chancery Street for the year 2001. For the year 2002 the figures include the Limerick area. In 2003 and 2004 the DMR Children Court was also included. In the annual reports the DMR areas and Limerick are presented separately.

As can be seen from Figure 11.5.1, the majority of summary drug offender cases between 2001 and 2004, with the exception of 2002, were struck out, taken into consideration or dismissed. In 2002, while the majority of cases were struck out, probation was the second most common outcome for such offenders, representing 54 out of 298 cases. This was followed by 49 cases taken into consideration. Imprisonment and fines were also common responses between 2001 and 2004. A suspended sentence of detention was consistently one of the least common outcomes for summary drug offenders.

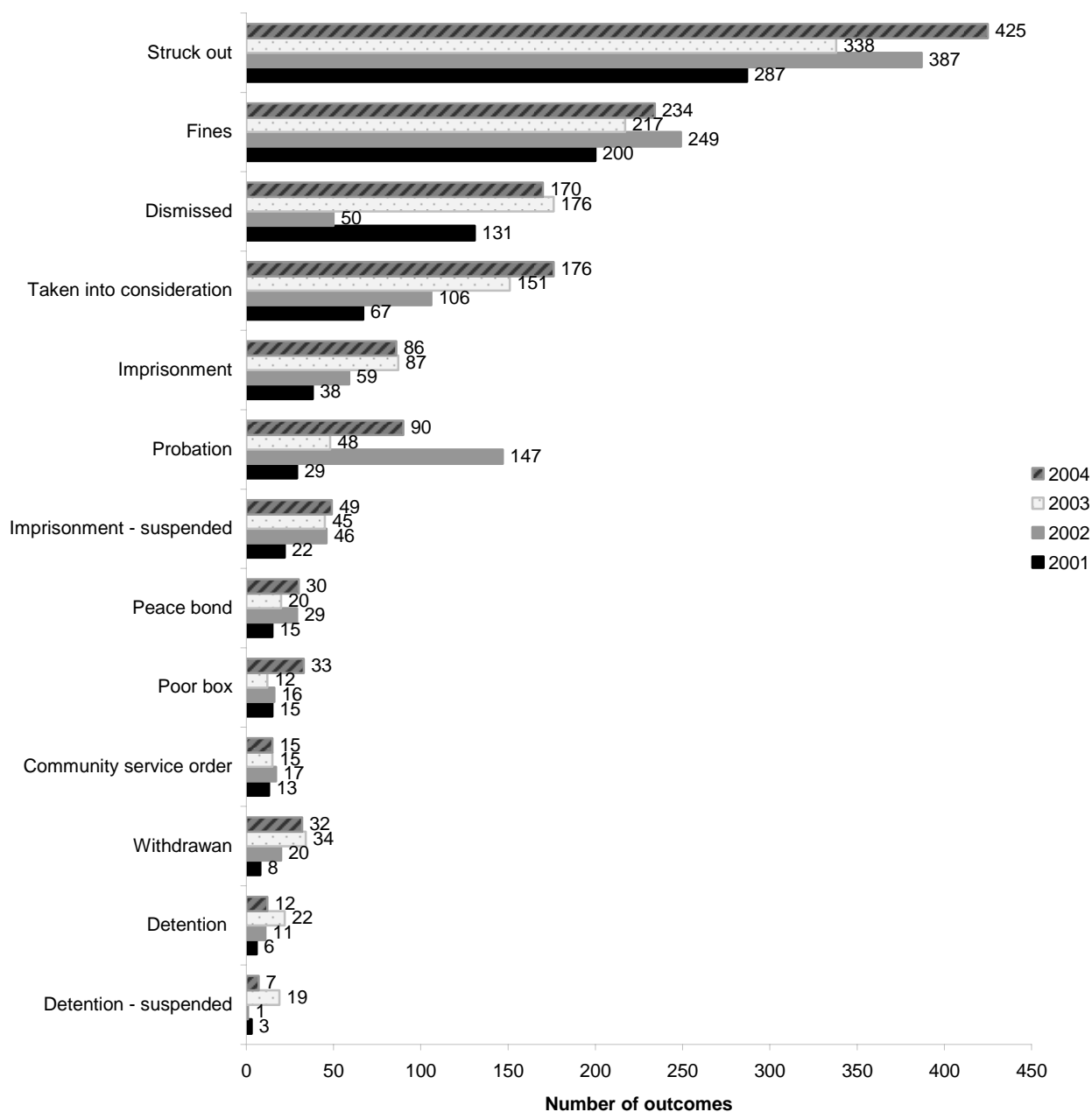
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<sup>9</sup> The annual reports of the Irish Prison Service are available at <http://www.irishprisons.iePublications-AnnualReports.htm>



