



European Monitoring Centre  
for Drugs and Drug Addiction



**2010 NATIONAL REPORT (2009 Data)  
TO THE EMCDDA  
by the Reitox National Focal Point**

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

**REITOX**

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## Summary of each chapter

This report, written following European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) guidelines,<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 2008 and, in some cases, for the first six months of 2009. These are covered under the following headings:

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

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

11. History, methods and implementation of national treatment guidelines
12. Mortality related to drug use: a comprehensive approach and public health implications

### Main points from Part A

#### 1. Drug policy: legislation, strategies and economic analysis

The main drug policy issue facing the Irish government in the reporting year was the rapid proliferation of 'head shops' selling 'legal highs', i.e. psychoactive substances that were not in breach of the existing law. In 2010 the Irish government took steps to outlaw these substances. In May it implemented a declaration order, declaring approximately 200 legal highs to be controlled drugs under the Misuse of Drugs Acts. In July the Criminal Justice (Psychoactive Substances) Act 2010 was passed, making it a criminal offence to sell or supply substances which might not be specifically controlled under the MDA but which have psychoactive effects. The new legislation was enacted to introduce more general control by way of criminal justice legislation to deal with head shop products as they emerge.

The Steering Group established in late 2009 to develop proposals and make recommendations on a National Substance Misuse Strategy, combining illicit drugs and alcohol in the one strategy, is due to submit its proposals to the Minister for Health and Children and the Minister for Drugs by the end of 2010. The combined Strategy will then be submitted to the government for consideration.

In response to the continuing economic downturn, Ireland's drug-related budget for 2010 is expected to show a decrease of approximately 4.5% on last year, down from €277 million to €264 million.

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

In the reporting year, no new information was published from the last iterations of the main drug prevalence surveys administered in Ireland. A comparison was made of drug use prevalence among young people, according to the data collected in the All Ireland Drug Prevalence, HBSC and ESPAD surveys, and a discrepancy found between the 2006 HBSC and 2007 ESPAD surveys. It is suggested that the marked

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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.

decrease in cannabis use reported in the ESPAD survey of 2007 might represent a genuine fall in the use of cannabis, a change in the profile (age, gender or socio-economic group) of the sample chosen, or in the way the questionnaire was administered.

The results of a study undertaken in 2008, comparing drug use among early school leavers and school attendees, showed that substance use is more common (with the exception of alcohol) among early school leavers.

An exploratory study of the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) people and their 'coping strategies' for dealing with stress reported on the use of alcohol, cigarettes, anti-depressants, prescription and illegal drugs by research participants.

At a conference in January 2010 Dr Des Corrigan, chair of the National Advisory Committee of Drugs, presented an overview of the products available in headshops in Ireland, their ingredients and their effects. Dr Pierce Kavanagh and colleagues (at Trinity College and the Drug Treatment Board) presented their work on identifying the active ingredients and other constituents in 51 products sold in headshops in Dublin.

### **3. Prevention**

A majority of secondary-school students aged 12–16 who responded to a survey on their experience of the Social, Personal and Health Education (SPHE) programme, a school-based universal health promotion programme, reported that alcohol, drug and solvent use was the most emphasised theme in the SPHE syllabus. A majority also reported learning how to make good decisions while participating in SPHE.

The Office of the Minister for Children and Youth Affairs (OMCYA) has published a best-practice guide and an accompanying toolkit for maintaining and developing youth cafés. In addition, the OMYCA recently published the National Quality Standards Framework for youth work, which provides for youth organisations and groups working with young people in Ireland to be subject to external assessment.

A number of recent publications have enhanced understanding of young people deemed to be at-risk of substance misuse and social exclusion. A study by the Irish Youth Justice Service identifies individual, family, educational and neighbourhood risk factors among young people who engage with Garda Youth Diversion Projects. A recently-published study of early school-leavers reports that patterns of early school-leaving in Ireland are strongly differentiated by gender and social class, with males from working-class and/or unemployed households being the most likely to leave school early. The report of the Commission to Inquire into Child Abuse, published in May 2009, acknowledges the association between state care and future poor outcomes for children who have been in state care, including addiction and homelessness.

### **4. Problem drug use (PDU)**

A repeat of a prevalence study in 2001, using a three-source capture-recapture method, has estimated that in 2006 there were 11,807 opiate users aged 15–64 years known to services in Ireland, and an estimated 8,983 users not known to the services. The national point estimate increased by 42%, from 14,681 in 2001 to 20,790 in 2006. The 2006 estimate is an over estimate for a number of reasons.

According to the annual report of the National Registry of Deliberate Self-Harm, presentations of deliberate self-harm to hospital emergency departments in 2009 increased by 5% over the 2008 figure.

A study of the usage of Mephedrone, Methylone and BZP among attendees at methadone maintenance programmes at the Drug Treatment Centre Board showed significant use of the compounds. A separate study of the extent, and the experience, of 'bath salts' use among problem drug users living in a hostel for homeless people in



Dublin city centre, revealed that 12 out of 17 respondents had tried bath salts on at least one occasion, and some had tried more than one product.

Information on drug testing in prisons in 2009 indicated that, excluding methadone, between one-tenth and two-fifths of those screened, tested positive for at least one drug; the common metabolites detected indicated use of cannabis, benzodiazepines and opiates.

A study of current or former heroin users attending general practice for methadone treatment estimated that 35% were problem alcohol users, and that 14% were dependent users.

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

During 2010 the Health Service Executive (HSE) prioritised integrating the recommendations of the national drugs and homeless strategies and set up a national framework for rehabilitation within the addiction services.

Two nurses working in the Drug Treatment Centre Board graduated in late 2009 as the first nurse prescribers in addiction in Ireland. A study of nursing services in Irish prisons found that nursing care for substance misuse was one of the most frequently performed clinical tasks and there was a need for specialist training.

Detoxification was the subject of three separate studies: examining the factors associated with early relapse following opiate detoxification; determining the outcomes and the factors influencing outcomes among a cohort of opiate users starting detoxification; and evaluating a community detoxification pilot project.

Trends in drug-related treatment for 2008, the most recent year for which data are available, showed that the incidence of treated problem drug use among 15–64-year-olds living in Ireland, per 100,000 of the population, increased from 79.6 in 2007 to 85.8 in 2008, and prevalence increased by 5%, from 444 in 2007 to 466 in 2008. An opiate (mainly heroin) was the most common main problem drug reported by cases entering treatment, and alcohol was reported as an additional problem substance in 41.4% of all treated cases.

## **6. Health correlates and consequences**

In 2009, 27% of reported HIV cases in Ireland were probably infected through injecting drug use. A rolling centred three-year average for the number of new HIV cases infected through injecting drug use each year indicates that since 2006 there has been a declining trend.

Between 2008 and 2009, reported cases of hepatitis B decreased by 12%. Among the cases in 2009 for which risk factor data were reported, 2.8% reported injecting drug use as the main risk factor. The number of such cases remained consistently low between 2006 and 2009, indicating the effectiveness of routine administration of the hepatitis B vaccine.

Reported cases of hepatitis C dropped between 2008 and 2009 by 18%. Among the cases for which risk factors were reported in 2009, 70.9% reported injecting drug use as the main risk factor.

Among all reported cases of overdose in 2008, non-opioid analgesics, including paracetamol, were present in 34.8% of cases; psychotropic agents in 21.5% and benzodiazepines in 20.8% of cases; and narcotic or hallucinogenic drugs in 12.6% of cases. There was evidence of alcohol consumption in 14.0% of cases.

In 2008, the rate of drug-related first admissions per 100,000 of the population to Irish psychiatric facilities increased marginally, from 6.3 in 2007 to 6.8. Of the 791

discharges with a drug disorder in 2008, 51% had spent less than one week in hospital and just under 15% spent more than one month in hospital.

The first combined annual report of Ireland's six sexual assault treatment units (SATUs), for 2009, reported that half (51%) of all patients who attended had consumed at least four units of alcohol in the 12 hours prior to the incident reported, 8% had taken illegal drugs and 3% were concerned that drugs had been used to facilitate sexual assault.

Three reports on research into health-related consequences of drug use, either conducted in Ireland or with an Irish component, have been published recently, including studies of learning and memory defects in ecstasy users; the prevalence and influence of substance misuse (drug/alcohol dependence of abuse) on age at onset of psychosis and psychopathology among patients with first-episode psychosis; and acute reverse reactions to cocaine use, leading to admission to emergency departments.

## **7. Responses to health correlates and consequences**

While people who have overdosed on drugs and been admitted to an intensive care unit (ICU) mostly survive hospitalisation, a 3-year evaluation of the functional outcomes and recovery patterns of 43 such patients found that of the 24 patients surviving after 31 months, 16% were in custody and 54% unemployed.

In response to the proliferation of 'legal high' drugs available in head shops, various Dublin-based community-based organisations published information leaflets, a web page and a booklet with advice and guidelines on how to minimise harm.

The plan to roll-out of needle exchange-services through community pharmacies in 65 new locations across Ireland continued during the reporting year, with the HSE and the Irish Pharmacy Union recruiting a national liaison pharmacist to support pharmacists participating in the scheme outside Dublin.

In June 2010, the independent group set up by the government to monitor implementation of *A vision for change*, Ireland's national mental health policy, reported that in 2009 there had been no further progress at national level in developing mental health services for persons with co-morbid severe mental illness and substance abuse problems.

A review of progress in implementing the recommendations of a 2006 report on how to reduce the high level of suicide in Irish society found that progress had been patchy, and the few recommendations that had been implemented now needed financial resources and political support to be effective.

## **8. Social correlates and social reintegration**

Early school-leaving and homelessness among individuals reporting for drug treatment showed a modest increase between 2004 and 2008. According to a recent report, most children aged 12–17 who were subject to an application for special care in 2007 had problems with alcohol and/or substance misuse. New research comparing self-reported substance use among a cohort of early-school leavers and school-attending students aged 15–18 in Ireland has concluded that relations between young people, their family and educational institutions can have a major impact on a young person's decision with regard to substance use.

The National Drugs Rehabilitation Implementation Committee (NDRIC) has published a National Drugs Rehabilitation Framework to enhance the provision of rehabilitation services to current and former drug users by creating integrated care pathways (ICPs).

A census of homeless adults living in temporary accommodation found that drug addiction had more than doubled and superseded alcohol as the main addiction among

the homeless population. The Homeless Agency has published a case management guidebook to assist those working in the area of homelessness and drugs.

A review of a community-based Education Bursary Fund that targets recovering drug users among other groups reports that the fund is perceived as useful to getting some recovering drug users into further education. FÁS, the national training agency, has developed a set of nine revised conditions to improve the operation and accessibility of vocational training for recovering drug users.

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

The link between the illicit drug market and an increase in gun crime in Ireland was the subject of an article in the *British Journal of Criminology*. The author concluded that policy responses to gun crime needed to consider the link between masculinity, poverty, the drug market and gun crime.

The Drug Treatment Court which operates on a multi-agency basis as an alternative to imprisonment is to be continued for a further eighteen months. A review of the Court recommends the establishment of an Advisory Committee to oversee the project. This will consider the entry requirements to the programme, expectations of participants and measures of success and how the numbers of participants in the programme can be increased quickly.

Pat Carey TD, Minister for Community, Equality and Gaeltacht Affairs (with responsibility for the National Drugs Strategy) announced his intention to extend the Dial to Stop Drug Dealing Campaign across local and regional drugs task forces.

The National Advisory Committee on Drugs (NACD) is currently in the process of commissioning a study to estimate the prevalence of drug use, including intravenous drug use, among the prisoner population in Ireland. A recently published paper based on data from the National Drug-Related Deaths Index (NDRDI) for the years 1998–2005 examined the relationship between date of release from prison and drug-related death. This was the first study of its kind in Ireland. Between 1998 and 2005, 2,442 drug-related deaths were recorded on the NDRDI. One hundred and thirty of the individuals who died had a documented history of imprisonment..

### **10. Drug markets**

Customs Drug Law Enforcement (CDLE) reports an increase in the detections of herbal cannabis sent through the post in 2009. Also, the trend in domestic cultivation of cannabis appears to be continuing; over the past 18 months there has been a noticeable increase in detections of sapling cannabis plants and seeds. CDLE also states that the economic downturn and scarcity of criminal funding has resulted in Organised Crime Groups resorting more frequently to the 'little but often' technique', i.e. using drug couriers to transport small quantities of drugs frequently.

In 2009 there was a further decrease in the total number of drugs seized, which can be partly explained by the significant decrease in cannabis-type substances seized, down by just over 59%. Cocaine seizures also fell during 2009. Seizures of cocaine, heroin and ecstasy-type substances have also significantly declined since 2007.

## **Main points from Part B**

### **11. History, methods and implementation of national treatment guidelines**

The first move to standardise treatment for drug dependence in Ireland coincided with the public health scare in the mid 1980s regarding the spread of HIV/AIDS, and the recognition that risky practices associated with injecting drug use were contributing to the spread of HIV infections. Guidelines for the prescription of methadone were first issued in 1987.

The current methadone treatment protocol (MTP), adopted in 1998, covers the statutory and regulatory issues around methadone prescribing and dispensing and does not deal with any clinical or treatment guidelines *per se* (buprenorphine is not currently available in Ireland). Guidelines specifically for general practitioners and for pharmacists managing opiate users in the primary care setting have been drawn up. Guidelines have also been developed for drug treatment in prison settings, and for clinicians prescribing benzodiazepines. The MTP was reviewed in 2002, and a further review was initiated in mid 2010.

A study in 2005 of drug users' experiences of the Irish health services revealed many problems, including negative or discriminatory attitudes and treatment by health care staff. This finding led to steps to ensure that, in future, the opinions of drug users would be sought and taken into account when planning and delivering services, including the MTP. A study of Irish GPs' attitudes to the MTP in 2006 found that the vast majority thought it beneficial to patients.

## **12. Mortality related to drug use: a comprehensive approach and public health implications**

Between 1998 and 2007 there were 3,465 drug-related deaths and deaths among drug users in Ireland. Of these deaths, 2,120 were due to poisoning and 1,345 were due to traumatic or medical causes (non-poisoning). Over the reporting period, the annual number of deaths by poisoning increased from 178 in 1998 to 274 in 2007. A study of positive toxicology reports of drug users who died owing to trauma between 1998 and 2005 showed that in many cases, more than one substance was present. The same study also looked at the history of drug use among those who died from medical causes between 1998 and 2005. This showed that the majority of drug users who died of medical causes had a history of opiate use, probably reflecting the long-term effects of problem drug use on a person.

For each death recorded by the NDRDI, any history of a blood-borne virus, including HIV, is documented if such data are recorded. However, this information is not always available. In total, between 1998 and 2007 there were 84 deaths where the individuals were HIV positive and 19 deaths where AIDS/HIV was in some way implicated in the death. The HPSC reported 84 AIDS deaths during the same period. Small numbers over the 10-year period make it difficult to discern trends.

Data from the NDRDI illustrate the total burden of mortality related to drug use in Ireland. The upward trend in deaths both by poisoning and by non-poisoning has both immediate and longer term implications and requires appropriate public health strategies.

## Part A: New Developments and Trends

### 1. Drug policy: legislation, strategies and economic analysis

#### 1.1 Introduction

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

The **National Drugs Strategy (interim) 2009–2016** provides the implementation framework for illicit drugs policy in Ireland (Department of Community Rural and Gaeltacht Affairs 2009). The Strategy has an overall strategic objective, 'To continue to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research'. Implementation is based on a 'partnership' approach, whereby over 20 statutory agencies, multiple service providers and community and voluntary groups work together in a nationwide network of regional and local drugs task forces (DTFs) to deliver the Strategy, with the statutory agencies critical in terms of core service provision. Two central entities provide national oversight: (1) the Office of the Minister for Drugs (OMD), and (2) the Oversight Forum on Drugs (OFD), comprising senior representatives of the various statutory agencies involved in delivering on the Strategy, and representatives from the community and voluntary sectors.

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

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

Other public funding mechanisms include the Dormant Accounts Fund and the national lottery. The statutorily-based Dormant Accounts Fund contains unclaimed monies transferred by credit institutions and insurance undertakings. The Dormant Accounts legislation provides that these funds may be allocated to projects and programmes designed to alleviate poverty and social deprivation.

## 1.2 Legal framework

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

This update covers drug-related Acts and Bills of the Oireachtas introduced or progressed during the reporting year. It also identifies new substances brought under control within the terms of the Misuse of Drugs legislation. Subject to the obligations of European Union membership as provided in the Constitution of Ireland, the sole and exclusive power of making laws for the State is vested in the Oireachtas (Parliament). The Oireachtas consists of the President and two Houses, Dáil Éireann (House of Representatives) and Seanad Éireann (Senate). Bills are proposals for new laws. They are usually approved by a Minister or another member of the Government. Occasionally, a Private Member's Bill is proposed by a member of the Opposition. Such Bills, because they have not originated in Government, are less likely than Government-sponsored Bills to become Law. To become law a Bill must first be approved by both the Dáil and the Seanad, although the Dáil can override a Seanad refusal to pass a Bill. Joint Committees are groups of members of Parliament, including both government members and members of the opposition, which discuss proposed legislation and make recommendations for amendments to the Minister. Once the Bill has been passed by the Oireachtas, the Taoiseach (Prime Minister) presents it to the President to sign into law, and then it becomes an Act. Acts do not come into operation until a Commencement Order is issued in the form of a Statutory Instrument. Notice of the making of the Commencement Order is published in the Oireachtas newsletter *Iris Oifigiúil*.

#### New psychoactive substances brought under control

The NDS, launched in September 2009, flagged as an emerging issue, the sale in Ireland of psychoactive substances that were not in breach of the existing law, commonly referred to as 'legal highs'; these substances were generally being sold in 'headshops'. Two actions in the NDS called for ongoing monitoring of the legislative framework.<sup>2</sup> Subsequently, as headshops continued to spring up across the country at a rapid rate, the government gave priority to implementing these two actions. The legislative and regulatory measures that have been introduced are described here, along with the wider policy debate that has taken place. (The full suite of interventions adopted to date by the government, spanning the Supply Reduction, Prevention and Research pillars of the NDS, are summarised in Section 1.3.2 below.)

In January 2010 John Curran TD, then Minister of State with responsibility for the National Drugs Strategy, opened a national conference on 'legal highs' organised by the regional drugs task forces (Long, Jean 2010). Minister Curran said that he had asked the Minister for Health and Children, who has responsibility in relation to the importation, exportation, production, supply and possession of a range of named narcotic drugs and psychotropic substances under the Misuse of Drugs Acts, 'to ensure that every effort is made to expedite the response to this issue through the early control of substances under that Act'. He had also asked the then Department of Enterprise, Trade and Employment to examine issues relating to insurance and consumer protection.

At its meeting on 2 March 2010, the government agreed to a proposal from the Minister for Health and Children, Mary Harney TD, to make a Declaration Order under the Misuse of Drugs Act 1977 declaring a range of so-called 'legal highs' to be controlled drugs. Following this government decision, a draft Declaration Order and associated draft Statutory Instruments were drawn up and on 1 April 2010 these were notified to

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<sup>2</sup> Action 14: Monitor the activities of head shops, and all businesses involved in the sale of psychoactive substances, with the objective of ensuring that no illegal activity is undertaken. Ensure that steps are taken to reform legislation in this respect where it is deemed to be appropriate. Action 15: Keep drugs-related legislation under continuous review, with particular focus of new synthetic substances, new or changed uses of psychoactive substances, and against the background of EU and broader international experience and best practice.

the European Commission in accordance with the Technical Standards Directives 98/34/EC and 98/48/EC, which require member states to notify draft technical regulations that may impact on trade. This process involves a three-month stand-still period. However, in light of growing concerns about the health risks associated with the use of legal highs, application was subsequently made to the Commission to use an urgency procedure and forego the three-month stand-still. The Commission advised on 10 May 2010 that the legislation could be implemented without awaiting the expiry of the three-month period.

At its meeting on 11 May 2010 the government made the Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order 2010 (S.I. 199 of 2010), declaring a range of legal highs to be controlled drugs. To give effect to this decision, on the same day the Minister for Health and Children also signed the Misuse of Drugs (Amendment) Regulations 2010 (S.I. 200 of 2010), the Misuse of Drugs (Designation) (Amendment) Order 2010 (S.I. 201 of 2010), and the Misuse of Drugs (Exemption) (Amendment) Order 2010 (S.I. 202 of 2010).

Under these statutory instruments, approximately 200 individual 'legal high' substances, which had been on sale in headshops and which included the vast majority of products of public health concern, were declared to be controlled drugs. They include broadly:

- synthetic cannabinoids (contained in SPICE products),
- benzylpiperazine (BZP) and piperazine derivatives (commonly known as 'party pills'),
- mephedrone, methyldrone, methedrone, butylone, flephedrone, MDPV (i.e. cathinones, often sold as bath salts or plant food), and
- Gamma butyrolactone (GBL) and 1,4 Butanediol.

In addition, the Declaration Order made under the Misuse of Drugs Act 1977 includes ketamine and tapentadol, substances that have legitimate uses as medicines but which can be subject to misuse. The Declaration Order also covers certain narcotic and psychotropic substances which Ireland is obliged to bring under control in order to comply with the UN Single Convention on Narcotic Drugs and the UN Convention on Psychotropic Substances. It is anticipated that, towards the end of 2010, further amendments to existing Acts will regulate other head shop products.

The process of introducing controls under the Misuse of Drugs Act is complex, particularly for substances which have legitimate uses but also have the potential to be misused. Some of the substances which have been controlled have legitimate uses in the pharmaceutical and chemicals industries, e.g. two of the BZP derivatives are used to manufacture authorised medicines, and GBL and 1,4 BD are widely used in the manufacture of plastics, as industrial solvents, as well as in many consumer products such as paints, toiletries, cleaning products, food products and others. Consequently it was necessary to engage with other government departments and organisations to ensure that appropriate and proportionate controls were introduced.

On 18 June 2010 the Minister for Justice and Law Reform, Dermot Ahern TD, published the Criminal Justice (Psychoactive Substances) Bill 2010. The intention of the Bill was to make it a criminal offence to sell or supply substances which might not be specifically controlled under the Misuse of Drugs Acts but which had psychoactive effects. Introduced in the upper house of the Oireachtas, Seanad Éireann, on 23 June 2010, just three weeks later the Criminal Justice (Psychoactive Substances) Act 2010 was signed into law on 14 July 2010. Notwithstanding the regulations introduced on 11 May, described above, the government recognised that new psychoactive substances could emerge quickly and there would always be a time lag before such substances could be made subject to control under the Misuse of Drugs Acts. This legislation was enacted to introduce more general control by way of criminal justice legislation to deal with head shop products as they emerged. The Act also gives appropriate powers to the Gardaí and to the courts to intervene quickly, by way of prohibition notices and

prohibition orders, to prevent the sale of psychoactive substances. The Act includes the following provisions:

- Section 3 provides for the offences of selling, importing and exporting psychoactive substances for human consumption. Section 3 (1) provides for the offence of selling a psychoactive substance, knowing or being reckless as to whether it is being acquired or supplied for human consumption.
- Section 4 creates the offence of selling an object, knowing that it will be used to cultivate by hydroponic means any plant. Hydroponic cultivation is the cultivation of plants in liquid containing nutrients, without soil, and under controlled conditions of light, temperature and humidity. This method of cultivation is known to be used for the purpose of growing cannabis indoors.
- Section 5 provides for the offence of advertising a psychoactive substance or object to which Section 4 applies.
- Section 7 provides that a Garda Superintendent (or higher) may serve a prohibition notice on a person where he or she believes that the person is selling, importing or exporting psychoactive substances for human consumption, selling objects for use in cultivating by hydroponic means any plant.
- Section 20 provides that a person guilty of an offence under the Act is liable on summary conviction to a fine of up to €5,000 or imprisonment for up to 12 months or both, or on conviction on indictment to a fine or to imprisonment not exceeding 5 years or both.

Having responded in line with Actions 14 and 15 of the NDS, the Irish government has also acknowledged that the issue is a complex and evolving one that needs to be dealt with on a number of fronts. The government continues to examine best practice and developments internationally, and has invited members of both Houses of Parliament and relevant committees to contribute ideas on how to tackle it. The on-going debate on the merits of outright banning versus strict regulation is summarised here.

Acknowledging the difficulties of introducing an effective ban on psychoactive substances, opposition parties have proposed measures, including new legislation, to license and regulate the market in 'legal highs'. These have included:

- a requirement for head shops to have an operating licence (Reilly 2010, 17 February),
- an amendment to Ireland's planning and development legislation to ensure head shops are required to obtain planning permission (Costello 2010, 25 February),
- the establishment of a new statutory authority to regulate, register and license the sale, importation, distribution and production of non-medicinal psychoactive substances (Ó Snodaigh 2010, 28 April), and
- a requirement for all substances sold in head shops to be passed by the Food Safety Authority and the Irish Medicines Board (Reilly 2010, 1 June).

To date, the government has preferred to focus on outlawing the substances in preference to controlling their production, distribution, sale and use. On 2 July 2010, former Minister of State with responsibility for the National Drugs Strategy, John Curran TD, stated: 'People indicated or suggested we should have planning laws relating to head shops. I have never supported this or licensing for head shops because my view is that it is the products they sell that are the problem. Therefore, we should not have the shops at all. ... People have suggested that by closing head shops and closing off home delivery services and Internet sales, we reduce the problem but do not remove it, because the substances being sold will eventually be sold as illegal drugs and that this would not be much different from what we deal with in terms of ecstasy, cocaine or heroin currently. However, I believe closing them is hugely significant, because when head shops emerged, a number of people experimented with head shop products who never would have dealt with or used illegal drugs. ... However, just because something is not illegal does not mean any quality control or standards are applied. It is because people felt a sense of security and safety in experimenting with some of these products that for some time I have been of the opinion that licensing, regulation or planning around head shops was not sufficient. My view is that the products being sold are



absolutely dangerous and that our target should be to close them down. That is the direction we are going.’ (Curran 2010, 2 July) pp. 672–673.

In the interests of maintaining a balanced response, one contributor called for the full range of possible responses to be considered, not just legislative and regulatory measures: ‘When we debate legislation aimed at a particular mischief and introducing prohibition orders, we are focusing on criminal law approaches but we must take a holistic and cross-departmental approach when addressing the broader picture of drug use and addiction. The then Minister of State accepted the need to be rational in considering the issue of drugs. We must also devise credible measures to reduce the harm associated with drug abuse and, in particular, to reduce the number of tragic deaths resulting from abuse.’ (Bacik 2010, 23 June): p. 542.

### Other Acts passed

- The Housing (Miscellaneous Provisions) Act 2009 obliges local housing authorities to adopt a strategy to prevent and reduce anti-social behaviour in their housing stock, with the additional objectives of the co-ordination of services and the promotion of co-operation with other agencies to that end. The Act also broadens the definition of anti-social behaviour in the Housing (Miscellaneous Provisions) Act 1997 to include significant or persistent impairment of a person’s use or enjoyment of their home, and damage to or defacement of any property.
- The Health (Miscellaneous Provisions) Act 2009 makes arrangements for progressing the integration of health service agencies in line with government policy on the rationalisation of public sector agencies. Part 5 of the Act provides for the dissolution of the Drug Treatment Centre Board and the transfer of its rights, liabilities, land and any other assets to the Health Service Executive.
- The Criminal Justice (Money Laundering and Terrorist Financing) Act 2010 provides for offences of, and related to, money laundering in and outside the State; to give effect to Directive 2005/60/EC of the European Parliament and of the Council of 26 October 2005 on the prevention of the use of the financial system for the purpose of money laundering and terrorist financing.
- The Criminal Procedure Act 2010 makes provisions for a modification of the rule against double jeopardy in order to allow a person who has been acquitted of an offence to be re-tried in circumstances where new and compelling evidence emerges or where the acquittal is tainted due, for example, to corruption or intimidation of witnesses or jurors or perjury. The rule against double jeopardy provides that no person may be put at risk of being punished twice for the same offence. The legislation applies to a number of drug-related offences.
- The Road Traffic Act 2010 provides for a reduction in the blood alcohol content (BAC) limit for drivers and also provides powers to assist the Garda Síochána in forming an opinion as to whether a driver is under the influence of an intoxicant (drug or drugs) and to carry out a preliminary impairment test on such drivers.