**Figure 11.5.1** Number of outcomes for summary drug offenders in Ireland, reported by the Courts Service, 2001 to 2004

As can be seen from Figure 11.5.2, 'cases struck out' represented the highest category of outcome for indictable drug offender cases between 2001 and 2004. Fines were the second highest outcome for indictable offences in each year. Many cases were taken into consideration or dismissed.



**Figure 11.5.2** Number of outcomes for indictable drug offenders in Ireland, reported by the Courts Service, 2001 to 2004

In 2005, 378 summary and 6,625 indictable drug cases were disposed of in the District Court. The Courts Service annual report provides a breakdown of outcomes for drug offences by county. As can be seen from Figure 11.5.3, fines were the most common outcome (1,862, 26%), followed by cases which were struck out. No cases resulted in a peace bond or were adjourned generally and only 2% were dismissed.



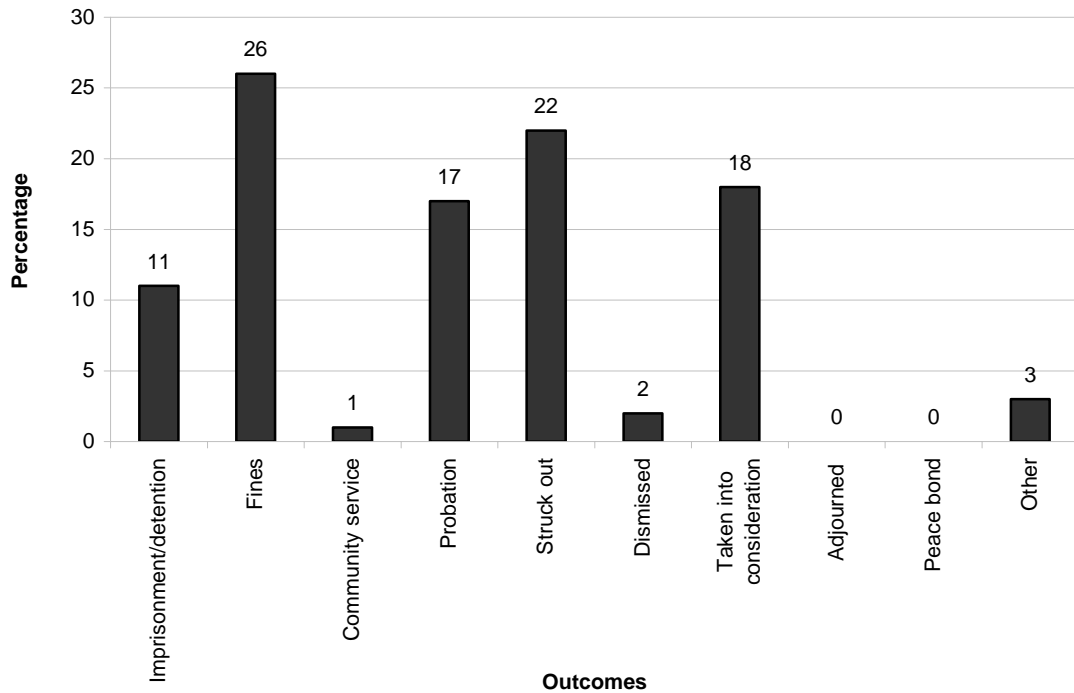


Figure 11.5.3 Percentage of outcomes for District Court drug offences in Ireland, reported by the Courts Service, 2005

In 2006, 497 summary and 8,357 indictable cases were disposed of in the District Court. As can be seen from Figure 11.5.4, fines continued to be the most common response to drug offences in 2006, accounting for 27% (2,418) of the total. This was again followed by cases struck out (21%). Imprisonment/detention accounted for 10%, while community service was at 2%.

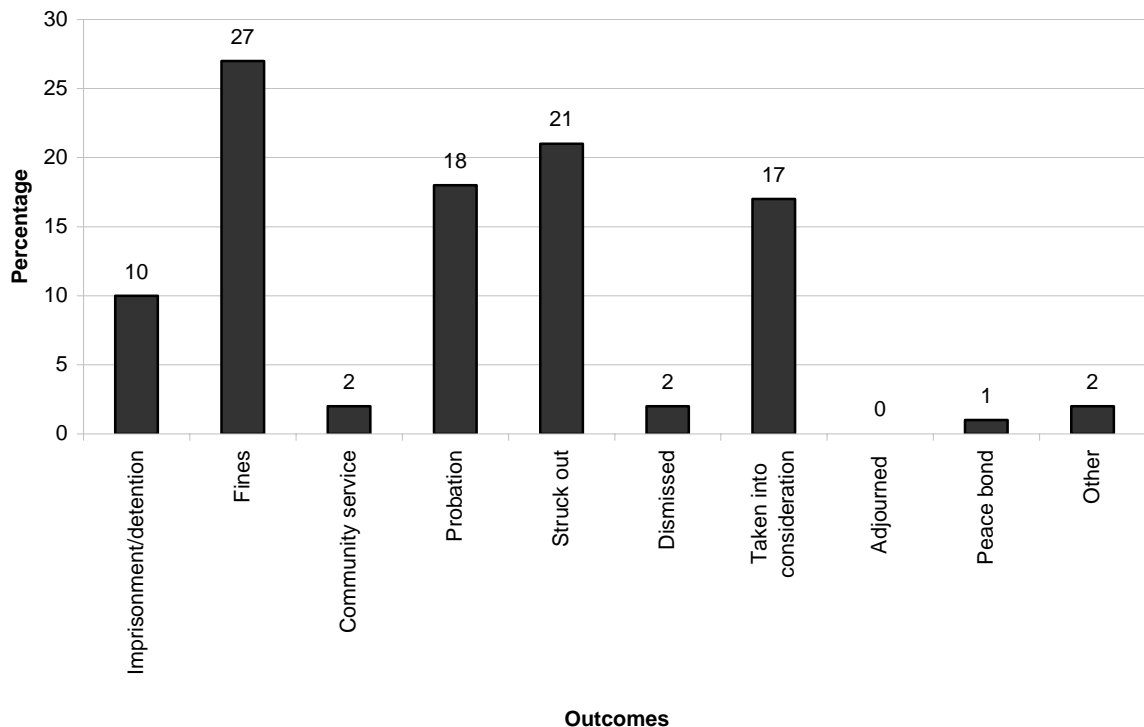


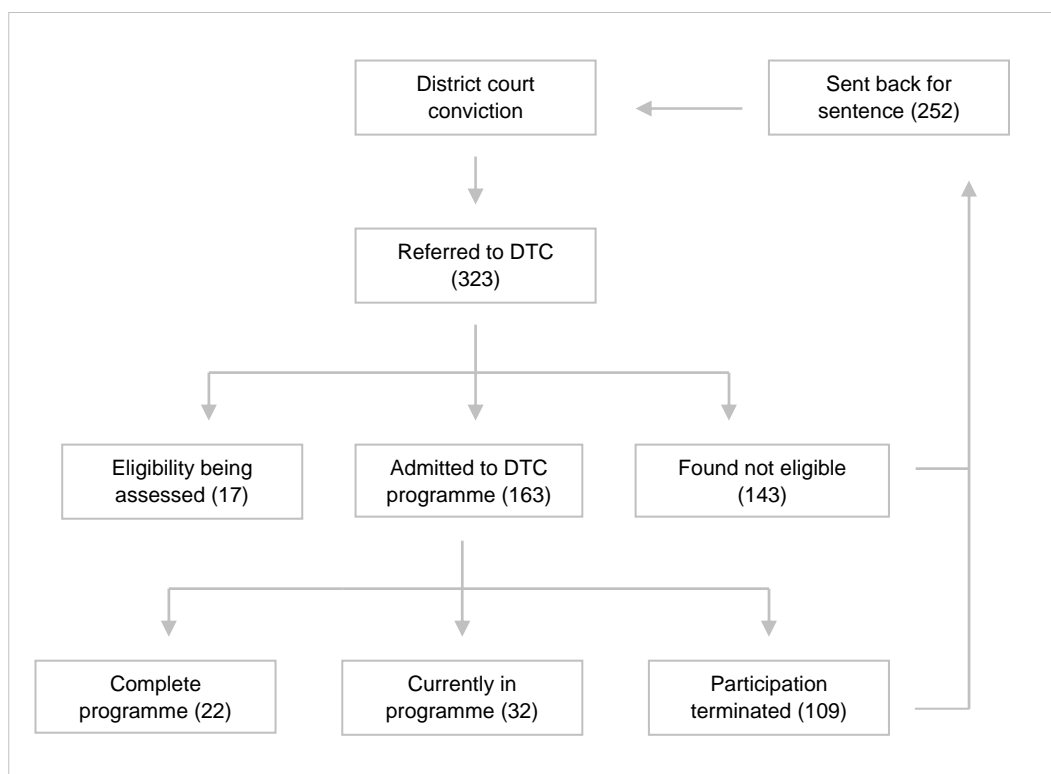
Figure 11.5.4 Percentage of outcomes for District Court drug offences in Ireland, reported by the Courts Service, 2006

### The Drug Treatment Court

A Drug Treatment Court, dealing with drug-related offences, was established in 2001 on a pilot basis in north inner-city Dublin (Connolly 2006b). A review of the Drug Treatment Court (Farrell et al 2002), while yielding a positive outcome overall, could

not fully assess whether the aim of the court to reduce recidivism was successful. This was due to the limited timeframe of the evaluation. There was, nonetheless, a notable decline in re-offending and the percentage of clean urine samples increased significantly. The offenders also participated in a range of classes and, despite the fact that none graduated, compliance had improved greatly by the end of the pilot period.

Three hundred and twenty-three people were referred to the Drug Treatment Court between 1 January 2001 and 31 July 2008. Of these, 143 were assessed as ineligible and thus referred back to the District Court for sentencing. and 17 people were still being assessed in relation to their suitability for the programme . Of the 163 who were eligible for the programme, 109 were referred back to the District Court for sentencing. Non-compliance with the programme or arrests for other offences were the main reasons for the termination of participants from the programme. Of the 54 participants who continued in the programme, there were 22 successful participants who graduated between January 2001 and July 2008 (personal communication, Office of the Comptroller and Auditor-General, 2008). This implies that one in five entries (23%) to the Drug Treatment Court is successful. This success rate is lower than observed in the USA (27% to 66%), but this could be due to the drug dependence and socio-economic profile of the population attending courts in north inner-city Dublin.



**Figure 11.5.5** Throughput of Dublin Drug Treatment Court , and outcomes for offenders, between January 2001 and July 2008 (Source: Office of the Comptroller and Auditor-General, 2008)