### Legislative Bills

**Table 1.2.1 Bills progressing through the Oireachtas**

Title and Explanatory Memorandum	Parliamentary Stage as at July 2010
The <b>Spent Convictions Bill 2007 (No 48 of 2007)</b> is intended to apply where a prison sentence not exceeding six months or a fine or penalty have been imposed, and then only after a certain number of years have elapsed without a further conviction. The purpose of the Bill is to help rehabilitate convicted persons through facilitating their reintegration into the workforce and allowing them to build new careers.	Private Member’s Bill. Barry Andrews, Fianna Fáil. Referred to Select Committee on Justice, Equality and Women’s Rights, 18 December 2008
The <b>Communications (Retention of Data) Bill 2009 (No 52 of 2009)</b> requires service providers, those engaged in the provision of a publicly electronic communication service or a public communication network by means of fixed line or mobiles or the internet to retain data relating to fixed and mobile telephony, for 1 year, and data relating to internet access, internet email and internet telephony for 2 years, and provides for disclosure in relation to the investigation of specified offences	Seanad Éireann. Second reading, 29 April 2010

Title and Explanatory Memorandum	Parliamentary Stage as at July 2010
including Customs offences.	
<p><b>The Criminal Justice (Forensic Evidence and DNA Database System) Bill 2010 (No 2 of 2010)</b>, among other things, replaces the existing statutory and common law arrangements governing the taking of samples for forensic testing from suspects for use as evidence in criminal investigations and proceedings with an updated statute-only regime, provides for the establishment of a DNA database system for use by the Garda Síochána as an intelligence source for criminal investigations, provides for the taking of samples for the purposes of the DNA Database System and other matters relating to the System, and implements the DNA-related elements of the Council Decision 2008/615/JHA of 23 June 2008 on the stepping up of cross-border cooperation, particularly in combating terrorism and cross-border crime.</p>	<p>Referred to Select Committee on Justice, Equality, Defence and Women's Rights, 4 March 2010</p>
<p><b>The Criminal Justice (Public Order) Bill 2010 (No 7 of 2010)</b> prohibits harassment or intimidation of members of the public by persons who engage in begging and confers powers on members of the Garda Síochána to give directions to persons to desist from begging, in certain circumstances such as where they are begging near cash machines or in front of places of business. It also provides for a series of sanctions including fines and possible imprisonment for breaches of the law.</p>	<p>Referred to Select Committee on Justice, Equality, Defence and Women's Rights, 10 June 2010</p>
<p><b>The Planning and Development (Amendment) Bill 2010 (No 10 of 2010)</b> provides that a change of use of a structure to use as a Head Shop or a Sex Shop shall not be exempted development, so as to ensure that such premises would have to obtain planning permission under the relevant Planning legislation</p>	<p>Private Member's Bill. Deputies Joe Costello and Jan O'Sullivan, Labour Party. First stage, 25 February 2010</p>
<p><b>The Non-Medicinal Psychoactive Substances Bill 2010 (No 18 of 2010)</b> establishes a new body known as An tÚdarás Rialála um Shubstaintí Neamhleigheasacha Sícihniomhacha (Non-Medicinal Psychoactive Substances Regulatory Authority). This Authority will regulate the sale, production, import, distribution and marketing of non-medicinal psychoactive substances and products that can have an effect on perception, health and wellbeing when consumed or otherwise used by persons.</p>	<p>Private Member's Bill. Deputy Aengus Ó Snodaigh, Sinn Féin. First stage, 28 April 2010</p>
<p><b>The Proceeds of Crime (Amendment) Bill 2010 (No 30 of 2010)</b> amends the Proceeds of Crime Act 1996. The purpose of the Bill is to reduce from 7 years to 2 years the waiting period before the Criminal Assets Bureau can apply to the High Court for the disposal and forfeiture of assets frozen under section 3 of the Proceeds of Crime Act 1996.</p>	<p>Private Member's Bill. Deputy Pat Rabbitte, Labour Party. First stage, 3 June 2010</p>

## Other regulations

In September 2009 the European Communities (Road Haulage and Road Passenger Transport Operator's Licences) Regulations 2009 (SI No 318 of 2009) came into effect. Under the regulations, where a person is convicted of a drug trafficking offence then for a period of between 2 and 5 years depending on the seriousness of the offence the person is disqualified from holding an operator's licence.

### 1.2.2 Laws implementation

#### Compulsory Random Drug Testing (CRDT) in Defence Forces

In October 2002 a Compulsory Random Drug Testing (CRDT) programme aimed at deterrence was introduced in the Irish Defence Forces. In November 2009, the then Minister for Defence, Willie O'Dea TD, reported that, to date, 10,178 tests had been conducted with 41 tests yielding a positive result (4.0%), and that a total of 25 members of the Defence Forces had been discharged as a result of a positive test result (O'Dea 2009, 19 November).

#### New regulations with regard to psychoactive substances sold in 'headshops'

On 1 June 2010 the chief pharmacist at the Department of Health and Children reported to the Joint Oireachtas Committee on Health and Children (Kinsella 2010, 1

June) that, the day after the banning of the 200 substances, referred to in Section 1.2.1 above, the Garda Síochána visited all 102 head shops then in existence throughout Ireland. They requested that the proprietors of the shops voluntarily provide their merchandise to the garda who was visiting. The chief pharmacist also reported that 36 head shops were still in operation on 1 June 2010 (Department of Health and Children 2010, 1 June). Following the introduction of the Criminal Justice (Psychoactive Substances) Act 2010, the gardaí visited head shops in early September, and found only 19 were open and none were selling psychoactive substances (Garda Síochána, personal communication 2010).

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

#### **1.3.1 National action plan and/or strategy**

The content of the National Drugs Strategy (interim) 2009–2010 (NDS) (Department of Community Rural and Gaeltacht Affairs 2009) was outlined in last year's national report (Alcohol and Drug Research Unit 2009): Section 1.3.1. In November 2009, in line with Action 1 of the NDS, a Steering Group, comprising representatives of the statutory, community, voluntary and industry sectors, was established to develop proposals and make recommendations on a National Substance Misuse Strategy that will incorporate the interim strategy. Its approach was described by the then Minister of State with responsibility for the Drugs Strategy, John Curran TD:

‘... the Steering Group will review existing policies and reports, including at EU and international level, and will set out an evidence-based framework through which to address the issues identified. While the Group will also be looking at what are the appropriate structures and frameworks for the effective and efficient implementation of the combined Strategy, the possible level of involvement of Local and Regional Drugs Task Forces in this regard has yet to be considered.

The Steering Group is due to submit its proposals to the Minister for Health and Children and myself by the end of October 2010. The combined Strategy will then be submitted to Government for consideration.

Finally, it should be noted that my Department has received 60 submissions from a range of organisations and individuals following the placing of an advertisement in the national newspapers in December last. The submissions are currently being reviewed and the issues arising will be considered by the Steering Group as part of its ongoing deliberations.’ (Curran 2010, 18 February): p. 855.

At the time of compiling this National Report, the date for submitting the proposals to the two ministers had been put back to the end of 2010.

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

In its renewed programme for government, agreed in October 2009, under the heading of ‘Community and Social Economy’, the government pledged to implement the new NDS, launched in September 2009, and under the heading of ‘Justice and Crime’, it pledged to maintain its focus on tackling gang criminality and to continue to target Garda actions within communities experiencing significant anti-social behaviour and drug crime (Fianna Fáil and the Green Party 2009): p. 20.

In June 2010 the Minister with responsibility for the NDS, Pat Carey TD, gave a brief report on overall progress in implementing the NDS:

‘Solid progress is being made on the implementation of the various Actions of the Strategy. ... An Garda Síochána and Revenue’s Customs Service continue to prioritise the targeting of those involved in the supply of drugs and I congratulate them on their recent successes in this area, both nationally and abroad.

Significant progress continues to be made in regard to treatment and rehabilitation services for recovering drug users. New opiate substitution facilities, greater opportunities for detoxification and the roll-out of a comprehensive needle exchange programme across the country are among the improvements that are coming on stream. Progress is also being made towards providing comprehensive rehabilitation services. In that regard, my officials have recently agreed on a way forward in regard to residential rehabilitation services with the HSE and the voluntary sector. It is envisaged that significant improvements can be achieved through interagency co-operation and comprehensive care planning for the individual clients.’ (Carey, Pat 2010, 9 June): p. 964–965.

Two particular developments relevant to implementation are described below – (1) the emergence of ‘head shops’, and (2) the reconfiguration of ministerial portfolios, including responsibility for the NDS, in March 2010.

### **Responding to the emergence of ‘head shops’**

The emergence of ‘head shops’, which sell legal psychoactive substances, was recognised and addressed by two actions in the NDS published in September 2009.<sup>3</sup> As head shops continued to spring up across the country at a rapid rate, the government used the institutional mechanisms provided for in the NDS to explore the options for responding. The suite of interventions adopted by the government to date span the Supply Reduction, Prevention and Research Pillars of the NDS, and are a result of cross-departmental and cross-agency co-operation.

- A two-pronged legislative approach has been adopted, including (1) regulations under the Misuse of Drugs Acts 1977 and 1984 to control approximately 200 specific substances (see Section 1.2.1 above), and (2) a new law making the sale or supply for human consumption of substances not specifically proscribed under the Misuse of Drugs Acts, but which have psychoactive effects, a criminal offence (see Section 1.2.1 above).
- As part of the interdepartmental/agency response to the issue, relevant government departments and agencies continue to review existing legislative provisions to establish whether head shops are in compliance with the existing legislative provisions.
- An Garda Síochána and Revenue’s Customs Service closely monitor the activities of head shops, with a view to ensuring that no illegal substances are sold.
- The HSE, in association with partner agencies under the national drugs strategy, has launched a national drugs awareness campaign focusing on the dangers of psychoactive substances available through head shops and the internet. See Chapter 3.2.
- The NACD commissioned research to look at (1) the risk factors associated with the consumption of products sold in head shops, and (2) measures taken in other jurisdictions to restrict psychoactive substances. At the time of going to press, this study had not been completed.

### **Reconfiguring ministerial portfolios**

A reorganisation of government departments and state agencies in March 2010 resulted in a reallocation of responsibilities, which may impact on the implementation of the NDS.

The Office of the Minister for Drugs (OMD) is now located in the new Department of Community, Equality and Gaeltacht Affairs (DCEGA), and the new Minister for Community, Equality and Gaeltacht Affairs, Pat Carey TD, has responsibility for the

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<sup>3</sup> Action 14: Monitor the activities of head shops, and all businesses involved in the sale of psychoactive substances, with the objective of ensuring that no illegal activity is undertaken. Ensure that steps are taken to reform legislation in this respect where it is deemed to be appropriate. Action 15: Keep drugs-related legislation under continuous review, with particular focus of new synthetic substances, new or changed uses of psychoactive substances, and against the background of EU and broader international experience and best practice.

NDS and the OMD. Responsibility previously sat with a Minister of State, who was outside the Cabinet.

Explaining the reconfiguration, the Taoiseach (Prime Minister) outlined how the new DCEGA would be better equipped to tackle the issues associated with social inclusion in a more integrated and coherent fashion:

‘... the Department of Community, Rural and Gaeltacht Affairs will become the Department of Community, Equality and Gaeltacht Affairs and will incorporate responsibility for social inclusion policy and family policy from the Department of Social and Family Affairs and for equality, disability, integration and human rights from the Department of Justice, Equality and Law Reform’ (Cowen 2010, 23 March): p. 9.

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

In the last two years the government has been engaged in researching, deliberating and consulting on the content of two planned White Papers<sup>4</sup> – on crime, and on strengthening local democracy – both of which may be expected to impact on the drugs policy domain. The options for strengthening local democracy, including examples of how the governance arrangements for local drug-related service providers might be strengthened, are discussed here; the White Paper on Crime is discussed in Section 9.4.2.

The decision-making relationships between national, local and community-level bodies – the governance framework – have attracted considerable attention in recent years. Following its establishment in 2002 the Department of Community, Rural and Gaeltacht Affairs undertook a ‘cohesion process’, whereby it significantly reduced the number of community-based bodies involved in providing local and community development and social inclusion programmes while seeking to maintain service provision across the country. Most recently, in January 2010, the Department merged its own two community development and local development social inclusion programmes into one integrated programme – the Local and Community Development Programme (LCDP) (Carey, Pat 2010, 11 May). In the drugs area the work of the National Drugs Strategy Team, which was made up of representatives of relevant departments, state agencies and the voluntary and community sectors and supported the work of the local and regional drugs task forces, has been absorbed into the Office of the Minister for Drugs, which is located in the Department of Community, Equality and Gaeltacht Affairs (Alcohol and Drug Research Unit 2009).

The assumptions underpinning these cohesion and rationalisation processes have recently been challenged by Ireland’s National Economic and Social Forum (McInerney and Adshead 2010). Exploring local participatory governance in Ireland, the authors argue that a certain level of seeming duplication is necessary to ensure that the complex array of needs and circumstances can be accommodated, that ‘different opportunities for participation and, most importantly, for the realisation of social inclusion’ are provided. Mapping the landscape of participatory processes, they have divided it into four zones:

1. in-house participatory government, e.g. strategic policy committees;
2. moving towards governance ‘out there’, e.g. county/city development boards, RAPID;
3. participating governance ‘out there’, e.g. area-based/community partnerships, local and regional drugs task forces; and
4. civil society organisations, e.g. community platforms.

Rather than streamlining structures, collapsing the range of governance frameworks into a one-size-fits-all, the authors argue that greater attention should be given to

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<sup>4</sup> A White Paper provides a high-level statement of government policy, its rationale and the strategies to give effect to that policy.

supporting participation and to strengthening performance within each of the 'zones'. In Zone 3, where the authors locate the drugs task forces, they suggest that participation could be enhanced by strengthening co-operation between the entities and elected local representatives; by promoting an approach to problem-solving based on reference to organisational values, such as social inclusion and finding a voice, rather than stressing rules and procedures, and ensuring that the local development culture is not weakened.

The authors of the NESF report expressed the hope that their analysis might feed into deliberations leading to the development of the government's White Paper on stronger local democracy. In the Green Paper published as a preliminary step towards the White Paper (Department of the Environment Heritage and Local Government 2008b), the government suggested that community participatory structures could be strengthened by giving local authorities the leadership role in the county/city development boards, which are intended to bring all state and local agencies together and co-ordinate their work. Unlike single focus agencies, local government is regarded as having the flexibility to be creative about new services it can provide.

Creating the conditions for innovation is easier said than done. In a separate initiative, a study was undertaken to investigate how to develop a capacity for foresight and innovation across the Irish economy and society as well as in the processes of governance and decision-making, in short, how to turn Ireland into a 'learning society' (FuturesIreland 2009).

The project reached four key conclusions:

1. Cross-fertilisation between the economy, society and public governance enhance the ability to learn and innovate.
2. Innovation and learning are systematic, almost always combining initiative, disciplined review and a willingness to confront challenges – institutional, inter-personal and personal.
3. Systematic review provides the basis for both innovation and accountability.
4. Organisational systems, particularly our systems of control and accountability in the public sector, need to be completely changed in order to promote innovation and learning.

SAOL – Service Provision for Women with Addiction Problems – based in inner-city Dublin was one several case studies that led to the fourth conclusion. The authors described how the rapid change from heroin to crack cocaine use rendered many of SAOL's services ineffective and they had very quickly to refocus their services. They did this following extensive consultations with colleagues in the Netherlands – known to them through joint work on European projects – in drug treatment services who had already dealt with this problem. SAOL piloted, tested and reviewed the new approach with women in their rehabilitation project. Notwithstanding this thorough review process, SAOL found it difficult to have this shift accepted by their statutory funding body. FuturesIreland suggested that, 'To a large degree, the difference between the staff delivering the service and the people in the funding body centred on the willingness, ability and familiarity with data and methods of review.' (FuturesIreland 2009): p. 41.

Finally, philanthropy was identified in the Green Paper on strengthening local democracy as an option worth further investigation: 'Philanthropy is considerably less developed in Ireland than abroad and there are opportunities to increase its role.' In launching the NDS in September 2009, the Minister for Drugs, John Curran TD, announced that needle exchanges would be rolled out in 65 new locations across Ireland using funding received from the Elton John AIDS Foundation (Curran 2009).

### **1.3.3 Co-ordination arrangements**

The new streamlined co-ordinating mechanisms, introduced in the NDS, were described in last year's National Report (Alcohol and Drug Research Unit 2009): Chapter 1.3.3. Within the OMD, a Drugs Advisory Group has also been set up to advise the Minister

on operational and policy matters relating to the NDS and to oversee and support the work of the drugs task forces. It comprises members drawn from across the statutory, community and voluntary sectors (Curran 2009, 17 November).

## 1.4 Economic analysis

### 1.4.1 Public expenditures

The most recent information available on public expenditure on the drug problem in Ireland is for the year ended 31 December 2009 (Table 1.4.1.1). The figures should be interpreted as indicative only. They relate to services that are broadly directly attributable to dealing with the drugs issue, i.e. 'labelled' drug-related public expenditure. They do not take account of mainstream services that also help to tackle the issue, i.e. 'non-labelled' drug-related expenditure. At present, it is not feasible to disentangle the funding aimed at assisting problem drug users from that aimed at the wider community.

**Table 1.4.1.1 Expenditure directly attributable to drugs programmes for government departments/agencies, 2008 and 2009**

Department/Agency	2008 Expenditure €m	2009 Expenditure €m
Office of the Minister for Drugs	65.207	39.377
Office of the Minister for Children and Youth Affairs	–	28.501
Department of Education and Skills	12.386	3.643
Department of Health and Children	1.033	0.949
Health Service Executive	101.867	104.867
FÁS	18.8	18.8
Department of Environment, Heritage and Local Government	0.496	0.461
Department of Justice and Law Reform	12.340	14.801
Irish Prison Service	5.0	5.0
An Garda Síochána	44.4	45.004
Revenue's Customs Service	14.9	15.837
<b>Total</b>	<b>276.429</b>	<b>277.240</b>

Source: Unpublished data from OMD, August 2010

The OMD's drug-related budget dropped from €65.207 million in 2008 to under €40 million in 2009; this was due for the most part to the transfer of funding for the Young People's Facilities and Services Fund (YPFSF) to the Office of the Minister for Children and Youth Affairs (OMYCA). A breakdown of expenditure under the Drugs Initiative in 2009 was published by the Minister for Drugs, Pat Carey TD, in May 2010 and these figures are shown in Table 1.4.1.2.

**Table 1.4.1.2 Public expenditure on the Drugs Initiative, administered by OMD, 2009**

Project	Amount (€ million)	Total (€ million)
LDTFs – 340 projects	22.000	
RDTFs – 146 projects	10.000	32.00
Specific projects dealing with cocaine – 14	0.550	
Specific projects addressing rehabilitation – 10	0.350	
Specific drug-related projects dealing with the homeless – 3	0.460	1.360
Large-scale capital projects predominantly in RDTF areas, including targeted funding for Limerick City – 6	2.12	
Small-scale capital projects in 23 task force areas to cover costs of refurbishments, renovations and the purchase of equipment – 100	0.552	2.564
Regional Youth Initiative – 6 projects		0.471
Dormant Accounts Fund – 80 substance misuse projects with a family support focus in task force areas		1.560

Project	Amount (€ million)	Total (€ million)
Total		37.955

Source: Carey, 2010

The UN's statistical framework COFOG and Peter Reuter's (Reuter 2004) 'effects of interventions' framework, first applied to Ireland's labelled drug-related public expenditure for 2005, as reported in the Selected Issue 'Public expenditure on drugs' (Alcohol and Drug Research Unit 2007), has not been applied to the 2008–2009 data. Although it is believed that it would reveal a similar pattern of drug-related public expenditure, the analysis has not been repeated as there were significant gaps in the original data that have not yet been filled.

#### 1.4.2 Budget

For 2010, the provisional allocation estimate is expected to show a decrease of approximately 4.5% to €264 million (Eddie Arthurs, OMD, personal communication, August 2010).

Ministers in government departments with responsibilities for the drugs issue have been seeking ways of maintaining service levels while reducing expenditure. For example, Ministers are seeking to maintain and develop the level of services by introducing administrative efficiencies and by using once-off funding to kick-start initiatives that will be integrated with and leverage existing projects.

#### Administrative efficiencies

Arising from the budget process 2010 the government decided that funding for the 38 DTF projects mainstreamed in the Department of Education and Skills would be reduced from €3.643 million in 2009 to €2.461million in 2010, and that funding would cease altogether in 2011 (O'Keeffe, Batt 2010, 9 February). During 2010 the Department of Education and Skills has been reviewing the mainstreamed projects in LDTF areas that it has been funding. Key questions being addressed in the course of the review include (1) is the Department of Education and Skills the appropriate location for these projects or would funding be more appropriately channelled through another Department or agency, for example would projects which involve a significant element of youth work be more appropriately located in the Office of the Minister for Children and Youth Affairs; (2) do some projects duplicate the work of other departmental initiatives aimed at preventing early school leaving; and (3) would some projects which concentrate on treatment or rehabilitation work be better located in other government departments? The review had not been completed at the time of completing this national report (Coughlan 2010, 1 June).

#### Integration and leveraging of existing programmes

On 12 April 2010 Minister for Children and Youth Affairs, Barry Andrews TD, announced details of a funding scheme of €1.5 million from the Dormant Accounts Fund for youth cafés. (See section 3.2.3 for an account of the best-practice guide and toolkit for setting up and running a youth café, launched on the same day.) The purpose of the funding scheme is the structured promotion and development of new and existing youth cafés around the country. As it is a once-off funding scheme, the focus is on capital outlay and initial set-up costs. However, the criteria for the scheme also focus on the broader issues of long-term sustainability and service planning.

In clarifying expectations of the scheme, Minister of State Áine Brady explained that the scheme is not designed to provide for ongoing staffing costs but instead encourages realignment of existing services for young people to help achieve more focused delivery (Brady 2010, 2 June). Priority will be given to applications from consortiums (which may comprise statutory, community or voluntary stakeholders), which demonstrate leverage of funding from other resources for finance, staffing or site provision. This is intended to place an emphasis on sustainable and tangible service delivery. Minister of State Brady emphasised that it will be a highly competitive process



and only those proposals which demonstrate clear and sustainable improvements in the services available to young people in their catchment areas will be successful under the programme.

### **1.4.3 Social costs**

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

## 2. Drug Use in the General Population and Specific Targeted Groups

### 2.1 Introduction

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

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

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

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

The third survey will be conducted in 2010/11.

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

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

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

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

The Health Promotion Research Centre, National University of Ireland, Galway was invited to join the HBSC network in 1994 and conducted the first survey of Irish schoolchildren in 1998 (Friel, *et al.* 1999); the survey has been repeated in Ireland in 2002 (Kelleher, *et al.* 2003) and 2006 (Nic Gabhainn, *et al.* 2007). HBSC Ireland surveys school-going children aged 10–18 years. To obtain the Irish HBSC participant sample, lists of primary and post primary schools are obtained from the Department of Education and Science, and schools across the country are randomly selected and invited to participate. The HBSC survey instrument is a standard questionnaire developed by the international research network and used by all participating countries. It contains a core set of questions looking at background factors, individual and social resources, health behaviours and health outcomes. Questions about smoking, alcohol use and cannabis use are asked under the heading of health behaviours.

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

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

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

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

According to the 2007 iteration of the all-Ireland general population drug prevalence 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 (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 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% to 5% (National Advisory Committee on Drugs and Public Health Information and Research Branch 2008).

The 2007 SLÁN survey found that 6% of respondents reported that they had used an illegal drug in the year prior to the survey (Table 2.2.1.1). The reported use of such drugs was higher for men (9%) than for women (4%) (Morgan, *et al.* 2008). 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 excludes those aged between 15 and 17 years and includes those over 65 years. In addition, the use of confidence intervals allows commentators to rule out sampling variation when comparing the SLÁN surveys, both over time and with other surveys completed at the same time.

**Table 2.2.1.1 Last-year prevalence of illegal drug use in Ireland, 2007**

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

Source: (Morgan, 2008)

## **2.2.2 Sedative, tranquilliser and anti-depressant use in Ireland**

The sixth bulletin of results from the 2006/7 all-Ireland general population drug prevalence survey, which focused on sedative or tranquilliser and anti-depressant use in the adult population (15–64 years) (National Advisory Committee on Drugs and Drug and Public Health Information and Research Branch 2009b), was reported on in the 2009 National Report (Alcohol and Drug Research Unit 2009).

## **2.2.3 Polydrug use in Ireland**

The fifth bulletin of results from the 2006/7 all-Ireland general population drug prevalence survey, which focused on polydrug use in the adult population (15–64 years) and patterns of polydrug use (National Advisory Committee on Drugs and Drug and Public Health Information and Research Branch 2009a), was reported on in the National Report 2009 (Alcohol and Drug Research Unit 2009).

## **2.2.4 NACD general population survey on drug use 2010/11**

Ethical approval for the conduct of the third iteration of the all Ireland general population drug prevalence survey was sought from and granted by the Royal College of Physicians in Ireland. The 2010/11 general population survey tender and questionnaire were prepared between January and March 2010. The questionnaire includes measures of alcohol use based on the European Comparative Alcohol Study (ECAS) guidelines and expert advice. The questionnaire will also be able to measure cannabis dependence using SDS (Severity of Dependence Scale which was developed for treatment surveys in order to measure dependence) and MCIDI (which is used in clinical settings to measure dependence). It was hoped to measure cocaine dependence but the potential sample was too small to ensure a reliable estimate.

A call for expressions of interest in conducting the 2011 general population drug prevalence survey was advertised in late December 2009 and three potential companies were invited to tender. The tender for data collection, validation and initial analysis was awarded to IPSOS/MORI in May 2010.

The full questionnaire was piloted in July 2010. In addition, the MCIDI cannabis dependence measures were translated from German to English and English to German. The translations were checked by two independent fluent German speakers and two independent English speakers. A small number of changes were made to ensure a common translation. The SDS and MCIDI were then tested with 19 cannabis users to ascertain whether their understanding of each question was the same as the researchers understanding. Following these interviews, a number of further changes were made to ensure that the questions will be clearly understood by survey respondents. At present the computer programme that will be used for all data collection is being revised. In September 2010 there will be survey training. Data collection will commence in October 2010 and be completed in June 2010 (Jean Long NACD committee member, 2010).

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

### 2.3.1 Drug use among early school leavers compared with school attendees

A new study (Haase and Pratschke 2010) estimated drug use among 479 early school leavers and 512 school attendees, aged 16–18 years, and identified risk and protection factors for substance use. Data were collected throughout Ireland during two periods: March–May and September–December 2008. The participants were interviewed face-to-face and their answers were recorded using computer-assisted personal interviewing devices. The proportions using each drug are presented in Table 2.3.1.1. It is clear that substance use is more common (with the exception of alcohol) among early school leavers than among school attendees. Table 2.3.1.2 presents the prevalence of drug use among the school attendees in this NACD study compared to drug use reported by participants in the 2007 ESPAD survey (Hibell, *et al.* 2009); the proportions in the two studies who reported use of each drug were very similar with the exceptions of crack cocaine and volatile inhalants.

**Table 2.3.1.1 Proportion of early school leavers (479) and school attendees (512) using different substances, 2008**

	Lifetime		Year prior to the survey		Month prior to the survey	
	Early school leavers %	School attendees* %	Early school leavers %	School attendees* %	Early school leavers %	School attendees* %
Tobacco	81.6	53.3	73.7	38.3	68.9	27.1
Alcohol	89.6	85.7	84.3	78.1	65.3	54.4
Cannabis	57.0	24.2	43.0	14.5	33.6	7.6
Cocaine	25.9	3.7	14.8	2.5	5.4	0.2
Crack	1.3	1.2	0.4	1.0	0.0	0.0
Amphetamines	18.4	3.1	5.6	1.0	0.8	0.0
LSD	5.6	2.0	2.3	2.0	0.0	0.0
Magic mushrooms	12.1	2.5	5.4	0.4	0.4	0.0
Heroin	1.3	0.0	0.4	0.0	0.0	0.0
Tranquillisers	3.8	1.2	1.9	0.2	0.8	0.0
'Legal' party pills	23.4	6.8	13.2	3.9	2.9	0.2
Anti-depressants	8.4	2.0	5.4	0.4	2.1	0.4
Ecstasy	27.3	4.9	17.5	2.3	7.1	0.4
Solvents	14.4	5.5	2.9	0.4	0.8	0.0
Anabolic steroids	0.8	0.02	0.2	0.2	0.2	0.0

\*Proportions for school attendees are adjusted by age and gender to match the composition of early school leavers.

Source: (Haase, 2010)

**Table 2.3.1.2 Proportion of school attendees (512) using different substances in 2008 (NACD study) compared to school attendees (2,249) in 2007 (ESPAD survey)**

	Lifetime		Year prior to the survey		Month prior to the survey	
	NACD school attendees (16-18yrs)*	ESPAD school attendees* (15-16 yrs)	NACD school attendees (16-18yrs)*	ESPAD school attendees* (15-16 yrs)	NACD school attendees (16-18yrs)*	ESPAD school attendees* (15-16 yrs)
	%	%	%	%	%	%
Tobacco	53.3	52	38.3		27.1	33
Alcohol	85.7	86	78.1	78	54.4	56
Cannabis	24.2	20	14.5	15	7.6	9
Cocaine	3.7	4	2.5		0.2	
Crack	1.2	4	1.0		0.0	
Amphetamines	3.1	3	1.0		0.0	
Magic mushrooms	2.5	4	0.4		0.0	
Heroin	0.0	1	0.0		0.0	
Ecstasy	4.9	4	2.3	3	0.4	1
Solvents	5.5	15	0.4	8	0.0	3
Anabolic steroids	0.02	2	0.2		0.0	

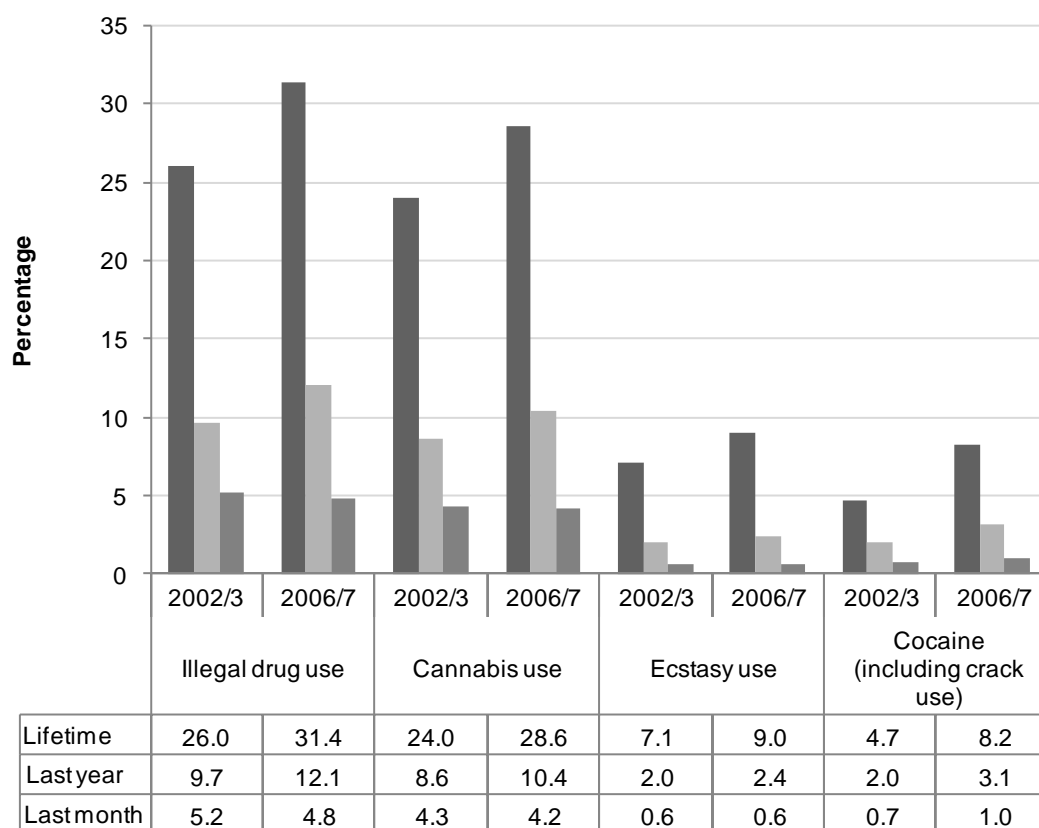
\*Proportions for school attendees are adjusted by age and gender to match the composition of early school leavers.

Source: (Hibell, 2009)

See section 8.2.2 for an account of the risk and protection factors for substance use among the interviewees.

### **2.3.2 Drug use among young people: comparison between All Ireland Drug Prevalence Survey, ESPAD and HBSC**

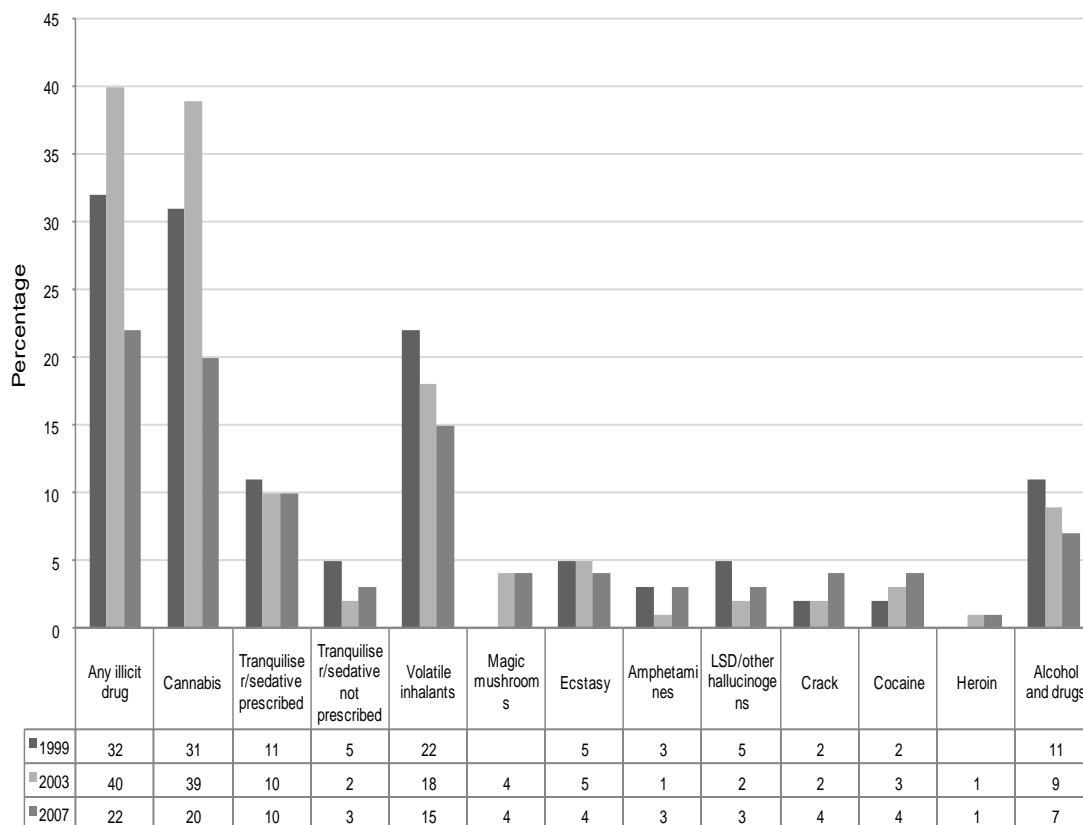
According to the first two iterations of the NACD general population survey (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005), (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008), the proportion of young adults (15–34 yrs) who reported using an illegal drug in the year prior to the survey increased from 10% in 2002/3 to 12% in 2006/7 (Figure 2.3.2.1). The proportions using cannabis in the previous year showed a similar increase, rising by almost two percentage points, to over 10%. The proportions using cocaine increased for all three time parameters and the proportions using ecstasy in the 12 months prior to the survey increased marginally.



**Figure 2.3.2.1 Lifetime, last-year and last-month prevalence of illegal drug use among 15–34-year-olds in Ireland, NACD/DAIRU 2002/3 and 2006/7**

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

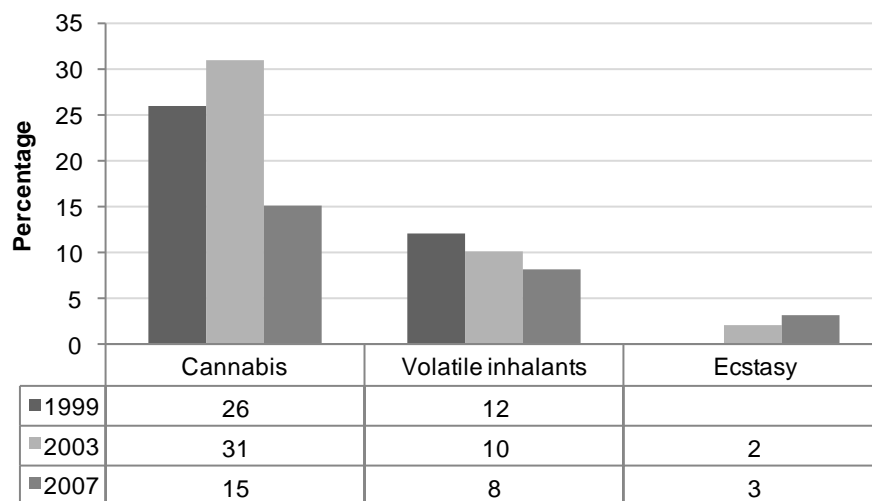
In the ESPAD surveys, the proportion of 15–16-year-old school children who reported use of any illicit drug at some point in their life decreased markedly between 2003 (40%) and 2007 (22%), a fall of 18 percentage points (Figure 2.3.2.2). As the majority of those who have tried any illicit drug have used cannabis (marijuana or hashish), the decrease in illicit drug use was influenced by the considerable decrease in the percentage of students who had tried cannabis at some point in their lives, from 39% in 2003 to 20% in 2007 (European average 19%). Lifetime use of solvents/inhalants decreased from 18% in 2003 to 15% in 2007, but remained higher than the European average (9%). In the case of amphetamines and cocaine powder, the proportions reporting lifetime use increased marginally to equal or exceed the European average of 3%. In 2007, one in ten of the survey participants reported that they had taken prescribed tranquillisers or sedatives at some point in their lives; the use of such drugs had decreased marginally since 1999.



**Figure 2.3.2.2 Lifetime use of drugs among 15–16-year-old school children in Ireland, ESPAD 1999, 2003 and 2007**

Source: ESPAD (2000, 2004, 2009)

As shown in Figure 2.3.2.3, trends in the use of cannabis and volatile inhalants in the 12 months prior to the ESPAD survey mirror the trends in lifetime use reported above.



**Figure 2.3.2.3 Use of drugs in the 12 months prior to the survey among 15–16-year-old school children in Ireland, ESPAD 1999, 2003 and 2007**

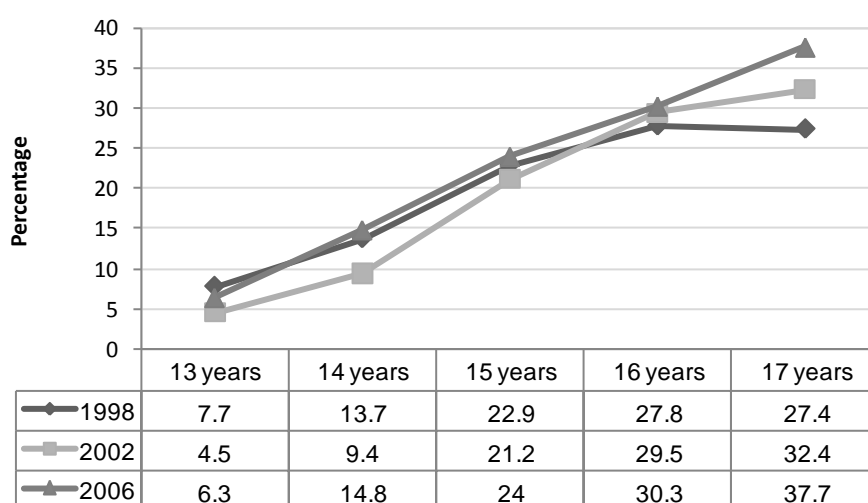
Source: ESPAD (2000, 2004, 2009)

The 2006 HBSC survey (Nic Gabhainn, *et al.* 2007) found that 16% of children reported using cannabis during their lifetime, compared with 12% 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.

The proportion of school children who reported cannabis use at some point in their life increased with each year of age between 13 and 17 in all three HBSC surveys, except for 17-year-olds in 1998 (Figure 2.3.2.4). In 2006, 6% of 13-year-olds reported lifetime



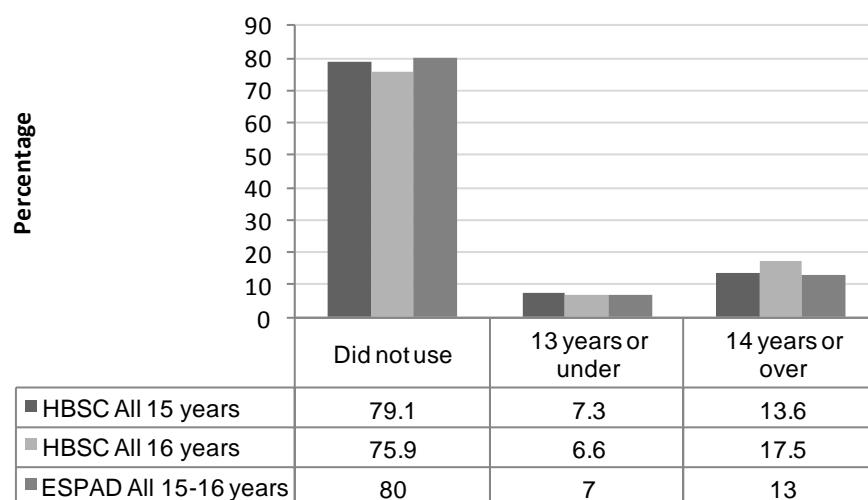
use of cannabis, and the proportion increased steadily with each year of age, to 38% for those aged 17 years. The proportions of those who had used cannabis in each age group from 14 to 17 years increased between 1998 and 2006.



**Figure 2.3.2.4 Proportion of children who used cannabis at least once in their life, by age, HBSC 1998, 2002 and 2006**

Source: Unpublished data from HBSC surveys

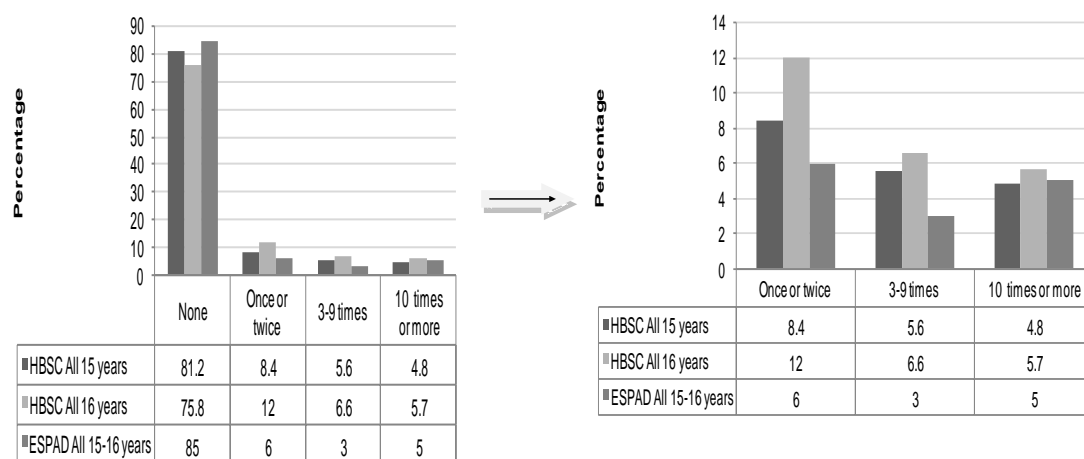
The proportion of children who reported commencing cannabis use at 13 years or under was considerable, and similar in both the HBSC and ESPAD surveys (Figure 2.3.2.5).



**Figure 2.3.2.5 Age commenced cannabis use for children aged 15–16 years, HBSC 2006 and ESPAD 2007**

Source: Unpublished data from HBSC survey 2006 and published data from ESPAD (2009)

In 2006/7, the proportion who had used cannabis three or more times was higher in the HBSC (10.4% and 12.3%) and than in the ESPAD survey (8%) (Figure 2.3.2.6).



**Figure 2.3.2.6 Frequency of cannabis use in the 12 months prior to the survey among 15–16-year-olds, HBSC 2006 and ESPAD 2007**

Source: Unpublished data from HBSC survey 2006 and published data from ESPAD (2009)

Overall, the HBSC surveys show a steady increase in cannabis use between 1998 and 2006, whereas the ESPAD surveys show a large increase between 1999 and 2003 and a larger, unexpected, decrease between 2003 and 2007. The HBSC survey results are in line with those of the NACD survey and other epidemiological indicators.

It is important to investigate the reasons for the marked decrease in cannabis use reported in the ESPAD survey of 2007; these figures could represent a genuine fall in the use of cannabis, or a change in the profile (age, gender or socio-economic group) of the sample chosen, or in the way the questionnaire was administered (Long, J and Mongan 2010).

### 2.3.3 Drug and alcohol use among adolescents in south-eastern Ireland

In the 2009 National Report (Alcohol and Drug Research Unit 2009), two reports on a study of drug and alcohol use in south-eastern Ireland were described (Van Hout 2009a) (Van Hout 2009b). The study included interviews with young people, service providers, and parents.

### 2.3.4 Exposure to illicit drug use and alcoholism among 9-year-old Irish children

On 7 December 2009 the Minister for Children and Youth Affairs, Barry Andrews TD, launched the first major report from Growing Up in Ireland (Williams, *et al.* 2009), the national longitudinal study of children, tracking the lives of over 8,500 nine-year-olds. The data were collected between September 2007 and June 2008.

The nine-year-old cohort was selected through the primary school network. A random sample of schools was drawn and, subject to the school's participation, age-eligible children in those schools and their families were invited to participate. The study included a wide range of perspectives, with information being recorded from parents, teachers, principals and carers, and the 'study child' him or herself. Aspects explored included the children's living situations; experiences of family life; state of health; use of health care services; emotional health and wellbeing; education; peer relationships; activities; and neighbourhood and community settings.

With regard to the children's experiences of stressful life, their mothers were presented with a list of 13 potentially stressful events and asked to report which ones, if any, their child had experienced. Just over 78% of children were reported to have experienced some form of stressful life event; 4% had experienced drug taking/alcoholism in their immediate family. As the following table shows (Table 2.3.4.1), in comparison with

children from two-parent families, children from single-parent families were more likely to have experienced drug taking/alcoholism in their immediate family.

**Table 2.3.4.1 Proportion of 9-year-olds experiencing drug-taking/alcoholism in their immediate family, 2007/8**

Family unit	Percentage of 9-year-olds experiencing drug-taking/alcoholism in their immediate family
Single-parent – 1 or 2 children	10.0
Single-parent – 3 or more children	10.7
Two-parent – 1 or 2 children	2.0
Two-parent – 3 or more children	2.0

Source: Williams, 2009

## 2.3.5 Solvent and volatile inhalant use in Ireland

Under the Irish Child Care Act 1991 it is an offence to sell, offer or make available solvents to a person aged 17 or under if there is reasonable cause to believe that he/she is likely to inhale them.

Solvents or volatile inhalants are a diverse group of substances whose chemical vapors, when inhaled, can have psychoactive or mind-altering effects. These substances vaporise at room temperature. A variety of products common in the home, school and workplace contain volatile substances that can be inhaled (Table 2.3.5.1); however, people do not typically think of these products as drugs because they were never intended to induce intoxicating effects (National Institute on Drug Abuse (NIDA) 2007). Yet, young children and adolescents can easily obtain these toxic substances and are among those most likely to abuse them.

**Table 2.3.5.1 Type, descriptor and examples of volatile inhalants and solvents**

Type	Descriptor	Examples
Volatile solvents	Liquids that vaporise at room temperature  Found in a multitude of inexpensive, easily available products used for common household and industrial purposes	Paint thinners and removers
		Dry-cleaning fluids, degreasers
		Gasoline, glues
		Correction fluids
Aerosols	Sprays that contain propellants and solvents	Felt-tip marker fluids
		Spray paints
		Deodorants, hairsprays
		Vegetable oil sprays
Gases	Medical anesthetics as well as gases used in household or commercial products	Fabric protector sprays
		Butane lighters, propane tanks
		Whipped cream dispensers
		Refrigerants
Nitrites	Nitrites, unlike most other inhalants, act primarily to dilate blood vessels and relax the muscles. While other inhalants are used to alter mood, nitrites are used primarily as sexual enhancers.	Chloroform, ether, halothane
		Nitrous oxide (laughing gas)
		Amyl nitrite
		Butyl nitrite

Source: US National Institute on Drug Abuse (2007)

The majority of volatile inhalant or solvent users are teenage boys and girls who are still in school. Only a small number seek treatment for problematic use of these

substances. Nonetheless, there are a number of fatalities each year as a result of inhaling these everyday household products.

#### **NACD general population survey – volatile inhalant use (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008)**

According to the 2006/7 survey, the proportion of the adult population who reported using a solvent or volatile inhalant in their lifetime was 1.9%, a small increase on the 2002/3 figure of 1.7%. Reported use was more common among men (2.3%) than women (1.4%). Lifetime use was highest among adults aged 15–24 years, at 4.2%.

#### **Surveys of school children – volatile inhalant use**

A study completed in 2004 examined the extent of tobacco, alcohol and drug use among primary school children aged 11 to 14 years in Limerick City, Limerick County, and counties Clare and North Tipperary (the Mid-West Region) (Houghton, *et al.* 2008). Of the 1,254 respondents to the survey questionnaire, 53 (4.2%) had used glue/solvents at least 'once or twice' in their lives. Forty-four out of the 53 said that they had only ever done this 'once or twice'. Thirty-three of the solvent users were male and 20 were female.

The fourth ESPAD survey (Hibell, *et al.* 2009) was conducted in 35 European countries during 2007 and collected information on alcohol and illicit drug use among 15–16-year-olds. Lifetime use of solvents or inhalants decreased in Ireland over three time points, from 22% in 1999 to 18% in 2003 and to 15% in 2007, but remained higher than the European average (9%). Girls were marginally more likely to have used solvents or inhalants than boys, 16% compared to 14%. Half of the users reported that they had taken these substances three or more times during their life.

#### **Volatile inhalant use among young people in the south-east of Ireland**

A recent study explored practices, social dynamics and effects of solvent or volatile inhalant use and suggested methods to deter or stop use among young people (Van Hout and Connor 2008). This inquiry was part of a much larger study on drug use. The authors interviewed 11 males and nine females (average age 13.2 years) living in the south-east of Ireland about their solvent or volatile inhalant use. The average age of first solvent use was 10.3 years; frequency of subsequent use was sporadic and opportunistic. Half of the solvent users also smoked cigarettes, despite the obvious danger associated with co-use. Solvent use was followed by initiation into alcohol use (average age of first use 12.5 years) and then a small number experimented with cannabis. Most used solvents outdoors with their peer group and during the summer holidays. There were some reports of solvent use during school breaks.

The type of solvent used was determined by cost, access and place of residence. Children who lived in rural areas used a limited number of products, namely, wood glue, diesel and petrol, whereas children in urban areas used a wide variety of products, including Pritt Stick, methylated spirits, hairspray, deodorant, chrome paint, butane, nitrous oxide and Vicks nasal spray. Some products were inhaled using a plastic bag, others by placing the spray nozzle in the mouth or nostril, and others by pouring the product on a damp cloth and placing this over the face. Participants reported a variety of reasons for continuing to use solvents, such as to be part of the peer group, to relieve boredom, to experience a high, to deal with stress or to escape from reality. They reported a variety of physical effects such as fainting, vomiting, inflamed nostrils or headache. Some reported doing things following use that they would not normally do, such as having sex, being involved in vandalism or acting on a dare. All respondents knew someone who had died as a result of solvent use. In general, they reported that teachers were uncomfortable delivering information about drug use. They suggested that shopkeepers should not sell these substances to children. They also suggested that use would be deterred if the negative effects of these substances were explained and life stories shared. The latter suggestion is not in line with the current evidence-based practice.

See section 5.5 for the most recent data on treated volatile inhalant use and deaths as a result of volatile inhalant use.

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

### **2.4.1 Mental health and well-being of LGBT people – the role of alcohol and drugs**

On 2 February 2009 an exploratory study of the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) people in Ireland was published. Commissioned by the Gay and Lesbian Equality Network (GLEN) and BeLonG To Youth Services, and funded by the Health Service Executive's National Office for Suicide Prevention, the research was undertaken by a team of researchers from TCD, UCD and UCC (Mayock, P, *et al.* 2009).

The purpose of the study was to examine mental health and well-being, including an investigation of suicide vulnerability (risk) and resilience, among LGBT people in Ireland, and to make recommendations on policy, service delivery and practice related to mental health promotion and suicide prevention.

The research adopted a multi-modal approach, including the administration of a primarily quantitative on-line survey, and the conduct of a community assessment process and of in-depth individual interviews with 40 individuals who identified as LGBT. The researchers used the 'minority stress model' to aid their understanding of the negative impacts on health and well-being caused by a stigmatising social context. External stressors were found to include presumed heterosexuality, homophobia, prejudice and victimisation; internal stressors related to the anxiety of coming out. Negative reactions from others when an individual 'came out' to them also featured, as did the stress of self-concealment.

The findings on mental health indicators suggested that the stigma and discrimination encountered by LGBT people can result in an extremely negative experience of being LGBT. Many participants in the study described having experienced depression, and a significant minority reported engaging in self-injurious behaviour, including hazardous drinking or problem alcohol use, and suicidal thoughts.