### Central Statistics Office (CSO)

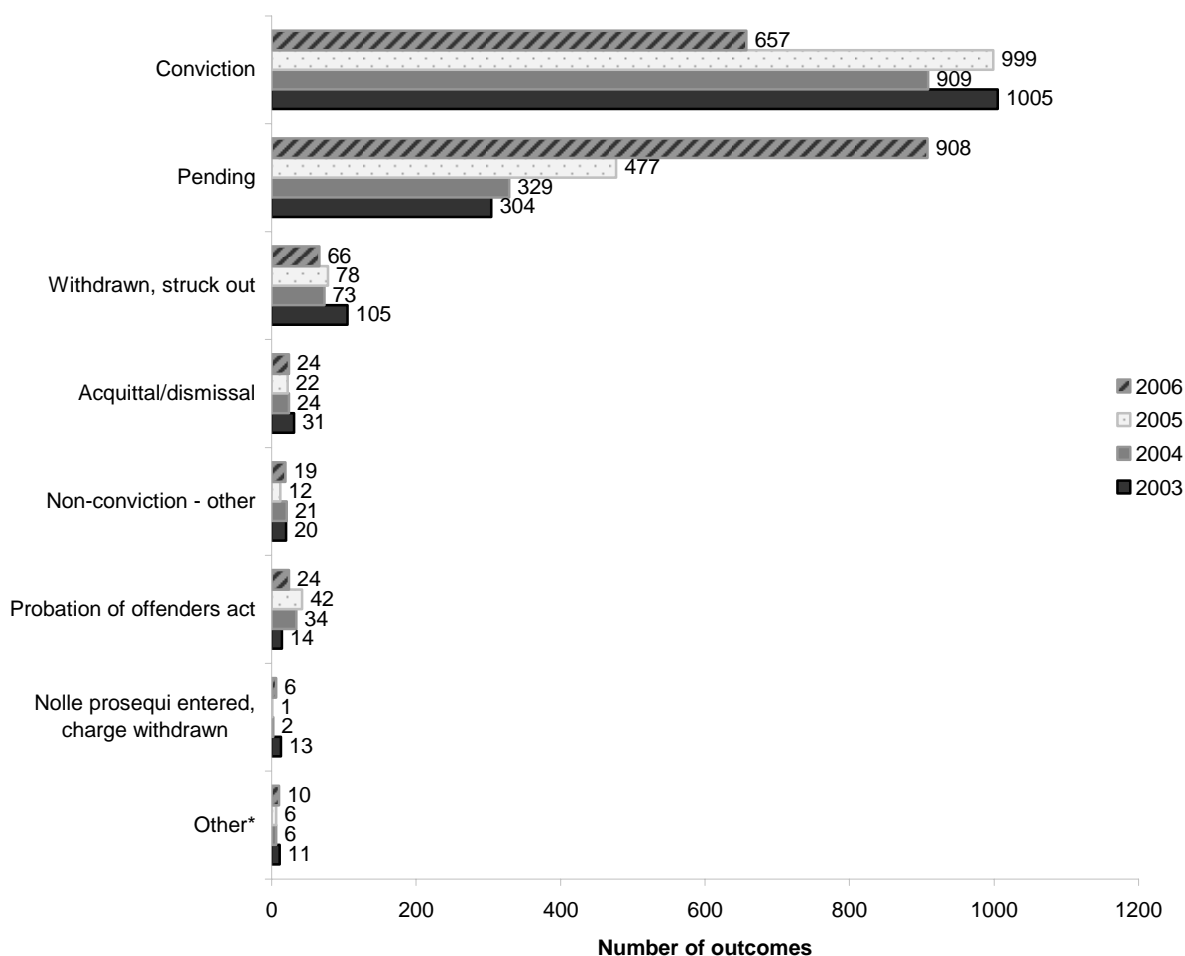
The results of court proceedings are reported for outcomes for controlled drug offences. Cases which are closed and assigned a status 'no further action required' are not reported. Prosecutions started and then suspended owing to the offender voluntarily starting treatment are not reported. While the incidence of cases coming before the courts is reported, their outcomes are not.

Appendix II of the CSO report (2008c) provides information on the Diversion Programme, which replaced the Juvenile Liaison Officer Scheme. It is described as a package of measures for dealing with children under the age of 18 who commit an offence or offences. These data are provided by the Garda National Juvenile Office and is based on the old headline/non-headline distinctions as the ICCS was not available at the time the data were generated. Referrals are reported by region, gender and Garda division. In 2006, 4% (995) of the total referrals were for drug possession and 0.6% (142) for sale/supply.

[http://www.cso.ie/releasespublications/pr\\_crimejust.htm](http://www.cso.ie/releasespublications/pr_crimejust.htm).

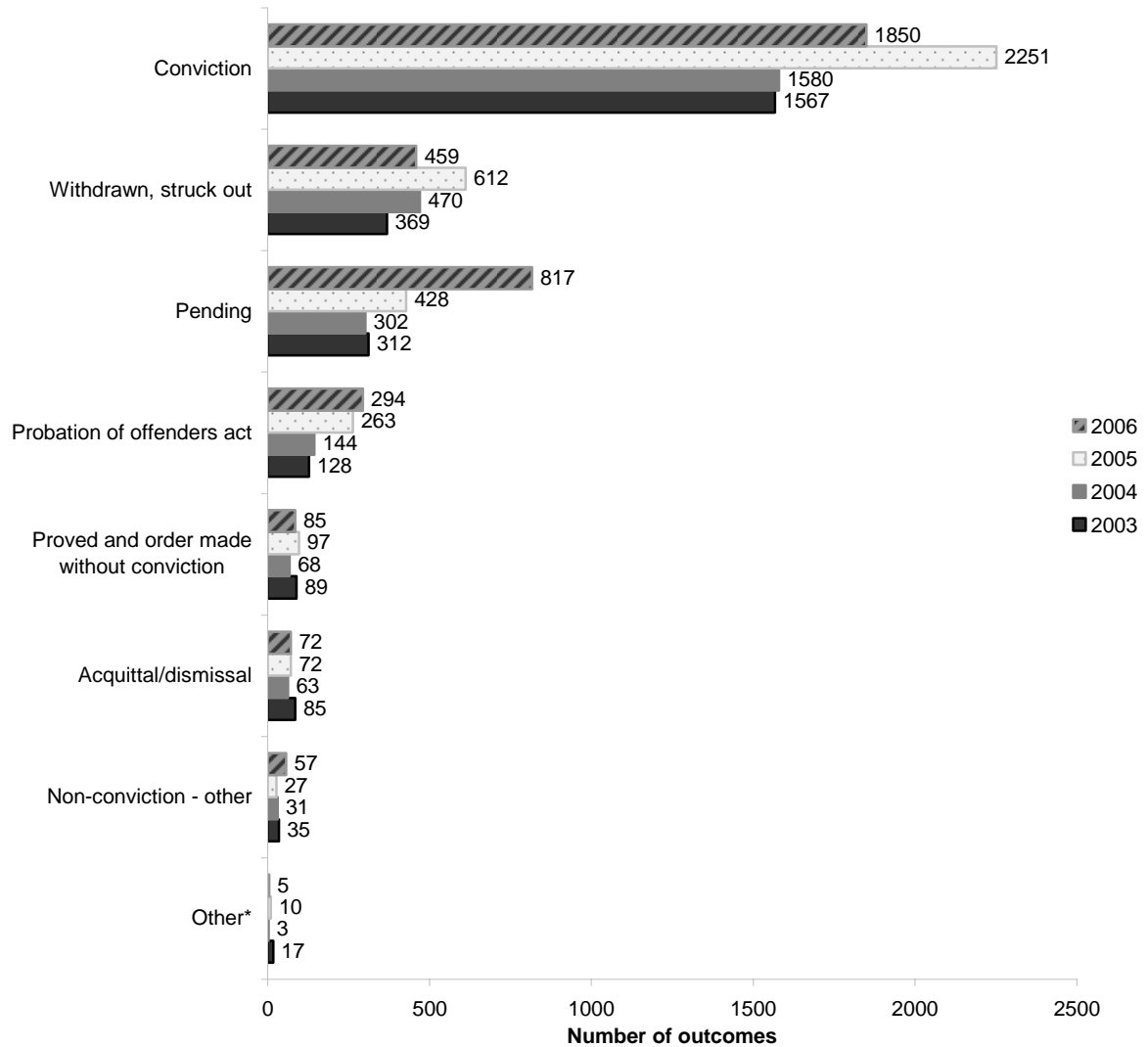
Restorative justice events, such as cautions and conferences, are also reported by region and Garda division.