The 'resilience narratives' of LGBT individuals were explored, with special reference to self and others, and also in relation to the social environments or contexts where LGBT people interact. Five key sources of social resilience were discerned – friends, family, the LGBT community, school and the work place.

With regard to 'self-resilience', the researchers found evidence to suggest that resilience is an ongoing and emerging process rather than simply a trait possessed by some LGBT individuals and not by others. Positive life experiences and turning points were observed to have led to greater self-esteem and self-efficacy among participants.

Many also identified 'coping strategies' that they used to alleviate stress. Six of the 20 coping strategies listed in the survey instrument related to the use of licit and illicit substances, and participants (N=1,110) identified using these strategies as follows:

- drink alcohol to get drunk 28.2% (n=313),
- drink alcohol (not to get drunk) 25.5% (n=283),
- smoke cigarettes 24.5% (n=272),
- take medication prescribed by a doctor/psychiatrist (e.g. anti-depressants) 17.3% (n=192),
- take prescription drugs (without advice of a doctor or medical worker) 12.3% (n=136), and

- take illegal drugs 10.0% (n=111).

#### 2.4.2 Substance use among Travellers and new communities

The 2009 National Report (Alcohol and Drug Research Unit 2009) described two reports commissioned by the Western Region Drugs Task Force (WRDTF). The first, on the nature and extent of drug use in the Traveller population in the WRDTF area (Van Hout 2009c), reported similar findings to those of a 2006 study (Fountain 2006) and showed that levels of illicit drug use among Travellers are low compared to those in the general population, particularly in the case of substances scheduled under the MDA such as heroin and cocaine.

The second on substance use in new communities in the WRDTF area (Kelly, C, *et al.* 2009b) uncovered little evidence of substance use as a substantial problem, or one that required immediate action, among new communities in the west of Ireland. However, the reluctance of members of new communities to access health services, as acknowledged in this report, suggests that the views of service providers as to the extent of substance use may not reflect the true situation in the communities. Alternative methods of collecting primary data, such as training people from new communities to undertake in-depth fieldwork, including interviews and observation, may yield a different picture to that conveyed here. A 2004 study using these methods found that heroin and cocaine use were becoming a problem among some sections of new communities in Dublin (Corr 2004).

#### 2.4.3 Psychoactive substances sold in head shops and on line

##### Type of drugs sold and their effects or possible effects

On 26 January 2010 the regional drugs task forces held a national conference on 'legal highs' in Mullingar. Dr Des Corrigan, chairman of the National Advisory Committee on Drugs, presented an overview of the products available in head shops, their ingredients and their effects (Long, Jean 2010). He said that it was common for head shops to use the Latin name of plants and chemicals in their list of ingredients. He said that a number of plants were used as stimulants and that there were many strong caffeine-based products on the market. In addition, he noted that many head-shop drugs contained piperine, the main chemical in black pepper, which increases the ability of the body to absorb the drugs.

Dr Corrigan's description of the main psychoactive drugs sold in head shops in Ireland is summarised below:

- **Ephedrine**, which is chemically similar to amphetamine, is available in head shops in the form of *Sida cordifolia*, which is not controlled in Ireland. Two other forms of the drug, Ma Hung and synthetic ephedrine, are available in Ireland only on medical prescription dispensed by a pharmacist. The producers of one product containing *Sida cordifolia* state on the packaging that they take no responsibility for any consequences associated with its use. Chemically similar to amphetamine, ephedrine can induce dependence, psychosis, high blood pressure and increased heart rate.
- **Morning glory (*Ipomoea*) and Hawaiian baby woodrose (*Argyreia nervosa*)** are listed as ingredients in a number of head-shop products that may be labelled 'not for human consumption'. Both plants contain LSA (lysergic acid amide), a relative of LSD. The side effects of LSA and related chemicals include: apathy, tiredness, decreased psychomotor activity and feelings of unreality. As a form of lysergamide, LSA is controlled under the Misuse of Drugs Act.
- ***Salvia divinorum* (divine mint)** contains chemicals called salvinorins that have a potency similar to that of LSD. Its use can lead to euphoria, feelings of levitation, out-of-body experience and, at high doses, uncontrolled delirium. The duration of its effects is short and the come-down is quick and therefore severe. It can induce mental health symptoms such as paranoia and derealisation.

- Three types of **hallucinogenic cacti** containing mescaline are sold in head shops. Their common names are peyote, San Pedro and Peruvian torch. Mescaline from peyote induces hallucinations as well as nausea and vomiting.
- **Kratom**, which contains mitragynine (an opioid agonist), is a leaf chewed in south-east Asia as a stimulant at low doses and as a painkiller or sedative at higher doses. It can cause constipation, weight loss, dependence, psychosis and withdrawal symptoms. It is not controlled in Ireland.
- **Piperazines** such as 1-benzylpiperazine (BZP), methylbenzylpiperazine, meta chlorophenyl-piperazine (mCPP) and 1-(4-fluorophenyl) piperazine are synthetic drugs with psychedelic and euphoric effects which mirror those of ecstasy. They are sold as an ingredient in recreational drugs known as 'party pills'. Examples include Loved up, E bomb. BZP was banned in Europe in March 2008 and in Ireland in March 2009. Other forms of piperazine are not controlled in Ireland. BZP can lead to hyperthermia, high blood pressure, fast pulse, and convulsions.
- **Spice products** are largely a mix of innocuous herbs, but six synthetic cannabinoids have been detected in the various spice products sold across Europe. Synthetic cannabinoids are more potent than the main psychoactive compound (THC) in natural cannabis, and do not contain the anti-psychotic substances found in natural cannabis. They may therefore lead to a higher incidence of psychosis associated with cannabinoid use. There is also potential for dependence. These products have been banned in eight countries across Europe.
- **Cathinone** is a naturally occurring stimulant found in the khat plant, and cathinones are a group of drugs related to amphetamine compounds. Methcathinone, methylmeth-cathinone (mephedrone) and methedrone, derivatives of cathinone, are sold as 'legal highs' online and in head shops in Ireland and across Europe under a variety of names, such as MCAT, Snow, and Charge. Some of these products are sold as bath salts or plant food. The contents listed on the package may contain the word 'ketones'. These compounds are advertised as a replacement for 'Charlie' (cocaine). Some users have reported injecting the compounds. The use of these drugs can induce anxiety and paranoia. Reports say that their use can become compulsive and can create a state of psychological dependence. Mephedrone was linked to two deaths in Sweden in 2008. The authors reported that the negative effects of cathinones were: dehydration, erectile dysfunction, discolouration of the knees attributable to vascular damage ('blue knees'), cardiac arrhythmias, and paranoia. They also said that mephedrone had been linked with at least one death in Europe and was suspected in other deaths. Dr Pierce Kavanagh and colleagues (at Trinity College and the Drug Treatment Centre Board) identified the active ingredients and other constituents in 51 products sold in head shops in Dublin and illustrated their results in two posters (Table 2.4.3.1). These posters are useful for staff working in emergency departments and drug treatment centres. Eighteen of the products analysed contained cathinone derivatives, either in isolation or in combination: mephedrone (28% of cathinone products), flephedrone (17%), methylone (22%), butylone (17%) and MDPV (22%) (Kavanagh, *et al.* 2010). In June 2010 and sometime after the conference mentioned in this section ethcathinone and iso ethcathinone were identified in White Columbia by Dr Pierce Kavanagh and colleagues at Trinity College. This was the first time these psychoactive substances were identified in Ireland.

**Table 2.4.3.1 Active ingredients identified in head shop products, in Dublin up to 11 May 2010**

Product	Cathinone	Other constituents
<i>The Business</i>	mephedrone	
<i>Diablo XXX</i>	mephedrone	
<i>Magic</i>	mephedrone	
<i>Blow</i>	mephedrone	benzocaine

Product	Cathinone	Other constituents
<i>Wild Cat</i>	mephedrone	benzocaine, caffeine
<i>Oceanic Deeper</i>	flephedrone	lignocaine, caffeine
<i>Charge +</i>	flephedrone	lignocaine, caffeine
<i>White Ice</i>	flephedrone	lignocaine, caffeine
<i>Snow</i>	methyldone	
<i>Mint Mania</i>	methyldone	
<i>Craic</i>	methyldone	
<i>Dog's Bollox</i>	methyldone, MDPV	
<i>Hurricane Charlie</i>	MDPV	
<i>Ivory Wave</i>	MDPV	lignocaine
<i>Sextacy</i>	MDPV	lignocaine
<i>Doves</i>	butylone	
<i>Summer Craze</i>	butylone	
<i>Ethcathnone</i>	White Columbia	
<i>Iso-ethcathinone</i>	White Columbia	

Source: Kavanagh, 2009

Several additional psychoactive substances were identified in June 2010:

### Pyrovalerone

Pyrovalerone is a psychoactive drug with stimulant effects that was developed in the late 1960s for the clinical treatment of chronic fatigue and as an appetite suppressant for weight loss purposes. Because of problems with abuse and dependence, it is now less frequently prescribed, but there are reports of its continued use in France and South-East Asia. Its side effects include loss of appetite, anxiety, sleep disturbance, and tremors. The user may become depressed when use is discontinued. Its use is controlled in Ireland, Australia, Britain and the US. Pyrovalerone is closely related in structure to a number of other stimulants, such as methylenedioxypyrovalerone (MDPV) (banned in Ireland under Order of 11 May 2010). Naphyrone (O-2482, NRG-1, Energy 1), also known as naphthylpyrovalerone, is a drug derived from pyrovalerone that has stimulant effects and has been reported as a novel designer drug. It is sold as a plant food on line. No safety or toxicity data are available on naphyrone.

### Aminoindans

2-Aminoindan is an uncommon short-acting stimulant with effects that have been compared to those of 1-benzylpiperazine or methamphetamine. Little is known about its recreational use, but aminoindans are the active ingredient in at least one head-shop product, Pink Champagne pills, which also contain cola vera and caffeine. The pills may cause an increased heart rate and short-term insomnia. Online sellers of these products indicate that they should not be consumed in combination with alcohol or other drugs, particularly anti-anxiety or anti-depressant drugs, or by people with any medical condition (in particular, heart or liver disease), with mental illness, or who are pregnant or breast feeding.

### 1,3-dimethylamylamine (DMAA)



1,3-dimethylamylamine or DMAA, also known as methylhexanamine, is a derivative of geranium oil which acts as a central nervous system stimulant. Methylhexanamine is registered for use as a nasal decongestant. In combination with caffeine and other ingredients, it has been marketed as a dietary supplement under trade names such as Geranamine and Floradrene. Methylhexanamine, at extremely low concentrations (less than 1%), is a component of geranium oil which is approved for use in foods. In New Zealand, DMAA is emerging as an active ingredient in party pills. Recreational drug users have reported adverse effects of DMAA, including headache, nausea, and stroke. Online user reports describe a desire to reuse the drug, episodes of profuse sweating, and feeling depressed and paranoid. In November 2009, the New Zealand government indicated that methylhexanamine would be scheduled as a restricted substance. Products containing DMAA are available in head shops and on line under names such as Iced Diamond, Vegas Nights and Blessed.

**Dimethocaine**, also known as larocaine, is a local anesthetic with stimulant properties that are nearly as potent as those of cocaine. However, anecdotal user reports indicate no euphoria and only mild stimulating effects. This drug may induce a fast and irregular heart beat which could be problematic for those who continuously redose. The drug has induced respiratory arrest. Dimethocaine was identified in the head-shop products Amplified, Mint Mania and Mind Melt. The Ana Liffey Drug Project reported that a number of clients experienced negative effects of a product called Amplifier (most likely Amplified). The clients reported that the drug is available in two forms; a rock which is smoked by pipe and a tablet which is broken down to inject. According to the users of this drug, it has a stimulant effect and a bad come down. Some users reported paranoia or auditory or visual hallucinations.. In August 2010 three users, who had a previous mental health diagnosis, were admitted to a psychiatric hospital following hallucinations and depression.

**AM-694** is a drug which acts as a potent and selective agonist for the cannabinoid receptor CB1. No public data about AM-694 metabolism is known. AM-694 has emerged as a designer drug, and in Ireland, it was detected in the product Shamrock. Concerns have been raised over the possible toxicity of this compound, because of its likely metabolism to  $\omega$ -fluoroalkanoic acids.

**Glaucine** is an alkaloid found in several different plant species. It has bronchodilator and anti-inflammatory effects and is used as a cough suppressant in some countries. Glaucine may induce fatigue or hallucinations (which are usually colourful visual images). This substance was detected as the active ingredient in the head-shop product Entrophy.

**Phenethylamine (PEA)** is a natural monoamine alkaloid and a psychoactive drug with stimulant effects. This substance was detected in the head-shop products Diablo, Dr Feelgood, Entrophy, Nemesis, and Party On.

**Metamfepramone** also known as dimethylcathinone, dimethylpropion, or dimepropion, is a stimulant drug of the phenethylamine, amphetamine, and cathinone chemical classes. Dimethylcathinone was evaluated as an appetite suppressant and for the treatment of hypotension, but was never widely marketed. Metamfepramone is used for the treatment of the common cold. This substance was detected in a product sold in tablet form as BluE.

**Synephrine** is the main active compound found in the bitter orange which is an extract of a plant called *Citrus aurantium*. It is a stimulant that constricts the blood vessels, increases metabolic and heart rates. Synephrine has been identified in the head shop products Energy, Go-E, Empathy, Bio Happiness, Exotic and Molotov.

**Mitragynine**, an opioid agonist, is a stimulant at low doses and a painkiller or sedative at higher doses. It can cause constipation, weight loss, dependence, psychosis and withdrawal symptoms. It is not controlled in Ireland. Mitragynine is an active ingredient in the products Kratom and Xscape.

**Hordenine** occurs in a variety of grassy plants and grains, and in some species of cactus. It stimulates the release of norepinephrine in humans, and also has antibacterial and antibiotic properties. There are unsubstantiated claims that hordenine helps people lose weight. It was detected in the products Go-E and Dr Feelgood.

**5-hydroxytryptophan (5-HTP)** is a naturally-occurring amino acid and a metabolic intermediate in the biosynthesis of the neurotransmitters serotonin and melatonin from tryptophan. 5-HTP sourced from the seeds of the plant *Griffonia simplicifolia* is sold over the counter in the US and Canada as a dietary supplement and as an antidepressant, appetite suppressant, and sleep aid. It is marketed in many European countries for the treatment of major depression. Several double-blind placebo-controlled clinical trials have demonstrated the effectiveness of 5-HTP in the treatment of depression, though the quality of the studies has been disputed. There are no regulated manufacturing standards in place for many herbal compounds and some marketed supplements have been found to be contaminated with toxic metals or other drugs. 5-HTP was detected in the head-shop product Dr Feelgood.

**L-dopa (levodopa)** is a naturally occurring dietary supplement and psychoactive drug found in certain kinds of food and herbs. It is synthesised from the essential amino acid L-tyrosine in humans. L-dopa is the precursor to the neurotransmitters dopamine, norepinephrine (noradrenaline), and epinephrine (adrenaline). Aside from its natural and essential biological role, L-dopa is also used in the clinical treatment of Parkinson's disease (PD) and dopamine-responsive dystonia (involuntary spasms of the limbs). It was detected in the product Raz.

**Desoxypipradrol** was developed in the 1950s, and has been researched for applications such as the treatment of narcolepsy (a condition which results in uncontrolled sleeping) and attention deficit hyperactivity disorder (ADHD), and facilitation of rapid recovery from anesthesia; for various reasons its development for application in these areas was not continued. The hydroxylated derivative, pipradrol, was introduced as a clinical drug for the treatment of depression, narcolepsy and cognitive enhancement in organic dementia. Desoxypipradrol was detected in the head-shop product Whack.

A number of psychoactive substances identified in recent weeks. There is very little information on these drugs available on the web. They include:

**3',4'-Methylenedioxy- $\alpha$ -pyrrolidinobutiophenone (MDPBP)** is a stimulant compound developed in the 1960 which has been reported as a novel designer drug.

**Oleamide** was found in the smoking blends "Smoke" and "Skunk" alongside the synthetic cannabinoid JWH-018 which was classified as the active ingredient. However, there is no evidence that this drug is used specifically as a recreational drug.

**Octopamine** and synephrine are the adrenergic amines in bitter orange.

**Buphedrone**, also known as  $\alpha$ -methylamino-butyrophenone, is a stimulant of the phenethylamine, amphetamine, and cathinone chemical classes that was first synthesised in 1928. It has similar effects to methcathinone but is several times more potent by weight.

**4-methylethcathinone** for which there is no information available

**Caffeine and lignocaine** were found in numerous head shop products.

- Caffeine is a legal psychoactive stimulant and easy to acquire. Caffeine was found in the products Blowout, Bliss Bomb, Diablo, Dr Feelgood, Energy, Embrace, Extreme Star Dust, Go-E, Koru, Nemesis, NRG Now, Pure NRG, Pinkys, Raz, Sno\*berry, Star Dust, and Party On.

- Lignocaine (or lidocaine) is an anaesthetic drug; it is found in Extreme Star Dust, Pure NRG, Raz, Star Dust.

### **Methods for the identification of the active ingredients in head shop products**

(Pierce Kavanagh, Trinity College Dublin, Personal Communication, 2010).

The product (1 mg) was extracted from basic (NH<sub>3</sub>) aqueous solution/suspension (500:l) into toluene (500:l).

The toluene extract and, in the case of dimethylamylamine which was derivatised by addition of an equal volume of pentafluoropropionic anhydride to the toluene extract and heating at 90°C for 20 minutes, evaporation and reconstitution in dichloromethane beforehand, was analysed by GCMS under the following conditions: Agilent 6890 gas chromatograph with split-splitless injection (2:l injected) and a HP-5MS column (30 m x 0.25 mm, 0.25 µm film thickness). Helium (He) was used as the carrier gas at a flow rate of 1.0ml/minute. The GC was coupled to an Agilent 5973 MSD (EI, 70eV, TIC mode scanning m/z 40-800) and injector port was set at 300°C, the transfer line at 280°C, the ionization source at 220°C and the quadrupole at 150°C.

The following temperature program was used for mephedrone, methylone, flephedrone, ethcathinone, iso-ethcathinone, butylone, MDPV, naphyrone, dimethocaine, fluorotropacocaine and 2-aminoindane: 90°C for 1 minute, 15°C/minute to 280°C, 280°C for 6.33 minutes, 10°C/minute to 300°C, 300°C for 13 minutes.

The following temperature program was used for dimethylamylamine (PFP derivative) and 2-phenylethylamine (PFP derivative): 50°C for 1 minute, 15°C/minute to 280°C, 280°C for 6.33 minutes, 10°C/minute to 300°C, 300°C for 10.34 minutes.

Samples were diluted appropriately if overloading was observed. A mass spectral library of the above compounds for Agilent Chemstation software is available on request (contact [pierce.kavanagh@tcd.ie](mailto:pierce.kavanagh@tcd.ie)).

Standards of methylone, mephedrone, butylone, flephedrone, ethcathinone and MDPV were kindly provided by Ms. Sinéad McNamara (Drug Treatment Centre Board, Dublin). Naphyrone was synthesised in our laboratory. 2-Aminoindane was purchased from Alfa Aesar (UK). Dimethylamylamine and 2-phenylethylamine were purchased from Sigma Aldrich (Ireland). Dimethocaine and fluorotropacocaine were identified from their mass spectra as it is currently not possible to buy authentic standards from a reputable company. 'iso-Ethcathinone' was identified from mass spectral evidence as it is not commercially available. Our laboratory is currently in the process of synthesizing it.

### 3. Prevention

#### 3.1 Introduction

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

- Universal (primary) prevention programmes, aimed at the general population such as students in schools, to promote overall health of the population and to prevent the onset of drug and alcohol misuse. Measures often associated with this type of programme include awareness campaigns, school drug/alcohol education programmes and multi-component community initiatives.
- Selected (secondary) prevention programmes, aimed at groups at risk, as well as subsets of the general population including children of drug users, early school leavers and those involved in anti-social behaviour, to reduce the effect of risk factors present in these subgroups by building on strengths and developing resilience and protective factors.
- Targeted (tertiary) prevention programmes, for people who have already started using drugs/alcohol, or who are likely/vulnerable to engage in problematic drug/alcohol use (but may not necessarily be drug/alcohol dependent), or to prevent relapse. These programmes are aimed at individuals or small groups and address specific needs.

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

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

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

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

the development of timely awareness campaigns targeted in a way that takes individual social and environmental conditions into account key areas such as third-level institutions, workplaces, sports and other community and voluntary organisations.

## **3.2 Universal prevention**

### **3.2.1 School**

Recent research by the (Office of the Minister for Children and Youth Affairs 2010b) surveyed a cohort of students in post-primary schools on their experience of receiving SPHE. Questionnaires were administered by young people who had been trained by the lead researcher in peer research skills and in compiling the questionnaires. The questionnaires were distributed to secondary school students while they were participating in youth council meetings; participants included representatives of secondary schools, youth organisations and hard to reach groups. A total of 134 young people (aged 12–16) from 68 secondary schools in 12 different counties completed the questionnaire on the SPHE programme, 53% male and 47% female. The report does not contain information on whether or how young people were sampled.

The majority of young people that completed the questionnaire (88%) received SPHE classes in 2009 and 84% had SPHE classes once a week during that year. SPHE is timetabled as a class in almost all schools surveyed (97%). Respondents were asked to indicate the emphasis placed on the various themes covered in the SPHE syllabus in their school, marking whether there was a high or a low emphasis put on them; 83% of respondents indicated that alcohol, drug and solvent use was the most emphasised theme in the SPHE syllabus.

Respondents to the survey reported the following outcomes as a result of participation in SPHE classes:

- helped understanding of how to make good decisions: 60%
- provided the chance to think and talk about interesting subjects: 56%
- improved self-respect: 48%
- improved physical health and well-being: 45%
- improved emotional health and well-being: 41%
- developed personal and social skills, such as self-confidence and self-esteem: 41%
- improved mental health and well-being: 37%
- not improved physical, emotional or mental health: 22%

The National Drugs Strategy [interim] 2009-2016 was launched in September 2009 and has 63 actions to be implemented in the lifetime of the Strategy (Department of Community Rural and Gaeltacht Affairs 2009) Actions 20 and 21 of the NDS relate to prevention and education in primary and post-primary schools. The DES has responsibility as lead agency for both actions, and is supported by the Department of Health and Children (DoHC) and the Health Service Executive (HSE) on Action 20.

*Action 20:* Improve the delivery of SPHE in primary and post-primary schools through the implementation of the recommendations of the SPHE evaluation in post-primary schools, and the development of a whole-school approach to substance use education in the context of SPHE. (The SPHE evaluation referred to in Action 20 had reported that support and training for teachers were regarded as essential for the success of SPHE (Geary and McNamara 2003).

Implementation of Action 20 is under way (John Moloney, Department of Education and Science, personal communication). In 2008/9 there were 33 SPHE in-service training events, attended by 185 teachers. Twenty of these events were school-based. In 2009/10 seven events were scheduled, and at the time of reporting three events had taken place with 29 teachers attending. Guidelines for visitors to primary and post-primary schools, such as Gardaí or drug prevention workers, are currently being issued to schools. The DES is currently reconfiguring the delivery of support for teachers in

light of the current resources available. Support across a range of educational areas, including SPHE, is to be provided by multidisciplinary regional teams, which will be part of the newly-formed Professional Development Service for Teachers (PDST), which will work in cooperation with the national network of Education Centres. It is intended that support for substance misuse prevention will be further integrated with SPHE support.

*Action 21:* Ensure that substance use policies are in place in all schools and are implemented; monitor the effectiveness of the implementation of substance use policies in schools through the whole-school evaluation process and the inspectorate system and ensure that best practice is disseminated to all schools.

Recent feedback from the DES suggests that implementation of Action 21 is under way (Liam Hughes, Department of Education and Science, personal communication). For example, a Life Skills postal survey was undertaken by the DES in 2009 to ascertain if substance use policies were being developed as part of SPHE in both primary and post-primary schools. An initial analysis of the data indicated that up to 12 December 2009:

- Primary level (67.8% response rate): 84% schools had a substance use policy.
- Post-primary level (55.1% response rate): 95.8% schools had a substance use policy.

In addition, the DES reports that there is a plan to monitor the implementation and effectiveness of substance use policies in schools through the whole-school evaluation process. In 2009, the number of Whole-School Evaluations (WSE) completed was as follows:

- WSE Primary: 246
- WSE Post-primary: 48
- Subject inspections SPHE Jan 2007–March 2010: 66 inspections (approx.)

In June 2009 a preliminary analysis of qualitative findings from 29 published SPHE subject inspection reports was undertaken. This information was used to refine the inspection process, inform policy development and highlight continuous professional development (CPD) needs among teachers. In the 2010/11 school year, the team of post-primary inspectors plans to conduct approximately 40 SPHE evaluations in post-primary schools. The team of post-primary inspectors who conduct SPHE subject inspections is being expanded, and training is being provided for all team members in 2010.

### **3.2.2 Family**

The Family Support Network (FSN) published a set of good-practice guidelines for peer-led family support groups, the purpose of which is to support families coping with a drug-using member(s) (Family Support Network 2010). The compilation of the guidelines was overseen by a steering group and involved extensive consultation with a large number of family support groups and relevant stakeholders, visits to family support groups, and a review of the literature with particular emphasis on the peer-led model of family support. A draft set of guidelines was developed and workshops were undertaken with nine family support groups to allow for further feedback. Family support groups attending their national conference in 2009 were also consulted on the draft guidelines and feedback was received on the training needs of groups.

The objectives of the guidelines are to:

- assist family support groups to develop good practice in all areas of the work of the group,
- identify training and other resources required to support good practice,
- ensure consistency of practice among family support groups throughout the country, and
- provide a basis for affiliation to the FSN.

The document has six sections and each section concludes with reflective exercises and 'top tips', which are also available in the form of a separate resource pack. The sections are:

1. Introduction: outlines whom the guidelines are intended for and how best to use them.
2. Starting a peer-led family support group: discusses the composition of groups, drawing up a code of ethics and a code of practice, and advises on how to convene meetings.
3. Providing support in a group: examines aspects of confidentiality, the identification of members' needs, and group development;
4. Facilitation: describes the role and attributes of a good facilitator;
5. Seeking external support: deals with identifying information, self-development and training needs of a group; and
6. Setting up a family support network: outlines the benefits and issues involved in setting up a network of support groups.

### **3.2.3 Community**

#### **Youth cafés**

The OMCYA recently published a best-practice guide and an accompanying toolkit to maintain and develop youth cafés around Ireland (Office of the Minister for Children and Youth Affairs 2010b). The best-practice guide was developed following an extensive literature review, which examined peer-reviewed studies, grey literature, technical reports, working papers and information retrieved from international experts. Interviews were undertaken with stakeholders in youth cafés in Ireland and among those working in the youth sector. Interviews were also undertaken with young people who use youth cafés in Ireland and with a panel of young people recruited through the OMCYA. It is estimated that there are more than 20 youth cafés in operation around Ireland.

The guidelines provide a conceptual model and framework for the development of youth cafés. They suggest that 'one of the most attractive features of a youth café is that it can work with young people across all levels of need, including universal populations through to those "at risk" '(page 2). The guidelines also set out guiding principles and discuss operational issues and monitoring and evaluation systems.

The youth café toolkit describes the processes involved in setting up and operating a youth café in Ireland. It provides guidance on the types of activities and programmes that might be organised in youth cafés, the role of staff and volunteers, and the training of staff, volunteers and young people. Guidance is also provided on the design and location of youth cafés, their management and funding, and the promotion and development of policies for youth cafés.

To ensure the success of a youth café, the toolkit recommends that policies be developed regarding respect and behaviour – to ensure the café remains a safe, drug- and alcohol-free space in which young people can hang out – and on drug and alcohol use.

#### **Youth work standards**

The OMCYA recently published the *National Quality Standards Framework (NQSF) for Youth Work* (Office of the Minister for Children and Youth Affairs 2010a). For the first time in Ireland, this framework provides the basis for youth organisations and groups involved in working with young people in Ireland to be subject to external assessment by Vocational Education Committee (VEC) officers and NQSF officers. The framework encourages self-assessment by youth organisations, and invites practitioners to assess their work under the following headings:

- components of practice
- progression
- monitoring and assessment

- policies and procedures
- governance and operational management
- volunteers
- human resources management
- collaboration and integration.

The framework list five core principles that should underpin youth work including the protection and safety of young people, equality and inclusiveness.

### 3.3 Selective prevention in at-risk groups and settings

#### 3.3.1 At-risk groups

##### Young people at-risk of offending

The Garda Youth Diversion Projects (GYDPs) are a community-based, multi-agency crime prevention initiative, which seeks to divert young people from becoming involved (or further involved) in anti-social and/or criminal behaviour by providing suitable activities to facilitate personal development and promote civic responsibility. Participation by young people and their families is on a wholly voluntary basis.

In 2009 the Irish Youth Justice Service (IYJS) undertook a baseline analysis of 96 of the existing 100 projects, in order to gain a deeper understanding of the nature and extent of risk factors that participants were presenting with and the local context within which the projects were operating (Irish Youth Justice Service 2009). The aim of this work was to improve the effectiveness of the projects.

The analysis was based on data gathered during site visits, which took place between March and July 2008. The person with responsibility for the project (usually the project co-coordinator) was present in all cases and local Gardaí were present during 66 of the 96 visits. Interviews were undertaken with management and front-line staff. Eighty-two of the 96 projects visited (85%) put alcohol and public-order-related crime at the top of the list of offences committed in their catchment area; other offences included theft, drug-related matters, violent offences, unauthorised taking of motor vehicles, burglary and road traffic matters. Table 3.3.1.1 summarises the types of risk factors identified in the lives of participants in the projects.

**Table 3.3.1.1 Profile of GYDP participants according to individual, family, educational and neighbourhood risk factors, 2008**

Type of Risk Factor	Risk profile of GYDP participants	No of GYDPs
Individual	Participants 'normalised' their offending behaviour.	47
	Participants verbally or physically aggressive.	34
	Participants prone to impulsivity.	14
	Participants presented with delayed social and emotional competence.	9
	Participants experienced chaotic lifestyle patterns; active during night-time and sleeping during daytime.	8
	Participants presented with learning difficulties.	6
	Participants did not show empathy.	5
Family	Parents had problematic drugs and/or alcohol use problems.	37
	Family member(s) had involvement with the criminal justice system.	36
	Parents were involved in alcohol-related anti-social behaviour.	15
	Absence of a positive male parental influence.	10
	Participants experienced violence at home.	11
Educational	Participants performed poorly at school.	58
	Participants had mixed or poor school attendance.	55
	Participants presented with discipline problems at school.	31
Neighbourhood	Neighbourhoods accepting of receiving stolen goods.	18
	Neighbourhoods tolerant of under-age drinking, drugs misuse and/or anti-social activity.	13
	Neighbourhoods accepting of drug dealing.	11
	Neighbourhoods with adult criminal activity.	11



Type of Risk Factor	Risk profile of GYDP participants	No of GYDPs
	Neighbourhoods with negative attitudes towards the Garda.	6

Source: Adapted from Irish Youth Justice Service, 2009

### Early school leavers

Action 23 of the NDS gives lead responsibility to the DES to implement SPHE in Youthreach Centres of Education (YCsE) and in Youth Encounter Projects (YEPs) and ensure that substance misuse policies are in place in these recognised centres for education; implement age-appropriate substance prevention/awareness programmes in training settings, including the **Vocational Training Opportunities Scheme (VTOS)** and community training facilities; introduce monitoring and follow-up procedures in relation to substance prevention activity in the above settings. The YCsE and other settings mentioned in this action cater for the educational and training needs of early school leavers.

In response to Action 23, the following initiatives are under way (John Moloney, Department of Education and Science, personal communication).

- A Quality Framework Initiative (QFI) has been developed for YCsE and Senior Traveller Training Centres (STTCs). As part of the QFI, the overall social, personal and health education needs of learners are assessed. Following this, a programme of learning in the area of SPHE is developed and delivered.
- Health promotion is an integral part of policy and practice in YCsE and STTCs, and learners have access to information and training on health-related issues.
- All YCsE have implemented internal evaluation and development planning processes.
- All YCsE and STTCs have staff trained in the Substance Abuse Prevention Programme and they offer the programme.
- Drug education is included in VTOS and other adult education programmes as necessary.
- Community training centres, operated by FÁS, include a module on drugs and substance abuse, prevention and awareness, in their life and social skills programme.
- Community training workshops, which operate in LDTF areas, have appointed a drugs education and prevention officer.
- Youth Encounter Projects include SPHE among the subjects taught.

The DES Regional Office Inspectorate has been undertaking a programme of evaluation of YCsE and STTCs since 2006. A composite report based on the first 25 evaluations has been prepared and the DES is considering the recommendations.

Action 31 of the NDS gives responsibility to the DES to maintain the focus of existing programmes targeting early school leavers and the retention of students in schools and improve the measurement of the outcomes of such programmes in order to target and expand them in areas of greatest need.

In response to Action 31, the following measures are under way (John Moloney, Department of Education and Science, personal communication). The DEIS programmes support some 151,000 children in 881 schools. 46,000 at-risk children are directly targeted in schools through the Home School Community Liaison (HSCL) programme and the School Completion Programme (SCP). The SCP targets those most at risk of early-school leaving as well as those who are already outside of the formal system. Provision includes in-school, after-school and holiday-time supports. Integration of HSCL, SCP and the Visiting Teacher Service for Travellers with the National Educational Welfare Board, which commenced on 1 September 2009, is expected to be largely completed by June 2010. DEIS is currently being evaluated, and at the time of completing this National Report, a report was due to be submitted to DEIS.

## **Schools' Business Partnership**

The Schools' Business Partnership (SBP) is operated by Business in the Community Ireland (BITC) and aims to develop partnerships between schools in disadvantaged areas and a local business. According to the BITC website, the number of schools currently matched nationwide is 158. The businesses involved in the SBP are drawn from a number of sectors including financial, manufacturing, pharmaceutical, technology, retail and food.

The objectives of the SBP include assisting schools in disadvantaged areas to increase the number of students completing the Leaving Certificate examination and to reduce early school leaving. The SBP partnership operates four sub-programmes: student mentoring, management excellence for school principals, skills at work and the summer work placement programme (School's Business Partnership 2008).

## **Research with regard to early school leavers**

A recently-published study of early school-leavers in Ireland (Byrne, Delma and Smyth 2010) may be useful to policy makers and practitioners when designing interventions to prevent early school-leaving or improve the life chances for those students that have left school early. Although the researchers did not focus on the role of substance misuse in the lives of early school-leavers, the findings provide useful information on their school experience and reasons for leaving school.

A mixed-methods approach was used, combining quantitative data from the Post-Primary Longitudinal Study (PPLS) with in-depth qualitative interviews with young people who had left school before completing the senior cycle. Undertaken by the Economic and Social Research Institute (ESRI),<sup>5</sup> the PPLS drew on data gathered from a theoretical sample of 12 Irish schools, identified on the basis of a postal survey of all post-primary principals. These schools were selected to capture varying approaches to ability grouping, subject choice and student integration, and encompassed a range of sectors, sizes, locations and student characteristics. The study followed a cohort of approximately 1,000 students from their entry to first year to their completion of second-level education. Students completed a written questionnaire each year, covering their attitudes to schools, their choice of programmes and subjects, and their aspirations for the future. In addition, in-depth interviews were carried out with groups of the students, and with key personnel in the school, including principals and guidance counsellors.

By matching PPLS data collected on individuals from their first to their fifth year, Byrne and Smyth were able to compare young people who left school early with those who completed second-level education on a range of dimensions, including background, aspects of the transition to post-primary education, school experiences in junior cycle, ability grouping, and out-of-school activities. The authors also conducted in-depth life history interviews with 25 young people between January and May 2008 to obtain a detailed understanding of their school experiences, their decision to leave school and their post-school plans and pathways. These 25 young people were drawn from a pool of early-school leavers, who had been identified by going through the year-on-year questionnaires completed in the course of the PPLS; a list of potential school-leavers was identified and sent to the principals of the 12 schools that had participated in the PPLS. Following advice from the principals regarding the status and contact details of those on the list, attempts were made to contact 145 individuals. As an incentive to participate and in order to maximise response, each school-leaver was offered €50 for the expenses involved in travelling to the place of interview.

The authors reported that patterns of early school-leaving in Ireland are strongly differentiated by gender and social class, with males from working-class and/or unemployed households being the most likely to leave school early. According to the

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<sup>5</sup> The PPLS has been extensively described in a series of reports, the first of which was published in 2004, which may be accessed on the ESRI's web site at [www.esri.ie](http://www.esri.ie)

authors, the higher drop-out rate among this category is largely related to their school experiences: these young men are more frequently allocated to lower stream classes, and are more likely to be reprimanded by teachers for 'acting up'.

The authors reported that those in lower-stream classes were almost 13 times more likely to drop out than those in mixed-ability classes, even controlling for social class background, academic ability on entry into second-level, school climate, and student engagement. The authors noted, moreover, that in recent years streaming had been disproportionately prevalent in disadvantaged schools. This has important implications for the implementation of Action 31 in the NDS, which calls for the maintenance of the focus of existing programmes targeting early school-leavers and the retention of students in schools, with particular regard to the operation of the DEIS programme, which is delivered to disadvantaged schools.

The authors reported the following school experiences of early school leavers:

- Academic struggle: Students who have low reading and maths test scores on entry to post-primary education are significantly more likely to drop out of school.
- Negative relations with teachers: Many of the young people stated that their teachers did not listen to them, showed little interest in them and tended to 'put them down'.
- Interaction with peers: Poor interaction with peers was more prevalent in schools that used streaming; bullying interfered with school attachment and had a lasting negative influence on victims.
- Nature of classroom environment: Many young people experienced their education in particularly disruptive classroom environments. It was suggested that some schools and classes had a culture of early school leaving.

According to the authors, the decision to leave school at an early stage is heavily influenced by negative experiences of school, these experiences leading young people either to feel rejected by the school or to reject the school themselves, and in some cases these factors combined. Young people from particularly disadvantaged or Traveller backgrounds are more likely to leave school without gaining any qualifications.

### **3.3.2 At-risk families**

Action 29 of the NDS calls on the HSE and the DES to lead the development of a series of prevention measures that focus on the family under the following programme headings:

- supports for families experiencing difficulties due to drug/alcohol use;
- parenting skills; and
- targeted measures focusing on the children of problem drug and/or alcohol users aimed at breaking the cycle and safeguarding the next generation.

In response to this action, the HSE plans to develop an integrated service group, including representatives of addiction services, children and families (Gretta Crowley and Eddie Matthews, HSE, personal communication).

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

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

## **3.4 Indicated prevention**

### **3.4.1 Children at risk (e.g. children with AD(H)D, children with externalising or internalising disorders)**

Research with young homeless people in Ireland has established that 'leaving state care' is a distinct pathway into homelessness and addiction. Between September 2004

and February 2005, Mayock and colleagues (Mayock, Paula and Vekic 2006) interviewed 40 young homeless people living in Dublin. Forty per cent of the cohort reported a history of state care, of varying duration, in foster homes, residential care placements or residential placement homes; respondents also reported moving between care settings. Half the cohort reported having used heroin, with the majority of heroin users initiating use when they became homeless. In a later study, Mayock and colleagues (Mayock, Paula and Carr 2008) again highlighted the association between leaving state care and becoming homeless and using drugs. Thirty-seven young homeless people living in Cork City were interviewed; the majority had spent time in state care and a feature of their pathway into homelessness was inadequate preparations for leaving the care setting and lack of aftercare. The vast majority reported lifetime use of alcohol and drugs and 22 reported past or ongoing problems associated with substance use.

In July 2009 the government (Office of the Minister for Children and Youth Affairs 2009) published its plan to implement the 20 recommendations contained in the report of the Commission to Inquire into Child Abuse (commonly referred to as the 'Ryan Report'), which was published in May 2009. The implementation plan contained 99 actions to be taken by government departments and agencies. It acknowledged the association between state care and future poor outcomes for children who have been in state care, including addiction and homelessness: 'those with a care history continue to be over-represented among those who are, for example, accessing addiction services, coming into contact with the criminal justice system and experiencing homelessness in adulthood...' (page xii).

The implementation plan included an appraisal of the gaps in service provision around pre-release planning and aftercare for young people leaving care, and called for recognition of the fact that 'there has been a serious deficit of implementation over the past decade in areas such as the allocation of social workers to children in care, care planning and aftercare services' (page 3). The plan included two actions to improve care planning:

- Action 33: The HSE will ensure that all children in care will have an allocated social worker and a care plan, in accordance with the regulations.
- Action 67: The HSE will ensure that care plans include aftercare planning for all young people of 16 years and older.

The implementation report also highlighted the gaps in aftercare services for young people. While acknowledging that some attempts to provide aftercare have been effective in the past, the report stated that, 'Aftercare services are not provided consistently to all children across the State. Some HSE areas have dedicated aftercare workers, but most do not. ...The provision of aftercare by the HSE should form an integral part of care delivery for children who have been in the care of the State. It should not be seen as a discretionary service or as a once-off event that occurs on a young person's 18th birthday, but rather a service that he or she may avail of up to the age of 21...' (page 48).

The plan includes two specific actions to provide and monitor the provision of an enhanced system of aftercare, which, if implemented consistently and effectively, could contribute to a reduction in youth homelessness and a concomitant reduction in exposure to substance use.

- Action 64: The HSE will ensure the provision of aftercare services for children leaving care in all instances where the professional judgment of the allocated social worker determines it is required
- Action 65: The HSE will, with their consent, conduct a longitudinal study to follow young people who leave care for 10 years, to map their transition to adulthood.

### 3.5 National and local media campaigns

On 7 July 2010 the HSE launched a national drug awareness campaign about head shop drugs, with the slogan 'Legal or illegal highs [head shop drugs] can cause serious health problems – they're anything but safe'. The physical health risks highlighted by the campaign include heart problems, kidney failure, impotence and seizures; mental health problems, such as paranoia, and acting foolishly when high are also highlighted. The campaign is aimed at people aged between 15 and 40 years of age.

The campaign consists of a series of slogans on A4 size posters; the posters show a male or female dressed in a tee-shirt emblazoned with different messages, which are linked to the over-riding message on the poster about the risks. The posters will be distributed in bars and clubs and at festivals. The campaign will also use radio advertisements and on-line 'pops-ups' for Facebook.

An information booklet has been prepared for parents and guardians. It explains what legal highs are and the current legal situation, and advises how to talk to your child about these drugs and what to do if they are using them. It also includes harm-reduction messages and what to do if someone is having a bad reaction to a drug. This booklet is also available as a handy Zed card (concertina credit card size), which can be carried in a wallet. Both the booklet and the wallet card can be downloaded from the website used to support the campaign [www.drugs.ie](http://www.drugs.ie). The website also contains a number of video clips, which answer frequently asked questions (FAQs); the information in the clips is provided by health professionals and covers powders, pills, smokeable products and hallucinogenic substances. There is no information available on whether the campaign will be evaluated.

## 4. Problem Drug Use (PDU)

### 4.1 Introduction

This chapter provides an overview of developments and trends in the prevalence and characteristics of problem drug use in Ireland ranging from data for 2006 relating to the prevalence and incidence estimates of PDUs, to more recent studies relating to data on problem drug users from non-treatment sources and on varieties of problematic drug use. A PDU is defined as an 'injecting drug user or long duration/regular user of opiates, cocaine and/or amphetamines' (EMCDDA 2004).

It is not possible to estimate the number of injecting drug users or problem drug users in Ireland as the National Drug Treatment Reporting System (NDTRS) does not use a unique identifier. This issue has been raised in strategy submissions and it is hoped that it will be addressed in the forthcoming health information bill. Three sources containing information indicative of the nature of problem drug use in Ireland are described below.

A **national 3-source capture-recapture study**, to provide statistically valid estimates of the prevalence of opiate drug use in the national population during 2006, was commissioned by the National Advisory Committee on Drugs (NACD). The three data sources used in the study were the Central Drug Treatment List (CTL), the Hospital In-patient Enquiry (HIPE) database and the Garda list of opiate users. The findings were published in 2009 (Kelly, Alan, *et al.* 2009a): they updated a similar study for the year 2001 (Kelly, Alan, *et al.* 2003). The new study indicates that use has increased since the previous survey. There were 11,807 known opiate users in 2006. The major expansion of the national methadone treatment programme between 2001 and 2006 is the main reason for the inflation of the figures. There is considerable doubt over the estimate produced of a possible further 8,983 opiate users who have not come into contact with any of the drug treatment services, hospital in-patient services or the Gardaí.

The following are among the trends (2001–2006) seen in the study results:

- the rate of opiate use among females and males aged 15–24 decreased, indicating a significant reduction in the number of young people commencing opiate use,
- an increase in opiate use outside of Dublin, and
- a higher proportion of opiate users in treatment in Dublin than elsewhere, reflecting the more recent spread of opiate use outside Dublin and the later development of treatment services.

The **National Registry of Deliberate Self-Harm** is a national system of population monitoring for the occurrence of deliberate self-harm, established at the request of the Department of Health and Children, by the National Suicide Research Foundation (National Parasuicide Registry Ireland 2004). Since 2006–2007 the Registry has achieved complete national coverage of hospital-treated deliberate self-harm.

The Registry defines deliberate self-harm as 'an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences'. All methods of deliberate self-harm are recorded in the Registry, including drug overdoses and alcohol overdoses, where it is clear that the self-harm was intentionally inflicted. All individuals who are alive on admission to hospital following a deliberate act of self-harm are included. Not considered deliberate self-harm are accidental overdoses, e.g. an individual who takes additional medication in the case of illness, without any intention to self harm; alcohol overdoses alone, where the intention was not to self-harm; accidental overdoses of street drugs (drugs used for recreational purposes),

without the intention to self harm; and individuals who are dead on arrival at hospital as a result of suicide.

In 2005 new **Prison Rules** were introduced, dealing with all aspects of prison life, including accommodation, visiting rights, discipline, health and education (Department of Justice Equality and Law Reform 2005). They also provided for the introduction of compulsory or mandatory drug testing (MDT) of prisoners. Section 28 (5) (a) of the Rules states: 'In the interest of good order, safety, health and security and in accordance with directions set down by the minister, a prisoner ... shall, for the purpose of detecting the presence or use of an intoxicating liquor or any controlled drug ... provide all or any of the following samples, namely – urine, saliva, oral buccal transudate, hair.'

## 4.2 Prevalence and incidence estimates of PDUs

### 4.2.1 Indirect estimates of problem drug use

#### Problem opiate users in Ireland

An opiate is a drug containing opium or any of its derivatives which acts as a sedative and narcotic. Examples include heroin, methadone, morphine, codeine, hydrocodone, oxycodone, fentanyl and tramadol. Heroin is synthesised from morphine, a naturally occurring substance extracted from the seed pod of the Asian opium poppy plant. Heroin is available in three forms – a white powder, a brown powder, or a black sticky substance, known as 'black tar heroin'.

In a repeat of a prevalence study in 2001 (Kelly, Alan, *et al.* 2003), Dr Alan Kelly and colleagues estimated the prevalence of problem opiate users in Ireland in 2006 using a three-source capture-recapture method (Kelly, Alan, *et al.* 2009a). The three data sources used were the Central Treatment List (of clients on methadone), the Hospital In-Patient Enquiry scheme and the Garda PULSE data.

Data from the three sources indicated that there were 11,807 opiate users aged 15–64 years known to services in Ireland in 2006, and an estimated 8,983 users not known to the services (hidden population) (Table 4.2.1.1). These data were presented in Standard Tables 7 and 8 in 2009. The national prevalence estimate of opiate users in 2006 was between 18,136 and 23,576; the point estimate was 20,790 (Table 4.2.1.2). This estimate is likely to be inflated. The respective rates per 1,000 of the 15–64-year-old population in Dublin and in the rest of Ireland are 17.6 and 2.9. These estimated figures are likely to be inflated because the population was not closed, that is, it continued to recruit significant numbers of people into treatment (in Dublin and outside Dublin) and police custody (outside Dublin) in 2006. In addition, the overlap between the three population sources was small. These two factors are known to inflate estimates obtained by the capture-recapture method. Twenty-eight per cent (5,886) of the estimated number lived outside Dublin and 72% (14,904) lived in Dublin.

**Table 4.2.1.1 Number of opiate users known, estimated number hidden, prevalence estimate and population rate in Ireland, in Dublin and in the rest of Ireland, 2006**

	Age group	Known number	Estimated number hidden	Estimated prevalence	Rate/1,000 population
Ireland	15–64	11,807	8,983	20,790	7.2
Dublin	15–64	9,442	5,462	14,904	17.6
Rest of Ireland	15–64	2,365	3,521	5,886	2.9

Source: Kelly *et al.* (2009)

**Table 4.2.1.2 Estimated prevalence of opiate use in Ireland, in Dublin, and in the rest of Ireland, 2001 and 2006**

	2001				2006			
	Estimate	Lower bound	Upper bound	Rate/1000 population	Estimate	Lower bound	Upper bound	Rate/1000 population
Ireland	14,681	13,405	15,819	5.6	20,790	18,136	23,576	7.2
Dublin	12,456	11,519	13,711	15.9	14,904	13,737	16,450	17.6
Rest of Ireland	2,225	1,934	2,625	1.2	5,886	4,399	7,126	2.9

Source: Kelly *et al.* (2003, 2009)

The national point estimate increased by 42%, from 14,681 in 2001 to 20,790 in 2006. The point estimate for Dublin increased by 20%, while the point estimate for the rest of Ireland increased by 165% – albeit from a low estimate in 2001. The rate of opiate use per 1,000 of the 15–64-year-old population living outside Dublin increased from 1.2 in 2001 to 2.9 in 2006.

Table 4.2.1.3 shows the 2006 estimate by age, gender and place of residence. Seventy-one per cent were male. One in five (21%) was between 15 and 24 years old and half (51%) were between 25 and 34 years old. In Dublin, the rate of opiate use per 1,000 of the 15–24-year-old female population decreased by 62%, from 18.7 in 2001 to 7.2 in 2006, which indicates that the number of younger women commencing opiate use has decreased. A smaller but still notable decrease in the rate of opiate use in Dublin was seen among males aged 15–24 years.

In an unpublished study, Kelly and colleagues report that retaining opiate users in treatment reduces their likelihood of being in contact with the Gardaí (Dr A Kelly, personal communication). For example, only 12% of males aged 25–34 years who were known to the Gardaí in 2001 and were attending treatment services between 2001 and 2006 were reported to be committing crime in 2006. This is in line with findings from the ROSIE study and indicates that methadone treatment reduces the incidence of crime.

**Table 4.2.1.3 Prevalence estimate by age, gender and place of residence, 2006**

Gender	Age group	Ireland	Dublin	Rest of Ireland
All	15–64	20,790	14,904	5,886
Males	15–64	14,787	10,395	4,392
	15–24	3,150	1,892	1,258
	25–34	7,238	5,172	2,066
	35–64	4,399	3,331	1,068
Females	15–64	6,003	4,509	1,494
	15–24	1,159	701	458
	25–34	3,298	2,605	693
	35–64	1,546	1,203	343

Source: Kelly *et al.* (2009)

### Research on data sources and methods

The NACD is commissioning research into methods and data sources which can be used to estimate the number of problem opiate and cocaine users and the prevalence of problematic opiate and cocaine use in Ireland. The objectives of the study are to:

- determine indirect statistical approaches to estimating numbers and rates of problematic opiate and cocaine users in Ireland,
- identify statistical or practical adaptations that would improve the reliability of the current capture-recapture estimate,
- identify all data sources in Ireland, which can be used in the estimation of the prevalence of problematic opiate and cocaine use and using a systematic approach evaluate their potential for use, and
- design pilot studies to test the preferred approaches.



The NACD will be able to estimate the number of problem cannabis and alcohol users from the general population survey on drug use 2010/11 (Jean Long, NACD committee member, 2010).

### **Health Information Bill**

The Department of Health and children (DoHC) launched a public consultation on a health information bill in June 2008. The response was very positive in terms of the number and quality of submissions. The DoHC has now prepared a thematic synopsis document setting out the main points raised. With regard to public opinion on a unique personal identifier for individual health records and health-related information systems, there was general support but many commentators (including the Data Protection Commissioner) recommended that this identifier should not be the PPSN used for taxation and social welfare purposes. It was also recommended that confidentiality and privacy be protected in any new system (Department of Health and Children, *et al.* 2009).

As part of its commitment to the consultation process and in line with the philosophy of engaging with individuals in Your Service, Your Say,<sup>6</sup> the DoHC in conjunction with the Health Service Executive (HSE) and the Health Services National Partnership Forum, held a consultative workshop on 20 January 2009. Once again there was general support for a unique identifier in health-related records but many people had reservations about the use of the PPSN (without specific protections) as the identifier, principally because of linkages fears.

### **4.2.2 Estimates of incidence of problem drug use**

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

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

#### **4.3.1 National registry of deliberate self-harm annual report 2009**

The annual report of the National Registry of Deliberate Self-Harm contains information on every presentation of deliberate self-harm to hospital emergency departments in 2009, giving complete national coverage of hospital-treated deliberate self-harm (National Registry of Deliberate Self Harm Ireland 2010).

In 2009, there were 11,966 presentations of deliberate self-harm, involving 9,493 individuals, to emergency departments. The rate of presentations increased from 200/100,000 of the population in 2008 to 209/100,000 in 2009, a 5% increase. Repeat presentations accounted for more than one in five (21%) of all presentations. The biggest rise in the number of presentations was observed in men, with a 10% increase on the 2008 figure. The 2008 figure was itself an 11% increase on the number of men presenting with self harm in 2007.

For the first time, the report details and maps the incidence of male and female deliberate self-harm by HSE local health office (LHO) area of residence. This, the authors hope, will raise awareness of the problem of deliberate self-harm among LHO primary and community care service providers. Limerick LHO area had the highest male rate and the second highest female rate. Cork North Lee and Louth LHO areas had high rates of deliberate self-harm for men only. Four of the eight Dublin LHO areas (Dublin North Central, Dublin West, Dublin South West and Dublin North West) were

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<sup>6</sup> The Office of Consumer Affairs has responsibility for developing and implementing best-practice models of customer care within the HSE and promotes service user involvement throughout the organisation through the concept of 'Your Service Your Say'.

associated with high rates of deliberate self-harm for both men and women. In contrast, the incidence of male and female self-harm was low in Dublin South East and Dun Laoghaire.

Concordant with previous reports, deliberate self-harm was largely confined to the younger age groups. Almost half (45%) of all presentations were by people aged under 30 years. Among females, those aged 15–19 years were most likely to present with deliberate self-harm. The increase in male presentations was observed in several age groups. The rate among men aged 20–24 years increased by 21%. There was also an increase in the number of 10–14-year-olds presenting.