As can be seen from Figures 11.5.6 and 11.5.7, in general, convictions were by far the most common outcome for possession of drugs for sale or supply and possession for personal use offences between 2003 and 2006. Cases pending increased steadily, however, representing the most common outcome in 2006 for summary drug offences.



**Figure 11.5.6** Outcomes for possession of drugs for sale or supply offences, reported by the CSO, 2003 to 2006

\*Other includes: adjourned sinedie/otherwise disposed of, appeals allowed, and proceed and order made without conviction



**Figure 11.5.7** Outcomes for possession of drugs for personal use offences, reported by the CSO, 2003 to 2006  
 \*Other includes: adjourned sinedie/otherwise disposed of, appeals allowed, and proceed and order made without conviction

Table 11.5.1 presents outcomes for the other main offences prosecuted under the Misuse of Drugs legislation. Convictions resulted from most prosecutions in all crime categories, with a large number of cases pending.

**Table 11.5.1 Outcomes for the remaining drug offences, 2006**

	Importation of drugs	Cultivation or manufacture of drugs	Forged or altered prescriptions	Obstruction under the Drugs Act
Conviction	11	18	24	116
Proved & Order Made Without Conviction	0	1	0	0
Probation of Offenders Act	0	4	2	8
Appeals Allowed	0	0	0	0
Pending	20	10	37	105
Acquittals/Dismissals	0	0	2	13
Withdrawn, Struck Out	0	3	2	26
Appeals Allowed Nolle Prosequi	0	0	0	0
Entered, Charge Withdrawn	0	0	0	0
Non Conviction-Other	0	0	1	6

Source: Central Statistics office.

### Irish Prison Service

The Irish Prison Service (IPS) annual reports present figures on committals for drug offences as one category. These offences are classified by sentence length, age group and gender for the years 2001 to 2006. Since 2003 a profile of prisoners in custody under sentence on a specific day (usually in December) has been included: in 2003, prisoners were classified by offence type, age and gender; in 2004 sentence length was added as a further classificatory category. Cases which are closed and assigned a status 'no further action required' are not reported in the IPS annual reports. Prosecutions started and then suspended owing to the offender voluntarily starting treatment are not reported. There are no outcomes recorded for driving after taking drugs. Table 11.5.2 illustrates drug offences classified by sentence length for all offenders in 2006. This is the last year for which complete data are available.

**Table 11.5.2 Drug offences classified by sentence length, 2006**

	<3 mths	3 to <6 mths	6 mths to <1 year	1 to <2 years	2 to <3 years	3 to <5 years	5 to <10 years	10 years and over	Life	Total
2006	73	64	79	35	35	53	53	3	0	395

Source: (Irish Prison Service 2007)

Of the 395 prison committals reported for 2006, 216 received sentences of less than one year with 3 offenders receiving more than ten years.

## Part C

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## 12.2 List of relevant databases

- Central Treatment List
- General Mortality Register
- Hospital In-Patient Enquiry scheme (HIPE)
- National Drug Treatment Reporting System (NDTRS)
- National Drug-Related Deaths Index (NDRDI)
- National Psychiatric Inpatient Reporting System (NPIRS)
- National Parasuicide Registry Ireland
- Computerised Infectious Disease Reporting System (CIDR)

## 12.3 List of relevant internet addresses

<http://www.citywide.ie>  
<http://www.courts.ie>  
<http://www.cso.ie>  
<http://www.dap.ie>

<http://www.dewf.ie>  
<http://www.dohc.ie>  
<http://www.drugs.ie>  
<http://www.drugsinfo.ie>  
<http://www.drugpolicy.ie>  
<http://www.esri.ie>  
<http://www.healthpromotion.ie>  
<http://www.hpsc.ie>  
<http://www.hrb.ie>  
<http://www.hse.ie>  
<http://www.iprt.ie>  
<http://ireland.com>  
<http://www.irishprisons.ie>  
<http://www.mqi.ie>  
<http://www.nacd.ie>  
<http://www.ndc.hrb.ie>  
<http://www.oireachtas.ie>  
<http://www.oireachtas-debates.gov.ie>  
<http://www.pobail.ie>  
<http://www.taoiseach.ie>