Drug overdose was the most common form of deliberate self-harm, occurring in 71% of all episodes reported in 2009. Overdose rates were higher among females (78%) than among males (64%). On average, at least 31 tablets were taken in episodes of drug overdose. The total number of tablets taken was known in 74% of cases. Forty-two per cent of all drug overdoses involved a minor tranquilliser, 29% involved paracetamol-containing medicines and 21% involved anti-depressants/mood stabilisers. The number of deliberate self-harm presentations involving street drugs increased by 26% in 2009 (from 461 in 2008 to 579).

There was evidence of alcohol consumption in 41% of all episodes of deliberate self-harm and this was more common among men (45%) than women (37%). Alcohol may be one of the factors underlying the pattern of presentation by time of day and day of week. Presentations peaked in the hours around midnight and almost one-third occurred on Sundays and Mondays.

Attempted hanging was involved in 608 of all deliberate self-harm presentations (7% of men and 3% of women). This is the highest number of attempted hangings recorded by the Registry, and was 18% higher than in 2008. Self-cutting was used in one in five cases (22%) and significantly more often by men (25%) than by women (19%).

The emergency department was the only treatment setting for 44% of all deliberate self-harm patients, that is, they did not proceed to further treatment.

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

- provide increased support for evidence-based prevention and mental health promotion programmes;
- develop and implement initiatives to increase awareness of mental health issues among the general public and service providers supporting the unemployed or people experiencing financial difficulties;
- develop a system to enable deliberate self-harm data to be linked with suicide mortality data to enhance insight into predictors of suicide risk;
- restrict access to minor tranquillisers as they are the most common type of medication involved in intentional acts of drug overdose;
- increase awareness among addiction service professionals and service users of the risk of suicidal behaviour related to drug abuse;
- enhance health service capacity at specific times and increase awareness of the negative effects of alcohol misuse and abuse, such as increased depressive feelings and reduced self-control;
- consideration should be given by LHOs to the development of response plans and intervention programmes related to suicidal behaviour;
- minimum guidelines for the assessment of deliberate self-harm patients should be implemented by the HSE in line with the guidelines of the National Institute for Clinical Excellence in the UK;
- provide uniform psychosocial and psychiatric assessment to all self-harm patients, paying particular attention to patients using highly lethal methods; and

- prioritise national implementation of evidence-based treatments shown to reduce risk of repetition, such as cognitive behavioural, dialectical behavioural and problem-solving interventions.

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

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

###### **Head shop compounds abuse amongst attendees of the Drug Treatment Centre Board**

The use of 'head shop' compounds has received much media attention lately, but there is very little research with regard to the extent of the usage of these substances among the drug-using population in Ireland. A study to examine the extent of the usage of Mephedrone, Methylone and BZP was undertaken among attendees at methadone maintenance programmes at the Drug Treatment Centre Board (DTCB) (MacNamara, *et al.* 2010). Two hundred and nine samples were tested. The results showed significant use of the compounds, with 29 (13.9%) samples tested being positive for Mephedrone, 7 (3.3%) positive for Methylone and 1 (0.5%) positive for BZP.

###### **Homeless problem drug users' experiences of head shop products**

Carol Murphy and colleagues (Murphy, *et al.* 2010) presented an abstract of their survey, displayed as a poster titled 'Head shop bath salts – not good clean fun', at the College of Psychiatry of Ireland's spring meeting on 25 March 2010. This survey sought to estimate the extent, and describe the experience, of 'bath salts' use among problem drug users living in a hostel for homeless people in Dublin city centre. Nurses or key workers administered a questionnaire to a random sample of 20 clients during December 2009, of whom 17 participated in the survey. The researchers found that:

- Twelve of those surveyed had tried bath salts on at least one occasion.
- Some of the 12 had tried more than one product; 10 had taken 'Snow'; five had taken 'Blow'; three had taken 'Vanilla Sky'.
- The 12 respondents either snorted or injected the products.
- Ten respondents had experienced a rush or euphoria similar to that after using cocaine, ecstasy or crystal methamphetamine.
- The products were cheaper than cocaine.
- The unwanted side effects included difficulty in sleeping, anxiety, agitation, hallucinatory experiences and paranoia.
- The 'come down' was associated with agitation, depression and paranoia.

###### **Drug-using sex workers**

A large-scale qualitative study has highlighted the need for adequately-resourced support structures to reduce the risk of harm to drug-using sex workers in Ireland. The first of its kind, this study by the NACD (Cox and Whitaker 2009) explored the local risk environment within which drug-using sex workers in Dublin live and work. The authors concluded that wider social and situational factors, such as poverty, housing, health, educational needs and employment prospects, are as important to reducing risk of harm in this vulnerable group as addressing drug use.

In-depth interviews were conducted with 35 drug users currently or formerly engaged in sex work, and biographical, drug use and offending behaviour data were collected by means of brief questionnaires. In addition, interviews were held with 40 professionals across the community, voluntary and statutory sectors whose work either directly or indirectly impacted on drug-using sex workers. This intensive, qualitative approach revealed that there was a range of behaviours associated with drug use and its accompanying lifestyle which placed individuals at particular risk of harm.

For the most part, participants in the study grew up in communities associated with social and economic marginalisation and high levels of unemployment. They moved more or less continuously through drug and alcohol services, homeless hostels, the

judicial system and other social care agencies. Participants used a range of strategies to reduce danger, but their perception of risk was relative to their situation, thus leading them to treat some risks as acceptable or necessary. Current harm reduction interventions tend to focus on individual risk behaviour, often overlooking the wider social context in which members of this group live and work.

Arising from analysis of the research, the NACD recommended:

- continued and adequate funding of existing services that deal with this client group;
- expansion of outreach services (particularly out of hours) to target existing and developing street sex markets, and development of peer outreach to areas of the city with known networks of drug-using sex workers;
- continued funding of programmes (such as specialist Community Employment (CE) schemes for drug users) aimed at getting drug users back to work;
- provision of flexible hostel accommodation for drug-using sex workers who are homeless, ranging from low-threshold facilities to accommodation that assists recovery and rehabilitation; and
- recognition of the role of drug services in identifying male and female clients involved in sex work and in providing advice on safer sex practices in order to reduce sexual risk in personal intimate relationships and commercial sex transactions.

In terms of policy, the authors recommended that 'harm reduction be explicitly stated as a guiding principle of the new National Drugs Strategy' (p.26), and that the strategy outline a continuum of harm-reduction activities, a 'model package' of interventions, minimum standards for services and optimal levels of service coverage.

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

Information on drug testing in prisons in 2009 was obtained from the Irish Prison Service. These data indicate that more than 28,000 voluntary tests were carried out to monitor drug use and responses to treatment in 2009. These tests included those carried out on some committals (new entries) as well as those carried out on existing inmates. It may be assumed therefore that some of the positive test results relate to drugs or alcohol consumed outside the prison.

Excluding methadone, between one-tenth and two-fifths of those screened tested positive for at least one drug. The common metabolites detected indicate use of cannabis, benzodiazepines and opiates (Table 4.4.1.1). It is not clear whether the number of positive cases excludes prisoners who were prescribed benzodiazepines; if they do not, these figures overstate the extent of unregulated use of benzodiazepine in prisons. Cocaine, amphetamines and alcohol were detected in a small number of tests. The profile of positive opiate and benzodiazepine tests indicates moderate use of such drugs among prisoners tested in Mountjoy, Wheatfield and Portlaoise prisons. A moderate number of women tested positive for benzodiazepines in the Dóchas Centre. The proportion of positive tests was very low in St Patrick's Institution and in the Training Unit. It would be useful if the test results of prisoners who were tested at committal interview could be removed from this analysis as this would provide a more accurate assessment of drug use in Irish prisons.

**Table 4.4.1.1 Number of drug tests, by prison, and number (%) of positive tests, by prison and by drug type, 2009**

Prison	No. of tests	Cannabis (%)	Benzodiazepines (%)	Methadone (%)	Opiates (%)	Cocaine (%)	Amphetamines (%)	Alcohol (%)
Mountjoy Male	<b>6102</b>	2661 (44)	2717 (45)	5148 (84)	3519 (58)	46 (0.8)	1 (0.02)	28 (0.5)
Mountjoy Medical Unit	<b>4366</b>	679 (16)	664 (15)	2018 (46)	667 (15)	7 (0.2)	3 (0.07)	7 (0.2)
Dóchas Centre	<b>2491</b>	450 (18)	1214 (49)	2045 (82)	557 (22)	53 (2)	4 (0.2)	21 (0.8)
Training Unit	<b>2607</b>	24 (0.9)	15 (0.6)	1 (0.04)	38 (1.5)	0 (0)	1 (0.04)	4 (0.2)
Wheatfield	<b>4131</b>	1303 (32)	1229 (30)	3664 (89)	1499 (36)	12 (0.3)	2 (0.04)	16 (0.4)
Cloverhill *	<b>2328</b>	290 (12)	414 (18)	1604 (69)	389 (17)	43 (2)	3 (0.1)	36 (2)
St. Patrick's Institution	<b>1312</b>	105 (8)	66 (5)	158 (12)	16 (1)	1 (0.1)	0 (0)	6 (0.5)
Castlereagh	<b>126</b>	33 (26)	33 (26)	23 (18)	36 (29)	1 (0.8)	1 (0.8)	2 (1.6)
Loughan House	<b>486</b>	157 (32)	88 (18)	4 (0.8)	44 (9)	2 (0.4)	5 (1)	5 (1)
Shelton Abbey	<b>770</b>	150 (19)	55 (7)	3 (0.4)	15 (1.9)	7 (0.9)	1 (0.1)	10 (1.3)
Limerick	<b>695</b>	120 (17)	236 (34)	593 (85)	176 (25)	2 (0.3)	3 (0.4)	4 (0.6)
Cork	<b>165</b>	26 (16)	18 (11)	0 (0)	3 (2)	0 (0)	1 (1)	1 (0.6)
Midlands	<b>2529</b>	400 (16)	551 (22)	2287 (90)	908 (36)	15 (0.6)	3 (0.1)	27 (1)
Portlaoise	<b>107</b>	31 (29)	39 (36)	59 (55)	32 (30)	2 (1.9)	0 (0)	0 (0)
Arbour Hill	<b>27</b>	3 (11)	2 (7)	1 (4)	1 (4)	1 (4)	1 (4)	0 (0)

\*Results for Cloverhill exclude all committals; those for all other facilities include some committals.

Source: Irish Prison Service, unpublished data, 2010

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

##### **Alcohol use among opiate users in methadone treatment**

Ryder and colleagues (Ryder, *et al.* 2009) estimated that 35% (95% CI = 28%–41%) of a sample of current or former heroin users attending general practice for methadone treatment were problem alcohol users, and that 14% of the sample were dependent users. According to data from the NDTRS, 24% of opiate users entering opiate treatment reported alcohol as an additional problem drug, which is lower than the estimate presented here.

The authors surveyed 196 patients, which represented 8% of those on the Central Treatment List. A random sample of 634 patients on the CTL was originally selected but of these, 358 were not invited to participate in the study because their GP declined to take part. This resulted in a smaller sample of 276 patients. In the event, only 71% (196) of the randomly-selected patients whose GPs agreed to participate took part. This final sample represented just 31% of the original random sample from the CTL. The response rate was lower than desired – an indication of the difficulty that can be associated with doing research among patients attending private general practitioners in Ireland.

The survey questionnaire included the Alcohol Use Disorders Identification Test (AUDIT) to assess participants' alcohol use. The questionnaire also collected data on socio-demographic, medical and substance use characteristics. The median age of the 196 participants was 32 years, 68% were male, 79% said that they had used one or more illicit drugs in the previous month, and 76% had ever injected drugs. Of those who knew their blood-borne viral status, 55% said that they were hepatitis C positive and 5% said that they were HIV positive. Other research indicates that self-reported

hepatitis C and HIV status can both over- and under-estimate the prevalence of these infections and should be interpreted with caution.

The cases classified as problem alcohol users were significantly more likely to have attended a local emergency department in the previous year and less likely to have attended a hospital clinic in the previous year compared to those who were not problem alcohol users. Among the 107 respondents who reported that they were hepatitis C positive, those who were problem alcohol users were significantly less likely to have attended a specialist hepatology clinic than those who were hepatitis C positive but were not problem alcohol users.

The authors concluded that problem alcohol use has a high prevalence among current or former heroin users attending primary care for methadone treatment, and that interventions that address this issue should be explored as a priority.

## 5. Drug-Related Treatment: treatment demand and treatment availability

### 5.1 Introduction

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

The **Health Service Executive (HSE)**, which manages Ireland's public health sector, provides an addiction service, including both illicit drugs and alcohol, delivered through Social Inclusion Services, which is part of its Integrated Services Directorate. Addiction treatment services are provided through a network of statutory and non-statutory agencies. Some of the principal non-statutory agencies include:

The **Ana Liffey Drug Project (ALDP)** is a 'low threshold - harm reduction' service, based in north inner city Dublin. The project works with people, experiencing addiction, to minimise the harm that problematic drug use causes them, their families and the wider community. In 2007, ALDP recorded a total of 3,267 client visits to the project.

**Coolmine Therapeutic Community** provides a comprehensive range of programmes designed to support and empower individuals and communities affected by alcohol and drugs. It was one of the first dedicated rehabilitation centres offering a range of vital support services to people all over Ireland.

**Cuan Mhuire** is a registered charity offering a comprehensive, structured, abstinence-based, residential programme to persons suffering from alcohol, other chemical dependencies and gambling in Ireland. Approximately 2,500 people are treated for addiction in its centres every year.

**Inchicore Community Drugs Team** is a community-based drug addiction service, offering locally-based supports including assessment for treatment on methadone programme, counselling, holistic healing, personal development courses and group work. It offers drop-in, outreach service and community work, prison links worker, family support and youth outreach services, and a children's project.

**Merchants Quay Ireland (MQI)** is a voluntary organisation, based in South Inner City Dublin, which provides a wide range of services to homeless people and drug users. In 2009, MQI worked with over 5,000 drug users and people who were homeless.

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

In 1998 a **Methadone Treatment Protocol (MTP)** was introduced, to ensure that treatment for opiate misuse could be provided wherever the demand exists. New regulations pertaining to the prescribing and dispensing of methadone were introduced, and a joint Health Board/Irish College of General Practitioners (ICGP) committee was formed to provide training, ongoing education and regular audit for general practitioners (GPs) taking part in the programme. Under this protocol, any GP wishing to take part in the provision of treatment services to drug users, must undertake training as provided

by the ICGP. Under the MTP, GPs are contracted to provide methadone treatment at one of two levels – Level 1 or Level 2. Level 1 GPs are permitted to maintain methadone treatment for misusers who have already been stabilised on a methadone maintenance programme. Each GP qualified at this level is permitted to treat up to 15 stabilised misusers. Level 2 GPs are allowed to both initiate and maintain methadone treatment. Each GP qualified at this level may treat up to 35 misusers. Practices where two Level 2 GPs are practising are permitted to treat up to 50 misusers. Locally-based methadone treatment for opiate misusers is now provided through drug treatment clinics, satellite clinics or through GPs in the community.

Under the **Community Pharmacy Contractor Agreement** the HSE can agree with individual pharmacies to dispense methadone mixture DTF1mg/ml to opiate dependent persons in their local areas on a special methadone prescription form. The involvement of community pharmacists in the dispensing of methadone also ensures that a large number of opiate dependent persons may be treated in their own local areas.

The **Irish Prison Service (IPS)** has a comprehensive drug treatment clinical policy document (Irish Prison Service 2008). It contains an extensive section on methadone treatment, outlining the background and rationale for methadone treatment, as well as the clinical management of a prisoner on methadone and the logistics of dispensing. The document also outlines the processes necessary for methadone treatment – whether a prisoner is already on methadone on admission, or treatment is to be initiated in prison, and for planned release of a prisoner on methadone. Issues around blood-borne viruses, including testing, clinical management and immunisation, are also addressed. The document states that the misuse of benzodiazepines is an endemic problem in the Irish prison population and recommends policies and guidelines around assessment of dependence, prescribing and detoxification.

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

The **National Drug Treatment Reporting System (NDTRS)** is a national epidemiological database which provides data on treated drug and alcohol misuse in Ireland. The NDTRS collects data from both public and private outpatient services, inpatient specialised residential centres and low-threshold services. For the purposes of the NDTRS, treatment is broadly defined as ‘any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their substance misuse problems’. The NDTRS is a case-based, anonymised database. The NDTRS is co-ordinated by staff at the Health Research Board (HRB) on behalf of the Department of Health and Children. The number of drug treatment services participating in the NDTRS continues to increase (Standard Table TDI 34). Although treatment is provided within the Irish Prison Service, it was only in 2009 that counsellors working in the prison service began to return information to the NDTRS.

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

The **Research Outcome Study in Ireland (ROSIE)** was the first prospective study of treatment outcomes for opiate users to be conducted in Ireland. The objective was to evaluate the effectiveness of treatment and other intervention strategies for opiate use. The study recruited 404 opiate users entering treatment between September 2003 and June 2004. Three treatment modalities, provided through both inpatient and outpatient settings, were the focus of attention – methadone maintenance, structured detoxification, and abstinence-based treatment programmes. In addition, a sub-sample



of individuals was recruited from needle exchange interventions. Participants were interviewed at treatment intake, or as soon as possible thereafter, and again at 6 months, 12 months and 3 years after the baseline interview. Data were collected by means of a structured interview. The interview instrument contained a comprehensive set of outcome measures detailing the social and psychological characteristics of the cohort, and a range of treatment process factors in relation to treatment outcomes. Between September 2006 and October 2008 seven papers in the ROSIE Findings series, concentrating on particular aspects of the study, were published; in June 2009 a report on outcomes at 1-year and 3 years for the whole population and the 'per protocol' population, i.e. participants who completed all three interviews, was published (Comiskey, Catherine M, *et al.* 2009).

## 5.2 Strategy/policy

### 5.2.1 HSE National Service Plan 2010

The HSE National Service Plan 2010 (NSP) sets out the agency's plans in the drugs and alcohol area for 2010 (Health Service Executive 2010). On foot of the HSE's Transformation Programme (see Section 5.3.1 below), a key focus for the HSE in 2010 has been to integrate the recommendations in the national drugs and homeless strategies into the provision of mainstream health services, and to put in place a national framework for rehabilitation in addiction services (see Table 5.2.1.1).

**Table 5.2.1.1 HSE's key result areas and deliverables in relation to illicit drugs, 2010**

Key result area	Outputs 2009	Deliverables 2010	Due
Implementation of the National Drugs Strategy (NDS) 2009–2016	Input into preparation of NDS completed and strategy launched	National rehabilitation framework in place	Q2
	Planning undertaken for implementation of HSE components	National liaison pharmacist appointed	Q1
	Rehabilitation Co-ordinator appointed	Harm reduction and treatment services further developed, including needle-exchange and methadone services	Q1
	National Drug Rehabilitation Implementation Committee established Recruitment of national liaison pharmacist under way National Addiction Training Programme (NATP) developed from pilot stage		
Development of National Substance Misuse Strategy		Input into development of National Substance Misuse Strategy completed (co-led by Department of Health and Children)	Q4

Source: NSP (2010: 43–44)

Regarding drug treatment, in 2010 the HSE planned to increase its level of activity and performance as follows:

- Average number of clients in methadone treatment per month per area: in 2009 the HSE exceeded by 136 its target of having an average of 7,636 clients in methadone treatment per month per area; it plans to maintain this increased level of throughput in 2010, i.e. 7,762 clients in methadone treatment per month per area. In prisons, the HSE set a target of an average of 612 clients in methadone treatment per month in 2009; however, the projected outturn came in 115 below this target and the HSE adopted this lower figure of 497 as the target for 2010.
- Number of substance misusers under 18 years of age for whom treatment, as deemed appropriate, commenced within one calendar month: in 2009 the percentage of substance misusers under 18 years of age for whom appropriate treatment was commenced within one calendar month exceeded the target of 88%, reaching 97%. For 2010 the HSE set its sights even higher, aiming to commence

appropriate treatment within one calendar month for 100% of drug treatment clients aged under 18 years.

- Number and percentage of substance misusers for whom treatment, as deemed appropriate, commenced within one calendar month: in 2009, 81% (1,365) of substance misusers aged 18 years and over entered appropriate treatment within one month, which was 3% below the target of 1,406 set for the year. In 2010, the HSE anticipated that 1,380 substance misusers would seek treatment for drug misuse and it aimed to ensure that 100% of these clients would commence appropriate treatment within one calendar month.

## **5.2.2 Community and voluntary organisations**

### **Strategic review and planning process in LDTFs**

In 2007/08 local drugs task forces (LDTFs) completed a strategic review and planning process, undertaken at the invitation of the National Drugs Strategy Team (NDST). The object of the exercise was to identify the needs in LDTF areas in relation to drug misuse, to contribute to the 'renewal' of LDTFs by enabling the sharing among all agencies and sectors of a clear strategic focus, and to help inform the choice of future drug strategies. The following summarises the findings of an unpublished analysis of the reports furnished to the NDST by the 13 LDTFs (Foran 2008).

#### **Community profiles**

The LDTFs identified a number of common themes indicating continuing social deprivation in their areas, including levels lower than the national average of educational attainment and higher levels of unemployment, local authority housing and lone parent households than the national average. They also outlined how local settlement patterns appeared to be affecting their work. LDTF catchment areas contained neighbourhoods experiencing deprivation interspersed with neighbourhoods experiencing 'significant advantage': this presented challenges for targeting services effectively. Certain LDTFs had seen the 'gentrification' of their areas: this had led to heightened feelings of isolation and marginalisation among some of the original residents.

#### **Nature and extent of drug use**

The LDTFs reported that heroin was still the primary drug of misuse. However, there had been a significant increase in the use of cocaine, alcohol and prescription drugs. In line with this expansion, the incidence of polydrug use had also increased. With regard to users, the LDTFs highlighted the much higher drug-use prevalence among males than females. They drew attention to the increased drug use among non-Irish and Traveller communities, and among the homeless. They also noted the increased prevalence of blood-borne viral infections and the relationship between drug misuse and mental health. These patterns of drug use raised challenging issues with regard to the design and delivery of effective drug-related services.

#### **Gaps in services**

A range of gaps in service provision was highlighted by the LDTFs, including:

- services accessible to non-national communities
- childcare services for clients wanting to attend treatment and rehabilitation services
- drug services catering exclusively for the needs of young drug users
- prevention initiatives for people in the early stages of drug use
- services for people misusing alcohol
- supply reduction initiatives at local level.

#### **Strategic priorities**

The role of the LDTFs is to prepare action plans that will ensure the implementation of the national drugs strategy at local level. The LDTFs identified strategic priorities under the pillars of the 2001–2008 national drugs strategy following its mid-term review, including the following:

- Research: develop a comprehensive monitoring and evaluation system to measure the effectiveness of drug projects; encourage projects piloting new programmes and evaluate them on a regular basis; and conduct locally-based research projects.
- Prevention: refocus prevention work to take into account peer processes, family support and community development, e.g. increase early intervention programmes in pre-school and early primary school years, with a special focus on children of drug users and children of families in difficult circumstances.
- Treatment and rehabilitation: adopt the continuum of care approach to meeting the needs of clients, and develop an appropriate range of treatment and rehabilitation services for young people (aged 12–18 years), e.g. develop a separate strategy for under-18s, or pilot psychosocial support projects for under-18s in collaboration with the HSE.
- Supply reduction: support existing anonymous ‘dial to stop drug dealing’ initiatives and establish similar schemes in LDTF areas where they do not exist; hold community information evenings to exchange information, network and build and develop partnerships between the gardaí, the community and drug-related services.
- Family support and co-ordination: establish training in strengthening families for all workers, and put in place early intervention initiatives to build capacity within families; develop policies and procedures to improve communication across the various groups and projects active within the LDTF areas.

#### Effectiveness of LDTF structures

LDTFs were generally positive about their role in introducing and supporting drug-related services and initiatives and were also confident that their structures and processes were functioning effectively. The management of mainstreamed projects, and the ongoing role and responsibility of LDTFs with regard to these projects, was raised as an issue. In parallel, some LDTFs highlighted the limited input and in some cases lack of interest on the part of statutory services regarding the task force process, and lack of clarity about their own roles on the LDTFs. Strategic priorities included:

- increasing the profile and understanding of the work of the LDTFs in the community through the development of comprehensive communication strategies,
- facilitating the involvement of people affected by drug addiction in the work of the task forces by supporting the establishment of service-user forums, and
- developing key performance indicators and systems to monitor progress and inform future development across programmes.

#### LDTF strategic plan

The Dublin 12 Local Drugs Task Force *Strategic Plan 2009–2013* was launched in May 2009 (Dublin 12 Local Drugs Task Force 2009). The plan is the product of extensive consultation with stakeholders in the catchment areas of Crumlin, Drimnagh, Kimmage and Walkinstown in Dublin city. The aims and objectives of the new strategy include:

- Treatment: continue to develop the cross-task force harm reduction/needle exchange service and increase collaboration between drug treatment and alcohol services.
- Rehabilitation: lobby for a rehabilitation/integration service (RIS) and increased rehabilitation options, and develop forums and networks such as the D12 Service Users Forum.
- Education: consolidate and develop interventions aimed at young people at risk, develop links with schools and provide accredited addiction studies courses locally.
- Supply control: work towards implementing initiatives such as the Joint Policing Committees and the Dial to Stop Drug Dealing campaign, and develop the Community Safety Partnership with the Gardaí and other community stakeholders.
- Research: strengthen data collection systems, commission local research to inform service planning, and participate in national-level studies.
- Family-support: re-establish family support groups and support the development of child care facilities for drug-using families.
- Alcohol: develop a plan to address alcohol misuse, identify local alcohol services and form stronger relationships with them.

### **Therapeutic community strategic plan**

Coolmine Therapeutic Community (CTC) launched its strategic plan for 2009–2011 in September 2009 (Coolmine Therapeutic Community 2009). Recent developments in Coolmine reflect the community's continuing commitment to the provision of a continuum of care, and to a vision of recovery which emphasises an enhanced quality of life rather than mere abstinence from drugs. The chief executive's overview lists Coolmine's achievements of note under the 2006–2008 strategy:

- creation of formal client consultation and participation structures,
- initiation of a stabilisation day-programme for active drug users in partnership with other service providers,
- establishment of clinical governance structures and procedures, including the creation of a limited detoxification service within its residential facilities,
- provision of full-time staff cover in residential facilities,
- reduction in the length of stay in all three residential facilities to an average of six months,
- change of institutional culture and styles at Ashleigh House to reflect the fact that the facility caters for mothers and children,
- provision of five community aftercare houses to facilitate clients who have completed primary treatment programmes,
- establishment of a part-time career guidance and counselling service and enhanced use of the Community Employment scheme to benefit clients,
- completed refurbishment of two of its main facilities and commencement of work on the third, and
- creation of an improved fundraising strategy.

The new strategy identifies two key objectives:

1. To consolidate and develop existing quality services,
  - establish an advisory group to ensure clinical governance, ongoing training and best practice is achieved,
  - increase resources and training to ensure that existing programmes are accessible to a greater range of people,
  - develop a volunteer programme and foster stronger links with external service providers, and
  - develop strategic partnerships with a number of housing providers to ensure that clients have the best opportunities for accommodation.
2. To build a strong and sustainable organisation,
  - complete capital works,
  - improve internal communications structures, and implement an effective IT strategy,
  - develop an external communications strategy to raise Coolmine's profile and to aid fundraising efforts, and
  - explore potential development opportunities at Coolmine Lodge site for housing units or a residential detoxification unit.

### **Community drug team strategic plan**

The Inchicore Community Drug Team (ICDT) launched its strategic plan for 2010–2012, *Taking stock and moving forward*, in April 2010 (Inchicore Community Drug Team 2010). The vision set out in the strategic plan is 'that all those living with drug addiction in Inchicore will have access to a holistic addiction service locally'.

Six strategic goals are identified:

- to provide a safe environment where people affected by drug addiction can explore in a non-judgemental way the issues affecting their lives,
- to promote opportunities for individuals to move out of the cycle of drug addiction,
- to develop opportunities for children and young people to reach their full potential,
- to identify gaps in service provision and initiate local responses,

- to promote a better understanding of how the drug problem affects the local area, and to increase the community's awareness of drug issues, and
- to develop ICDT structures, roles and responsibilities in accordance with the strategic plan.

The plan outlines a number of actions to be undertaken by ICDT:

- develop a minimum service level for those on low-threshold programmes,
- develop a needle exchange in Inchicore in partnership with the Canal Communities Local Drugs Task Force and the HSE,
- develop holistic interventions in response to drug-use trends among service users,
- develop programmes to meet the needs of children aged 10–14 years who have outgrown the Children's Project,
- develop an inter-agency youth programme targeted at those involved in drug dealing,
- establish a working group and develop a local strategy in response to benzodiazepine dependency,
- establish an inter-agency response to meet the mental health needs of service users,
- develop a family welfare forum in conjunction with local agencies, with the aim of improving the quality of life of children living in vulnerable families, and
- develop the ICDT website and publish a regular newsletter.

## **5.3 Treatment systems**

### **5.3.1 Organisation and quality assurance**

#### **HSE Addiction Services**

The HSE's Drug and Alcohol Services are delivered as part of the HSE's Social Inclusion Services (SIS), which also include homeless services, services for minority ethnic communities, Traveller health services, community development, HSE RAPID and CLAR programmes, HIV/STI services, services for LGBT communities, and community welfare services. SIS was part of the Primary Community and Continuing Care (PCCC) directorate. However, in late 2009, as part of its Transformation Programme, the HSE merged the PCCC directorate and the National Directorate for Hospitals into a single national Integrated Services Directorate (ISD). This directorate has responsibility for the delivery, reconfiguration, performance and financial management of all health and personal social services, including drug and alcohol services. A Quality and Clinical Care Directorate has also been established. This directorate is intended to strengthen clinical leadership and improve clinical performance, as well as support the working relationship between clinicians and managers across the organisation; the participation of clinicians in the management process is regarded as a key driver of service development at national, regional and local levels. Responsibility for implementation of this process lies with the Integrated Services Directorate (ISD) (Health Service Executive 2010).

#### **National Quality Standards framework**

The NDS includes two actions under the heading 'Treatment and Rehabilitation – Quality and Standards Framework'. They are:

- Action 45: Develop a clinical and organisational governance framework for all treatment and rehabilitation services, in line with the Report of the Working Group Examining Quality & Standards for Addiction Services, and subject to a timeframe for compliance given the resource implications involved.
- Action 46: Develop a regulatory framework on a statutory basis for the provision of counselling within substance misuse services.

The HSE has lead responsibility for implementing Action 45, in collaboration with the voluntary sector. Work is under way and development of a framework is expected to be completed by the end of 2010. The Department of Health and Children (DoHC) has

lead responsibility for Action 46, in collaboration with the HSE. The DoHC is in the process of registering twelve health and social care professional grades under the Health and Social Care Professionals Act 2005. However, given the importance of having a robust regulatory framework in place for substance misuse counsellors, this category of counsellor is not included in this first tranche, and further work is planned.

### **Primary medical care in Irish prisons**

Between November 2007 and February 2008, primary health care provision was assessed in 11 out of the 14 prisons in Ireland (Barry, *et al.* 2010). The independent assessment used a checklist based on the Competence Assurance Exercise in General Practice, which includes items such as state of premises, equipment, contracted hours, time allocation and support staff.

The report found that the medical facilities in six prisons were unsuitable (many had been built in the 19<sup>th</sup> century) but refurbishment was planned for some of them. In general, the standard of medical equipment was not at the same level usually available in Irish general practice outside the prison services. However, it should be noted that there is no international benchmark for the type, quality or quantity of essential medical equipment for prison medical facilities. The number of patients a doctor saw per hour varied between 3.7 and 18.7, depending on the facility. Much of this time was taken up with committals and transfers of prisoners. At the time of the assessment, seven prisons that took part in the study provided methadone maintenance treatment. The study also found that most medical facilities did not have a medical secretary. The authors stated that medical secretaries would increase the efficiency of the medical units.

The authors suggested that the IPS should consider adopting the UK strategy, whereby the Department of Health has responsibility for health care in the UK prison system, and proposed the HSE take responsibility for delivering health care in the IPS.

### **General clinical audit for the Methadone Treatment Protocol**

The findings of the general clinical audit of the operation of the Methadone Treatment Protocol (MTP) between July and December 2009 were summarised in the *Methadone Treatment Protocol Newsletter* (Irish College of General Practitioners 2010). The audit found the most common issues requiring a review were: vaccination and virology, record keeping, and supervision of dispensing. The newsletter gave examples of discrepancies between the standard expected and the actual practice among a small proportion of the GPs who participate in the MTP scheme, and suggested ways to improve practice in these areas.

- On transfer from Level 1 to Level 2 doctors, not all clients had their virology screening or vaccination completed, as required by the MTP. In some cases, screening or vaccination history was not documented.
- In relation to record keeping, in some cases transfer summaries were difficult to find or were missing, and not every consultation record was complete.
- In some cases where at least one supervised dose per week in the pharmacy was the expected standard, no request for such supervision was found in the file. In some cases, 'supervised dispensing did not appear to be responsive to clinical conditions', for example in failing to provide for increased supervision if a client appeared to be destabilising.

### **International quality improvement award**

Cuan Mhuire, which has provided detoxification and residential rehabilitation services in Ireland since 1966, has won the prestigious CHKS Quality Improvement Award 2010 (Carey, Pat 2010). This international award recognises significant improvements in patient care and patient experience, as well as in staff welfare, safety and morale. Candidate institutions are evaluated by experts representing medical and nursing colleges, healthcare associations and national quality institutes. It is the first time that this award has been given to a rehabilitation service. Speaking at the award ceremony

in London in May, Cuan Mhuire founder Sister Consilio Fitzgerald said: 'This Award shows how vocationally driven organisations such as Cuan Mhuire can deliver cost-effective services with the highest possible standards of care. The intrinsic value of each human being before God demands no less than our committed love.'

### 5.3.2 Availability and diversification of treatment

#### Merchants Quay Ireland annual review, 2008

Merchants Quay Ireland (MQI) published its annual review for 2008 in September 2009 (Merchants Quay Ireland 2009). MQI's needle-exchange service recorded that the number of client visits in 2008 remained steady at just under 40,000; however, almost 1,000 of those visits were by new clients. The report also highlighted a continuing high level of demand for homeless services, with a 4% increase in the number of meals provided for homeless people. There was a decrease in the numbers seeking help from MQI's primary health care services, resulting from a decision to limit the number of attendees and give adequate time to those presenting.

In 2008 MQI completed the implementation of a national prison-based addiction counselling service to 13 prisons and was providing in excess of 1,000 counselling hours per month and working with 440 prisoners. With the support of the Vodafone Ireland Foundation, MQI expanded its family support service, to include a confidential helpline, counselling, support groups and drug education awareness for families. In late 2008 MQI in association with the Midland Regional Drugs Task Force introduced the Midlands Family Support and Community Harm Reduction Service, providing outreach and working with families of those actively using drugs.

**Table 5.3.2.1 Types of service offered by MQI, the numbers of people accessing them, and the outcomes, 2008**

Service	Type of intervention	No. of participants	Outcomes
Needle-exchange and health-promotion services	Promoting safer injecting techniques	Not available	Not available
	HIV and hepatitis prevention	(1,000 new clients)	
	Safe sex advice	904	
	Information on overdose	Not available	
Stabilisation services	Methadone substitution	20	Not available
	Supportive day programmes	Not available	Not available
	Gateway programme	Not available	Not available
	Counselling	382	Not available
Settlement service	Assist service users to access interim and long-term accommodation	34 (monthly average)	Not available
Integration programmes	Access to transitional accommodation Ballymount House and Athlone for up to 24 weeks	15	11 clients moved to longer-term accommodation
	Group and one-to-one therapeutic sessions	Not available	Not available
Training and work programmes	FÁS Community Employment scheme	124	32% secured permanent employment or moved to further education
High Park	17-week, drug-free residential programme including individual counselling, group therapy, educational groups, work assignments and recreational activities	59 (of whom 18 were admitted for detoxification)	14 completed detox
St Francis Farm	Therapeutic facility offering a 6–12-month programme	29	14 completed three months or more

Source: Merchants Quay Ireland, 2009

## **Drug and alcohol use in the Midland region**

The Midland Regional Drugs Task Force commissioned a study in order to establish an evidence base regarding drug-related issues in the Midland region to inform the development of appropriate response strategies (Lyons, Suzi, *et al.* 2010b). The study used information from several different sources, including national drug prevalence data, the National Drug Treatment Reporting System and the Central Statistics Office. Interviews and focus groups were also conducted with key informants (e.g. service providers, drug users, family members) in four selected communities in the region.

Many of the issues identified were common to all four communities and could be generalised to the whole of the Midland region. The report highlights these issues and makes the following recommendations:

- Expand and improve existing addiction services to cope with increasing numbers of individuals requiring treatment for drug and alcohol problems.
- Facilitate access to addiction services by reducing waiting lists and by addressing issues of distance and adequate transportation when locating new or expanded services.
- Expand harm reduction programmes and set up additional ones as needed.
- Improve access to methadone treatment and reduce waiting lists by increasing the number of GPs providing methadone in the community and by expanding and improving existing services.
- Improve access to detoxification, rehabilitation and aftercare services in line with the recommendations of the report of the HSE Working Group on Residential Treatment and Rehabilitation (O'Gorman and Corrigan 2008).
- Address problem alcohol use in a more comprehensive way, not only by providing adequate treatment facilities but also by adopting broader strategies, including education, increased taxation and regulation.
- Address the lack of adequate services for under-18s by providing adolescent-specific services offering a complete, integrated range of services, in line with the recommendations of the Department of Health and Children (Working Group on treatment of under 18 year olds 2005).
- Improve drug awareness education for all age groups.
- Reduce drug-related deaths by using strategies such as providing education in overdose prevention and training in basic life support.
- Provide social reintegration services to recovering and former drug users through accommodation, re-training and employment supports.
- Evidence of drug crime, such as drug markets, was found in the region. A partnership approach involving all the key stakeholders is one strategy to tackle this problem.

## **Nurse prescribing in addiction services**

In 1998 An Bord Altranais, the nursing board, which is the regulatory body for the nursing profession in Ireland, recommended that nurse prescribing be introduced in Ireland (An Bord Altranais 2000). Internationally, this practice has been found to improve the quality of patient care when used in appropriate circumstances. The advantages of nurse prescribing in addiction services include increased access to services for clients, improved continuity of care, reduced waiting times and improved quality of service and care (Gallagher, *et al.* 2006).

In May 2007, the Minister for Health and Children signed the legislation to provide the legal authority for nurses and midwives to prescribe medication: Irish Medicines Board (Miscellaneous Provisions) Act 2006 (Commencement) Order 2007 (SI No. 194 of 2007), Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2007 (SI No. 201 of 2007) and Misuse of Drugs (Amendment) Regulations 2007 (SI No. 200 of 2007).

Prospective nurse prescribers must complete an approved six-month course and adhere to a set of practice standards and competencies for prescribing. In addition, An



Bord Altranais requires any health facility employing nurse prescribers to have certain support structures in place. Currently, nurse prescribers cannot prescribe methadone. However, they can, where appropriate, prescribe certain controlled drugs under specific conditions of the Misuse of Drugs Regulations, including drugs for the purpose of midwifery, such as pethidine, or drugs for palliative care, such as morphine sulphate.

In December 2009 two nurses working at the Drug Treatment Centre Board graduated as the first nurse prescribers in addiction in Ireland (Drug Treatment Centre Board 2009).

### **Nursing in the Irish Prison Service**

Nurses first began working in the Irish Prison Service (IPS) in 1999. The IPS and the Nursing and Midwifery Planning and Development Unit (NMPDU) of the HSE Eastern Region collaborated in a recent study exploring the opportunities for the development of nursing services in prisons (Nursing and Midwifery Planning and Development Unit & Irish Prison Service 2009).

The study included a literature review of the role of nurses in prison healthcare, a descriptive review of the IPS and the professional framework for nursing in Ireland, and a quantitative questionnaire completed by nurses and medical orderlies working in the IPS (32% response rate). The qualitative components were participant observation and semi-structured interviews with key informants, including prison management and those internally and externally involved in prison healthcare. Focus groups were held with three groups of nurses and three groups of prisoners. Data collection took place between November 2005 and December 2007.

The findings of the study covered a wide range of health and professional issues, but only the results related to substance misuse and addiction are repeated here. In the quantitative questionnaire, care related to substance misuse featured among the 14 most frequently performed clinical tasks, and was carried out on a daily basis by 50% or more of respondents. More than half of the nurse respondents identified addiction as one of the areas where specialist training should be developed.

In the qualitative part of the study, participants highlighted addiction and its consequences as an important healthcare problem. Participants reported that cannabis, benzodiazepines and heroin were the most common illicit substances used in prisons, although availability varied between prison sites. While methadone maintenance treatment was available in most prisons, the need for improved treatment for problem use of other substances, in particular benzodiazepines and alcohol, was raised by many participants. Treatment for addiction was reported to be inconsistent, with a lack of counselling services,<sup>7</sup> and there was 'some confusion in relation to approaches to detoxification, methadone dose and access to treatment' (p. 82). Most participants reported a need for improved education and training in addiction care for nurses. Prisoners also highlighted the need for peer support and improved discharge planning in relation to addiction care.

Mental health problems among prisoners, especially those who had a dual diagnosis (both a mental health issue and a substance use disorder), were identified as a significant and challenging health issue by all participant groups.

The authors concluded that nurses have a very important role in addressing the health needs of prisoners. They found that there was a strong awareness of the importance of prison healthcare and that nurses did receive recognition and support from all the stakeholders involved. However, they also found that nurses could be used more effectively within the IPS.

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<sup>7</sup> Since 2008 Merchants Quay Ireland has provided national prison-based addiction counselling services to 13 prisons.

The report set out 16 goals for the future development of prison nursing and healthcare in Ireland, each with its own set of recommendations. The authors stated that many of the associated recommendations did not require additional resources or funding, but restructuring and integration of existing services and resources and effective collaboration at all levels. The goals include:

- enhance the strategic development of prison healthcare,
- identify and meet prisoner health needs,
- develop and implement policies, procedures, protocols and guidelines,
- develop nursing role including role definition, advance capacity for specialist and advanced nursing practice, and advance skills and competencies,
- develop professional development infrastructure,
- support practice within the Scope of Nursing and Midwifery Practice Framework,
- enhance quality and governance,
- develop workforce planning,
- strengthen nursing practice with regard to access, and committal assessment and care planning,
- balance the therapeutic and custody roles,
- develop prison healthcare infrastructure, and
- implement recommendations through collaborative working by healthcare staff in partnership with prison management.

### **Inpatient treatment of opiate dependence**

A study published in 2010 (Smyth, *et al.* 2010) examined the factors associated with lapse and relapse. (A lapse was defined as any misuse of an opiate after discharge, and a relapse as a return to a pattern of daily opiate use.) The study was a prospective follow-up study of opiate users who had been admitted to an Irish residential detoxification facility between June 1995 and December 1996. Follow-up interviews were conducted by outreach workers between June 1998 and March 1999.

Of the 109 participants, 99 (91%) reported a relapse. Within the first week of discharge, 72 (66%) had lapsed and 64 (59%) had relapsed. Only 42 (32%) of those recruited had completed the full six-week programme.

The study identified several factors independently associated with early relapse: being aged 20 to 24, having a partner who had not used opiates, history of injecting drug use, using 1.5 to 3 'quarters' (a quarter-gram bag of heroin) per day, and failure to complete treatment or enter aftercare (Table 5.3.2.2).

**Table 5.3.2.2 Factors independently associated with early relapse following inpatient treatment\***

Characteristic	Odds ratio	95% CI	P value
<b>Age</b>			
Under 20	1.0		
20 to 24	0.5	0.3 – 0.8	0.007
25 and over	0.6	0.4 – 1.1	0.11
<b>Status of partner/spouse</b>			
Partner has history of opiate use	1.0		
Partner has not used opiates/no partner	1.7	1.0 – 2.7	0.04
<b>Quantity of heroin used</b>			
Up to 1.5 'quarters' per day	1.0		
1.5 to 3 'quarters' per day	2.2	1.2 – 3.9	0.008
More than 3 'quarters' per day	1.4	0.7 – 2.5	0.3
<b>Imprisonment</b>			
Never in prison	1.0		
In prison	1.4	0.9 – 2.3	0.15
<b>History of injecting drug use</b>			
No injecting	1.0		
Injecting previously	1.8	1.0 – 3.3	0.05

Characteristic	Odds ratio	95% CI	P value
<b>Type of discharge</b>			
Planned	1.0		
Unplanned	2.6	1.6 – 4.4	<0.001
<b>Aftercare</b>			
None	1.0		
Commenced aftercare	1.7	1.1 – 2.8	0.03

\*Identified by multivariate analysis using the Cox proportional hazards model.

Source: Smyth *et al.* (2010)

This study, based on data collected in the late 1990s, found that lapse and relapse occurred very soon after opiate detoxification: 80% of participants had lapsed within the first month. The study findings are similar to those of international studies based on more recent data. The authors recommended that clients be provided with improved psychological supports before and after entering residential opiate detoxification, for example encouraging clients to remain for the full treatment period, improving relapse prevention supports, especially during the first week after discharge, and providing prompt access to aftercare.

### Regulating administration of suboxone

The Department of Health and Children has commissioned an independent agency to evaluate the Suboxone feasibility study (see chapter 5.3.2 of National Report 2009 for an account of the feasibility study). The scope of the evaluation is to:

- conduct an audit using a recognised audit tool,
- evaluate the processes – how clients were recruited, prescribing and dispensing practices and the practical operation of the study,
- identify the core elements of the regulatory framework needed for safe and appropriate use of Suboxone in the Irish setting, and
- ascertain the views of patients, prescribers and pharmacists.

The results of the evaluation are expected in late 2010.

### Opiate users entering a detoxification programme

An Irish study was conducted to determine the outcome and factors influencing outcome among a cohort of drug users commencing detoxification from opiate use (Mullen, *et al.* 2010, 21 February. Published online). This was a national cohort study of randomly-selected opiate users commencing methadone detoxification treatment in 1999, 2001 and 2003 (n=327). The study found that 25.6% (n=62) of opiate users had a successful detoxification within 3 months, which was the criterion of success set by the authors. Receiving some inpatient treatment as part of a detoxification programme resulted in completion by 56% of drug users compared to completion by 21% of drug users undergoing treatments as outpatients. The factors found to be independently influencing detoxification were having some inpatient treatment (AOR 5.9, 2.63–13.64), and never having injected (AOR 2.25, 1.20–4.25).

An additional 31 (9%) opiate users had a detoxification between 3 months and 1 year and 27 (8%) moved into methadone maintenance. The authors concluded that having some inpatient treatment increases the likelihood of a successful opiate detoxification within three months. They recommended that offering opiate detoxification early in a drug-using career, i.e. during pre-injecting drug use, should be considered for suitable and motivated patients.

### Community detoxification

The Progression Routes Initiative carried out an evaluation of a community detoxification pilot project which commenced in 2007 (Lyons, S 2008). They conducted a survey of those involved in the project in December 2009. Not all services who participated in the pilot participated in the evaluation, so it may not be a true representation of the programme.

Since the start of the programme, out of the 29 individuals who started the programme, 16 engaged fully with it. Seven successfully completed the programme and a further seven were still engaged at the time of the evaluation (Caroline Gardiner, Progression Routes Initiative, personal communication).

Requests for detoxification were for heroin, methadone, codeine and benzodiazepines. The majority of clients (14) were self-referrals. Of the 7 clients who started a methadone detoxification, 2 had successfully completed, 3 were still engaged and 2 had left the programme. Of the 9 clients who started a benzodiazepine detoxification, 5 had successfully completed the programme and 4 were still engaged.

Overall, key workers (9) had a positive response to the programme, although insufficient communication and support from the GP was identified as an issue. All the service users (6) who participated in the evaluation stated that they would recommend the programme to a friend and would be willing to go through the programme again, if necessary. They reported high satisfaction levels with the support provided by their key workers. Of the three doctors who responded, two reported that they would participate in the programme again.

### **Self-detoxification**

Exploratory research, using a grounded theory approach, was undertaken to describe opiate users' experiences of self-detoxification (McDonnell and Van Hout 2010). Twenty-one in-depth interviews (n=12 heroin users, n=9 drug service providers from the statutory, community and voluntary sectors) were analysed. The study generated a substantive theory of self-detoxification as a subjective process of seeking heroin abstinence. Self-detoxification emerged as a frequent and reactive or proactive process in collaboration with others (heroin users, family and drug service providers). The authors suggested that this study has implications for drug service delivery in rural Ireland by increasing information provision and access to opiate detoxification through the development of low threshold services and community-based detoxification.

### **A guide to case management in the area of homelessness and drug use**

The Homeless Agency and Progression Routes Initiative have published a case management guidebook for those working with clients who are homeless, many of whom have drug and alcohol misuse problems (Homeless Agency Partnership and Progression Routes Initiative 2010). The book is intended as a companion to the Holistic Needs Assessment and Care Plan, the assessment tool developed by the Homeless Agency. The book and its accompanying protocols were piloted among those working with the homeless, and their feedback was incorporated into the final document. The online version of the guide will be updated as necessary to ensure that the information is up to date.

There are three sections in the guidebook: key support interventions, interagency protocols and a listing of services. Among the 12 chapters on key support areas are chapters on mental health, alcohol use and drug use. These three chapters are summarised here. (See Chapter 8.3.1 for a brief description of the interagency protocols.)

#### **Mental health**

Chapter 9 covers how to access mental health services, with a section on dual diagnosis (including both addiction and mental health problems). The role of the service provider outlined in the document is to make appropriate referrals, either to a GP or to the psychiatric services (within the addiction services). Other areas covered include how to make an application for involuntary admission to psychiatric care on behalf of a person deemed to be a risk to themselves or others, dealing with exclusion from the drug services because of mental health issues, and non-compliance with medication.

The second part of the mental health chapter deals with suicide and deliberate self-harm, and how the service provider should handle such issues. The association between mental health problems and suicide is well known, and although self-harm is not necessarily associated with suicide, it is an indicator of mental health issues.

#### Alcohol use

Chapter 10 cites evidence that alcohol, frequently combined with drugs, may be the most widely-misused substance among homeless people. The key interventions identified are access to detoxification and access to rehabilitation and supports. This chapter also deals with the issue of a service user who is misusing alcohol while on prescribed methadone. The guide advises that in cases of polysubstance use an alcohol detoxification should be carried out before an opiate detoxification, but that problem use of cocaine or amphetamines may have to be addressed before that of either alcohol or opiates. Any interventions should be made with the support of the prescribing doctor, with aftercare in place, along with a relapse prevention plan, including social support from family and friends.

#### Drug use

Chapter 11 outlines key interventions in drug treatment services, stressing that they should be seen as a continuum of care across services. The interventions are: harm reduction services, methadone treatment, stabilisation services, detoxification, rehabilitation (day and residential), aftercare and support services. Some of these interventions are described below.

#### Harm reduction

The book states that, as many problem drug users start injecting before accessing formal drug treatment, it is important that the service provider ensures that clients have access to harm reduction information and services in order to reduce drug-related harm. Such resources may be accessed through a client's own service or by referral to another appropriate service. This section summarises the types of intervention typically provided by harm reduction services.

#### Methadone treatment

This section gives the service provider an overview of the issues around methadone treatment, including assessment, changing a prescription, take-aways and polydrug use. It includes practical advice, for example what documentation the client needs when attending an assessment of suitability for treatment.

#### Stabilisation services

Stabilisation in this context is taken to mean compliance with a methadone treatment programme. This process requires the support of different services, such as counselling, relapse prevention or day programmes, to assist and support the client. This section outlines some of the different options and how to access them.

#### Detoxification

In general, a person must be on a reduced daily dose of between 40mg and 60mg of methadone in order to qualify for residential detoxification, according to this book. The criteria for other facilities vary, for example some require the person to be alcohol free or benzodiazepine free before entry. Inpatient facilities give priority to medical emergency cases (the nature of the emergency is not specified), and to people who are pregnant or are under the age of 18. While benzodiazepine detoxification can be carried out by a GP or by the doctor prescribing methadone, the guidebook notes that doctors are not obliged to carry out such detoxification in the community.

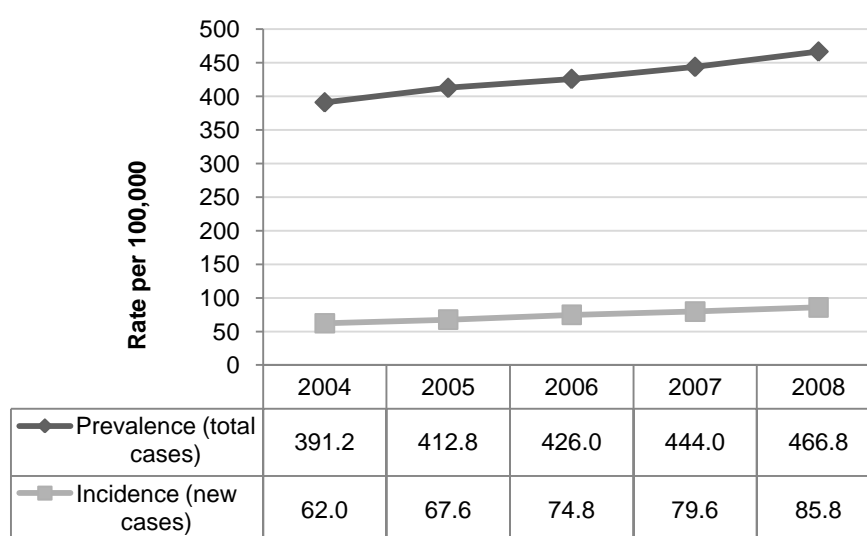
## **5.4 Characteristics of treated clients (TDI data included)**

### **5.4.1 Treated problem drug use in Ireland, 2008**

Figures from the NDTRS for treated problem drug use in Ireland in 2008 were analysed by HSE area of residence (Carew, A.M. 2010b). Some of the main results are noted below.

In total, 14,518 cases were treated in 2008, of whom 6,576 entered treatment in that year. The majority of cases attended outpatient services.

New cases entering treatment are an indirect indicator of recent trends in problem drug use. The incidence of treated problem drug use among 15–64-year-olds living in Ireland, per 100,000 of the population, increased from 79.6 in 2007 to 85.8 in 2008 (Figure 5.4.1.1). The prevalence of treated problem drug use among 15–64-year-olds living in Ireland, per 100,000 of the population, increased by 5%, from 444 in 2007 to 466 in 2008.