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### 13.4 List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ASBO	Anti-Social Behaviour Order
CBT	Cognitive Behavioural Therapy
CDLE	Customs Drug Law Enforcement
CDVEC	City of Dublin Vocational Educational Committee
CE	Community Employment
CLAN	College Lifestyle and Attitudinal National survey
COFOG	Classification of the Functions of Government
CSO	Central Statistics Office
CTL	Central Treatment List
DAIRU	Drugs and Alcohol Information and Research Unit (DHSSPS, NI)
DAP	Drug Awareness Programme
DAST	Drug Abuse Screening Test
DES	Department of Education and Science
DPAG	Drug Policy Action Group
DTC	Drug Treatment Court
DRCGA	Department of Rural, Community and Gaeltacht Affairs
DUID	Driving Under the Influence of Drugs
ECDL	European Computer Driving Licence
EDDRA	Exchange on Drug Demand Reduction Activities
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ERHA	Eastern Regional Health Authority
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
FESAT	European Foundation of Drug Helplines
FETAC	Further Education and Training Awards Council
FSL	Forensic Science Laboratory

GDL	Graduated Driving License
GMS	General Medical Service
GNDU	Garda National Drugs Unit
GP	General Practitioner
HBSC	Health Behaviour in School-aged Children Survey
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HIPE	Hospital In-Patient Enquiry scheme
HOST	Homeless Offenders Strategy Team
HPSC	Health Protection Surveillance Centre
HRB	Health Research Board
HSE	Health Service Executive
ICCL	Irish Council for Civil Liberties
ICD	International Classification of Diseases
ICGP	Irish College of General Practitioners
IDG	Inter-Departmental Group on Drugs
IHRC	Irish Human Rights Commission
IPRT	Irish Penal Reform Trust
IPS	Irish Prison Service
IPU	Irish Pharmaceutical Union
IYJA	Irish Youth Justice Alliance
JPC	Joint Policing Committee
KCCP	Kilbarrack Coast Community Programme
KPI	Key Performance Indicator
LDTF	Local Drugs Task Force
LIP	Labour Inclusion Project
MAOC-N	Maritime Analysis and Operational Centre – Narcotics
MAU	Medical Assessment Unit
MBRS	Medical Bureau of Road Safety
MDA	Misuse of Drugs Act
MDT	Mandatory Drug Testing
MQI	Merchants Quay Ireland
NACD	National Advisory Committee on Drugs
NAPD	National Association of Principals and Deputy Principals
NAPincl	National Plan for Social Inclusion
NESF	National Economic and Social Forum
NCI	National College of Ireland
NDP	National Development Plan
NDRIC	National Drug Rehabilitation Implementation Committee
NDS	National Drugs Strategy
NDRDI	National Drug-Related Deaths Index
NDST	National Drugs Strategy Team
NDTRS	National Drug Treatment Reporting System
NPIRS	National Psychiatric Inpatient Reporting System
NSP	National Service Plan (of the Health Service Executive)
NYCI	National Youth Council of Ireland
OMC	Office of the Minister for Children
PCCC	Primary, Community and Continuing Care
PCR	Polymerase Chain Reaction
PPR	Participation and Practice of Rights Project
PWS	Probation and Welfare Service
RAPID	Revitalising Areas by Planning, Investment and Development
RCSI	Royal College of Surgeons in Ireland
RCGP	Royal College of General Practitioners
RDTF	Regional Drugs Task Force
RNA	Ribonucleic Acid
ROSIE	Research Outcome Study in Ireland
RSA	Road Safety Authority
SPHE	Social, Personal and Health Education



TD  
WHO  
YPFSF

Teachta Dála (Member of Parliament)  
World Health Organization  
Young People's Facilities and Services Fund