**Figure 5.4.1.1 Incidence and prevalence of treated problem drug use among 15–64-year-olds, per 100,000 population, 2004–2008**

Source: Carew AM, 2010

An opiate (mainly heroin) was the most common main problem drug reported by cases entering treatment. Alcohol was reported as an additional problem substance in 41.4% of all treated cases. The majority of cases treated in 2008 reported problem use of more than one substance (70.0%), which was almost 3% higher than the 2007 figure. Cannabis (40.7%) and cocaine (36.8%) were the two most common additional problem drugs reported in 2008. The proportion of cases treated for benzodiazepines as an additional problem substance increased by 7.5% between 2007 and 2008. Polysubstance use increases the complexity of these cases, and is associated with poorer treatment outcomes.

In total, 561 new injector cases entered treatment in 2008, an increase of 88 cases on the 2007 figure. More than two in five of these cases were still injecting on entry to treatment, and 43% reported sharing injecting equipment, a decrease on the 2007 figure.

Many problem drug users in treatment are young and male, have low levels of education and are unlikely to be employed.

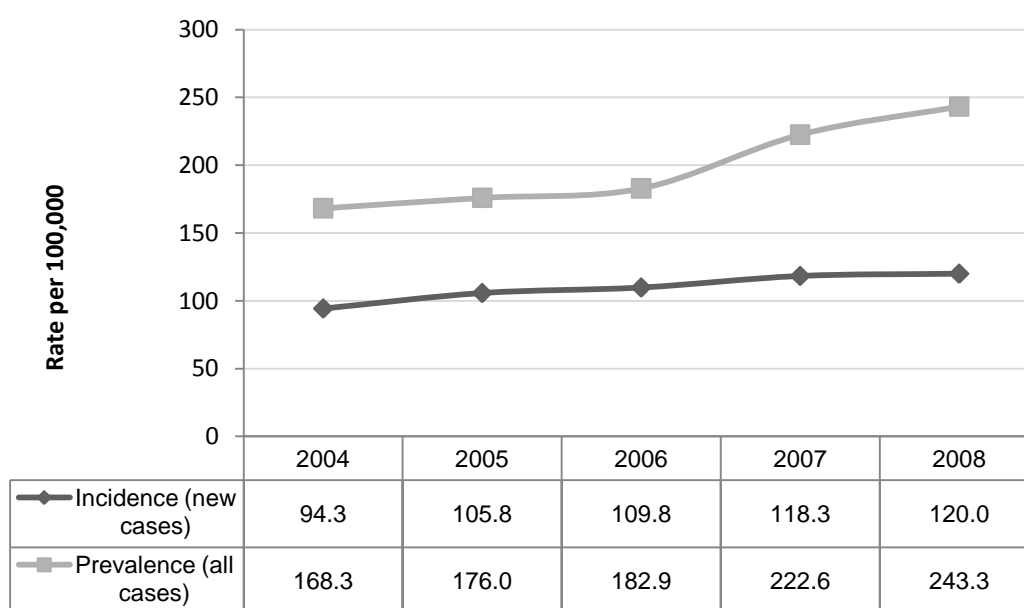
Over 14% of new cases and more than 3% of previously treated cases in 2008 were aged under 18 years, a slight increase on the 2007 figure in both cases. The proportion of new cases in employment decreased by more than 5% between 2007 and 2008. For further information please see Standard Table 24.

### Treated problem alcohol use in Ireland, 2008

Figures from the National Drug Treatment Reporting System (NDTRS) for treated problem alcohol use in Ireland in 2008 were analysed by HSE area of residence (Carew, A. M. 2010a). Some of the main results are:

In total, 7,940 cases were treated for problem alcohol use in 2007, an increase of 628 on the 7,312 cases treated in 2007. This may be attributed to an increase in the number of people presenting for treatment, or it may reflect the increase in the number of treatment centres participating in the NDTRS in 2008.

The incidence of treated problem alcohol use among 15–64-year-olds living in Ireland, expressed per 100,000 of the population, increased from 118.3 in 2007 to 120.0 in 2008 (Figure 5.4.1.2). The prevalence of treated problem alcohol use among 15–64-year-olds living in Ireland, expressed per 100,000 of the population, increased from 222.6 in 2007 to 243.3 in 2008 (Figure 5.4.1.2). These increases in incidence and prevalence may be explained by an increase in problematic alcohol use in the population, an increase in reporting to the NDTRS, or a combination of both.



**Figure 5.4.1.2 Incidence and prevalence of treated problem alcohol use, among 15–64-year-olds, 2004–2008**

Source: Carew AM, 2010

Almost one in five of those treated for problem alcohol use in 2008 also reported using at least one other substance, a similar proportion to that observed in 2007 and 2006. In 2008, the most common additional drugs used by treated alcohol cases were cannabis, cocaine, ecstasy and opiates. This ranking reflects a minor change since 2007, when benzodiazepines were the fourth most common additional drug. Use of more than one substance increases the complexity of cases and leads to poorer outcomes for the patient. Information about combinations of substances used is important in terms of individual clients' care plans.

In 2008, the median age at which both new and previously treated cases began drinking was 16 years, similar to previous years.

The age profile of cases treated for problem alcohol use was the same in 2007 and 2008. The median age for all treated cases was 39 years; for new cases, the median age continued to be younger (36 years). While the proportion of cases under the age of 18 remained small, the number of new cases in that age group continued to rise. The

majority of those treated for problem alcohol use were male, with low levels of employment.

#### **5.4.2 Substance misuse in the HSE South Eastern Area**

The HSE South published a report *Data co-ordination overview of drug misuse 2008* in August 2009 (Kidd 2009). The report comprises sections relating to treatment services, substance-related offences and cases dealt with by the Probation Service in the HSE South Eastern Area, comprising counties Carlow, Kilkenny, Tipperary South, Waterford and Wexford.

The section on treatment services analyses data collected from statutory and voluntary drug and alcohol treatment agencies, acute general hospitals and psychiatric hospitals in the HSE South Eastern Area.

The total number of individuals seeking treatment in 2008 was 2,686, a decrease of 265 on the 2007 figure. Some 60 concerned persons (family members or close friends of substance users) contacted treatment services in the south east in 2008.

The combined total of continuous care clients and new referrals who were treated was 2,376. Of these:

- 68% were male and 32% were female.
- 13% were under the age of 20, and 41% were aged between 20 and 34.
- Alcohol was the most common main problem substance for which treatment was sought (62%), followed by heroin (12%), cannabis (11%), and cocaine (5%). Cannabis, which had been second in this ranking for a number of years, was overtaken by heroin in 2008.
- The numbers seeking treatment for alcohol and cannabis have decreased annually from 2007. Up to 2007, cocaine figures were rising, but the numbers seeking treatment for cocaine decreased in 2008. The numbers seeking treatment for heroin, MDMA, amphetamines and volatile inhalants increased.

A total of 1,972 clients exited the services in 2008. Less than half (44%) of these clients completed treatment; 27% refused further sessions or did not return for subsequent appointments; 13% did not wish to attend further sessions as they considered themselves to be stable; 11% were transferred to another site for further treatment; 4% exited because of non-compliance; 1% exited for other reasons; and 0.6% died.

The client's condition on discharge was classified by service providers as stable if they had responded to treatment, and unstable if they had not responded. Of the 1,972 cases analysed, 1,347 (68%) were stable on exit from the services, 597 (30%) were unstable, the condition of 17 (0.9%) was classified as 'not known' and 11 (0.6%) had died.

### **5.5 Trends of clients in treatment (incl. numbers)**

#### **5.5.1 Solvent and volatile inhalant use in Ireland**

See Chapter 2.3.7 for an outline of the legal situation with regard to solvents and inhalants in Ireland, an overview of the types of substances that are available and the most recent data on volatile inhalant use prevalence in Ireland.

NDTRS data relating to treated volatile inhalant users shows that the numbers who entered treatment in the years 2003–2007 and reported solvents or volatile inhalants as their main problem substance ranged between 24 and 32, with a total of 137 for the five-year period. The vast majority (112) of these cases were entering drug treatment for the first time. Just over half (53%) were male and four-fifths were aged 17 years or under. Only 13% lived in Dublin (possibly an indication of service availability in Dublin) and 70% were still in school. The vast majority (97%) were Irish. The solvents or volatile inhalants most commonly reported as the main problem substance were



solvents (reported by 78 cases), nitrites (by 16), petrol (by 12) and butane (by 7), and the most common additional problem substances were alcohol and cannabis. In the same five-year period 164 cases reported solvents or volatile inhalants as an additional problem substance, of whom 106 were treated for the first time.

### **5.5.2 Alcohol usage and associated treatment outcomes for opiate users entering treatment in Ireland**

An Irish study published in 2010 looked at alcohol usage and associated treatment outcomes for opiate users entering treatment in Ireland (Stapleton and M 2010). Evidence has shown that frequency and quantity of drug usage are reduced after treatment but the effect of opioid addiction treatment on alcohol consumption remains unclear. Data on drug and alcohol use among the 404 opiate users recruited by ROSIE was analysed.

The analysis revealed that those who abstained from alcohol use at 3 years were less likely to be using heroin at 3 years than non-abstainers. In addition, those who abstained from alcohol use at 3 years were also less likely to be using methadone, benzodiazepines and cocaine at 3 years than alcohol users. Outcomes for medium and heavy drinkers were found not to be as good as alcohol abstainers. Finally, males tended to reduce the frequency and level of alcohol usage after entering treatment more frequently than females. Results demonstrated to clinicians that an alcohol strategy is a key component of opiate treatment planning and a comprehensive and regular assessment of the client's alcohol and drug use profile is essential if treatment interventions are to have maximum impact on outcomes.

## 6. Health Correlates and Consequences

### 6.1 Introduction

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

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

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

The **National Poisons Information Centre (NPIC)**, located in Beaumont Hospital, Dublin, provides a national telephone information service on the toxicity, features and management of cases of poisoning. This 24-hour service is offered mainly to doctors and other health care professionals. Queries are dealt with by poisons information officers at the Centre between 8 am and 10 pm daily, while out-of-hours calls are automatically diverted to the UK National Poisons Information Service (NPIS). Data from this source provide indications of the pattern of human cases of poisoning, including age, gender and agent.

The data collected by the **Primary Care Re-imbursement Service (PCRS)**, previously called the General Medical Services (GMS) Payments Board, are another source of information on the health correlates and consequences of problematic drug use among those who have medical cards, which are means-tested. Medical-card holders received certain health services, including approved prescribed drugs and medicines, free of charge up to December 2009 and since January 2010 for a minimal charge. Operated by the HSE, the PCRS administers payments to doctors, pharmacists and dentists who provide services under the PCRS scheme.

The **National Psychiatric In-Patient Reporting System (NPIRS)**, administered by the Health Research Board (HRB), is a national psychiatric database that provides detailed information on all admissions to and discharges from 56 inpatient psychiatric services in Ireland. It records data on cases receiving inpatient treatment for problem drug and alcohol use. NPIRS does not collect data on the prevalence of psychiatric comorbidity in Ireland. The HRB publishes an annual report on the data collected in NPIRS, entitled *Activities of Irish psychiatric units and hospitals*.

Problematic drug use can also 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 or incidental causes. Although illicit drugs are involved in many cases of drug-related death, licit (including prescribed) drugs are also frequently involved, either alone or in conjunction with an illicit drug. Alcohol has been reported as the third greatest risk factor for ill health and premature death in Europe. Established in 2005, the **National Drug-Related Death Index (NDRDI)**, which is maintained by the HRB, is an epidemiological database which records cases of death by drugs poisoning, and deaths among drug users in Ireland, extending back to 1998. The NDRDI also records data on alcohol-related deaths, deaths among alcoholics, and deaths from alcohol-related diseases, extending back to 2004.

The number of deaths as a result of poisoning fluctuated between 1998 and 2003; however, since 2003 the number of cases has risen from 107 cases to 169 cases in 2007. The rise is attributed to cocaine, opiates and/or poly-substance use.

The **Central Statistics Office (CSO)**, acting on behalf of the DoHC, compiles quarterly and annual statistical reports on deaths in the Irish population. These reports are based on administrative data supplied by the General Register Office. The principal variables collected include date of death, address of residence of deceased, place of death, underlying cause of death, occupation, age, sex, and marital status. Since 1 January 2007 the underlying cause of death has been coded according to ICD10 rather than ICD9.

For a description of the **National Registry of Deliberate Self-Harm**, see Section 4.1 above.

## 6.2 Drug-related infectious diseases

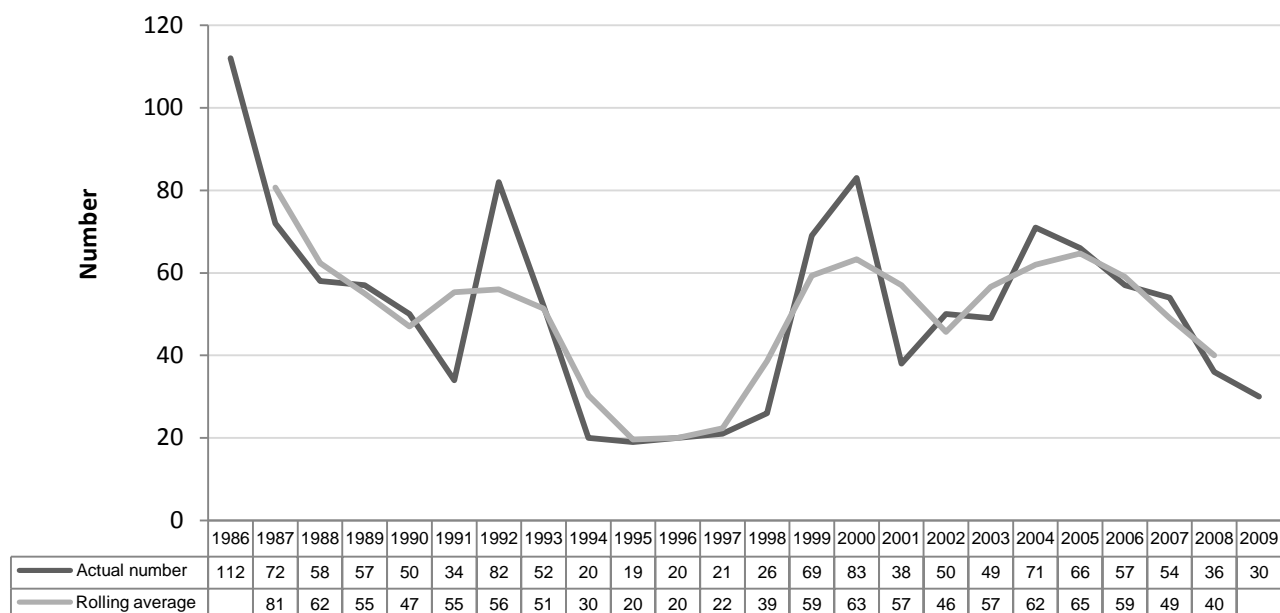
### 6.2.1 HIV/AIDS and viral hepatitis

#### HIV surveillance in 2009

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1985. According to the most recent report of the HPSC (Jackson, *et al.* 2010), at the end of 2009 there were 5,369 diagnosed HIV cases in Ireland, of which 1,417 (27%) were probably infected through injecting drug use.

Figure 6.2.1.1 presents the number of new cases of HIV among injecting drug users reported in Ireland, by year of diagnosis; data from 1982 to 1985 were excluded as these four years were combined in the source records. The number of HIV cases among injecting drug users fell between 1994 and 1998, with about 20 cases per year, compared to about 50 cases each year in the preceding years. There was a sharp increase in 1999 (69 new cases), which continued into 2000 (83 new cases). Between 2001 and 2009 there was an overall decline in the number of new injector cases (38, 50, 49, 71, 66, 57, 54, 36 and 30 respectively) when compared to 2000. It is difficult to interpret the trend owing to the relatively small numbers diagnosed each year, so a smoother curve (grey broken plot line in Figure 6.2.1.1) was calculated using a rolling centred three-year average. This curve presents a new baseline of between 40 and 60 cases each year since 2006 and a declining trend.

Of the 30 new HIV cases among injecting drug users reported to the HPSC in 2009, 24 were male and six were female, and the average age was 36 years (range 22–57). Nineteen of the 30 cases with a known address lived in the HSE Eastern Region (Dublin, Kildare and Wicklow). These data are presented in Standard Table 9.4.



**Figure 6.2.1.1 Actual number and rolling average number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland, 1986–2009**

Source: Unpublished data reported to DoHC, National Disease Surveillance Centre and HPSC

### Hepatitis B surveillance in 2009

Hepatitis B is a vaccine-preventable disease which is transmitted through contact with the 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 2006 and 2008 (Table 6.2.1.1). These data are presented in Standard Table 9.4. In 2009 the number decreased by 12% (from 931 to 820). Of the 820 cases in 2009, 647 had a chronic infection, 78 had an acute infection and the disease status of 95 cases was unknown.

The surveillance system has recorded risk factor data since 2004 and the percentage of cases notified to the HPSC that include data on risk factors increased from 31% in 2006 to 44% in 2009. In 2009 44% (358) of all cases had risk factor data reported, of whom ten (2.8%) reported injecting drug use as their main risk factor. The number of such cases remained consistently low between 2006 and 2009, indicating the effectiveness of routine administration of the hepatitis B vaccine.

**Table 6.2.1.1 Number (%) of acute and chronic hepatitis B cases reported to the HPSC, by risk factor status, 2006–2009**

	2006			2007			2008			2009		
	Acute	Chronic	Unknown	Acute	Chronic	Unknown	Acute	Chronic	Unknown	Acute	Chronic	Unknown
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
All cases	93 (11.5)	655 (81.2)	59 (7.3)	52 (6)	705 (82)	103 (12)	82 (8.8)	747 (80.2)	102 (11)	78 (9.5)	647 (78.9)	95 (11.6)
Cases with reported risk factor data	59 (63.4)	184 (28.1)	5 (8.5)	44 (84.6)	314 (44.5)	16 (15.5)	73 (89.0)	427 (57.2)	55 (53.9)	57 (73.1)	277 (42.8)	24 (25.3)
Of which:												
Injecting drug users	0 (0)	3 (1.6)	1 (2.0)	1 (2.3)	5 (1.6)	1 (6.3)	0 (0)	6 (1.4)	1 (1.8)	1 (1.8)	9 (3.2)	0 (0)
Cases without reported risk factor data	34 (36.6)	471 (71.9)	54 (91.5)	8 (15.4)	391 (55.5)	87 (84.5)	9 (11.0)	320 (42.8)	47 (46.1)	21 (26.9)	370 (57.2)	71 (74.7)
<b>Total</b>	<b>807</b>			<b>860</b>			<b>931</b>			<b>820</b>		

Source: Unpublished data from the HPSC

## Hepatitis C surveillance in 2009

Hepatitis C is one the most common blood-borne viral infections among injecting drug users and is transmitted through contact with the blood of an infected person. The main routes of transmission are mother-to-baby, unsafe injections, transfusion of blood and blood products, and unsterile tattooing and skin piercing. There were 1,255 cases of hepatitis C reported to the HPSC in 2009 (Table 6.2.1.2), compared to 1,527 cases in 2008. These data are presented in Standard Table 9.4.

**Table 6.2.1.2 Number of cases and notification rate per 100,000 population for hepatitis C, 2004–2009**

Year	Number of cases	Notification rate per 100,000
2004	1126	26.6
2005	1409	33.2
2006	1217	28.7
2007	1552	36.6
2008	1527	36.0
2009	1255	29.6

Source: Unpublished data from the HPSC

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 2009, 40% of newly reported hepatitis C cases had risk factor status reported (Table 6.2.1.3). As expected, the majority of these cases (70.9%) reported injecting drug use as the main risk factor. Four per cent 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, 2009).

**Table 6.2.1.3 Number (%) of hepatitis C cases reported to the HPSC, by risk factor status, 2007–2009**

Risk factor status	Hepatitis C		
	2007	2008	2009
Total number of cases	1552	1527	1255
Cases <i>with</i> reported risk factor data	662 (42.7%)	575 (37.7%)	506 (40.3%)
Of which:			
Injecting drug users	505 (76.3%)	442 (76.9)	359 (70.9)
Recipients of blood/blood products	31 (4.7%)	23 (4.0)	20 (4.0)
Other risk factors	90 (13.6%)	78 (13.6)	80 (15.8)
No known risk factor could be identified by patient or doctor	36 (5.4%)	32 (5.6)	47 (9.3)
Cases <i>without</i> reported risk factor data	890	952	749

Source: Unpublished data from the HPSC

In 2009, 83% of cases reporting injecting drug use as their main risk factor were notified by services in Dublin, Kildare and Wicklow (Table 6.2.1.4). Seventy-three per cent were male and 62% were under 35 years old.

**Table 6.2.1.4 Number (%) of hepatitis C cases who reported injecting drug use as their risk factor, by age, gender and place of residence, 2007–2009**

Risk factor status	Hepatitis C		
	2007	2008	2009
Total number of known injector cases	505	442	359
Gender			
Male	338 (66.9%)	316 (71.5%)	261 (72.7%)
Female	166 (32.9%)	124 (28.1%)	96 (26.7%)
Unknown	1 (0.2%)	2 (0.5%)	2 (0.6%)

Age

Risk factor status	Hepatitis C		
	2007	2008	2009
Mean	32.8	33.2	34.1
Median	31	31.5	33
Under 25 years	48 (9.5%)	45 (10.2%)	35 (9.7%)
25 to 34 years	284 (56.2%)	231 (52.3%)	189 (52.6%)
More than 34 years	171 (33.9%)	162 (36.7%)	134 (37.3%)
Age not known	2 (0.4%)	4 (0.9%)	1 (0.3%)
Place of residence			
Dublin, Kildare and Wicklow	448 (88.7%)	377 (85.3%)	299 (83.3%)
Elsewhere in Ireland	57 (11.3%)	65 (14.7%)	60 (16.7%)

Source: Unpublished data from the HPSC

### **The development of a qualitative RT-PCR assay for the detection of hepatitis C virus**

Real-time polymerase chain reaction (RT-PCR) represents a favourable option for the detection of hepatitis C virus (HCV). A real-time reverse transcriptase PCR (RT-PCR) assay was developed as a qualitative diagnostic screening method for the detection of HCV using the ABI PRISM® 7500 Sequence Detection System (Clancy, *et al.* 2008). A total of 650 serum samples were used for the development and optimisation of the RT-PCR assay. A further 200 samples were used in a clinical trial. All samples were collected from randomly selected patients attending the hepatology clinic in St James's Hospital, Dublin, Ireland.

The primers and probe were designed to target the 5'-untranslated region of the hepatitis C viral genome. A second heterologous probe assay was developed for the detection of the haemagglutinin gene of phocine distemper virus (PDV) and was used as an internal control. A semi-automated HCV extraction method was also implemented using the ABI PRISM™ 6100 Nucleic Acid PrepStation. The HCV assay was optimised as a qualitative singleplex RT-PCR assay with parallel testing of the target and internal control.

The assay results ( $n=200$ ) were compared to the COBAS AMPLICOR™ HCV Test v2.0 assay. The assay demonstrated a high rate of sensitivity (99%), specificity (100%) and an acceptable limit of detection (LOD) of 100 IU/ml. The development of a qualitative multiplex assay for the simultaneous detection of HCV and internal control indicates the same high rates of sensitivity and specificity. This sensitive real-time assay may prove to be a valuable method for the detection of HCV.

### **Proposed NACD and Irish Prison Service study to estimate the prevalence of drug use and blood-borne viruses in Irish prisons**

The National Advisory Committee on Drugs (NACD) is commissioning a study to

1. describe the nature, extent and pattern of consumption of different drugs among the prisoner population when in the community and when in prison;
2. describe methods of drug use, including intravenous drug use, among the prisoner population;
3. estimate the prevalence of blood-borne viruses among the prisoner population and to identify associated risk behaviours; and
4. measure the uptake of individual drug treatment and harm reduction interventions (including hepatitis B vaccination) when in the community and when in prison.

This study is being done to determine the need for drug treatment and harm reduction (including needle exchange) services in Irish prisons (Jean Long, personal communication, NACD committee member, 2010).

### 6.2.2 STIs and tuberculosis

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

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

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

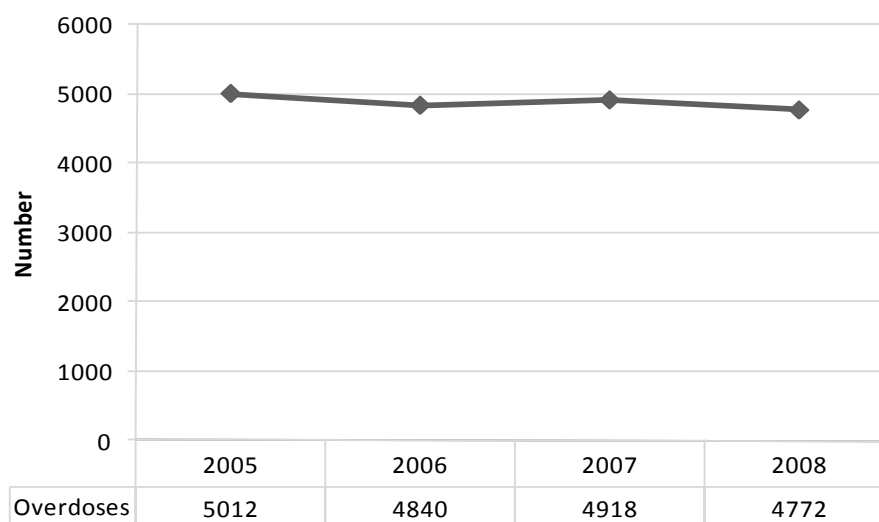
### 6.2.4 Behavioural data

There are no behavioural data recorded in Ireland.

## 6.3 Other drug-related health correlates and consequences

### 6.3.1 Non-fatal overdoses and drug related emergencies

Data extracted from HIPE were analysed to determine trends in cases of non-fatal overdoses discharged from Irish hospitals in 2008. There were 4,815 overdose cases in that year, of which 43 died in hospital. The 4,772 discharged cases are included in this analysis. The number of overdose cases decreased by 2.9% between 2007 and 2008 (Figure 6.3.1.1).



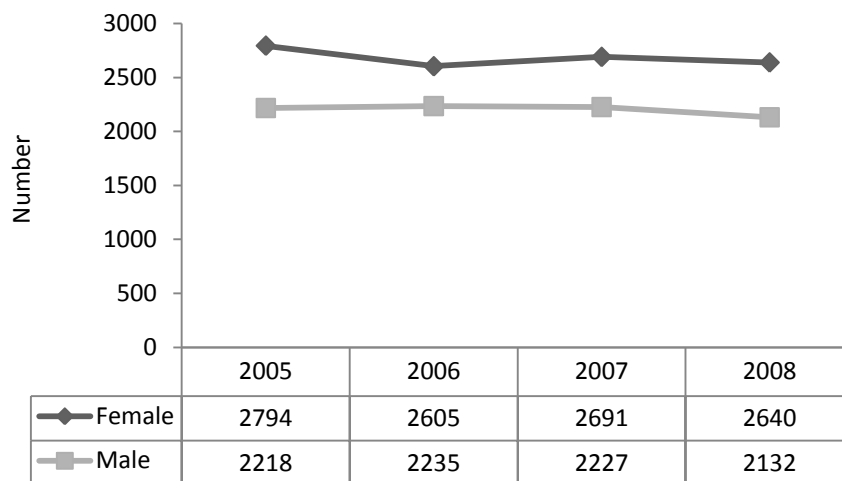
**Figure 6.3.1.1 Overdose cases by year, 2005–2008 (N=19,542)**

Source: Unpublished data from HIPE

### Characteristics of cases

#### Gender

Between 2005 and 2008 there were more overdose cases among females than among males (Figure 6.3.1.2), with females accounting for 55% of all overdose cases in 2008.

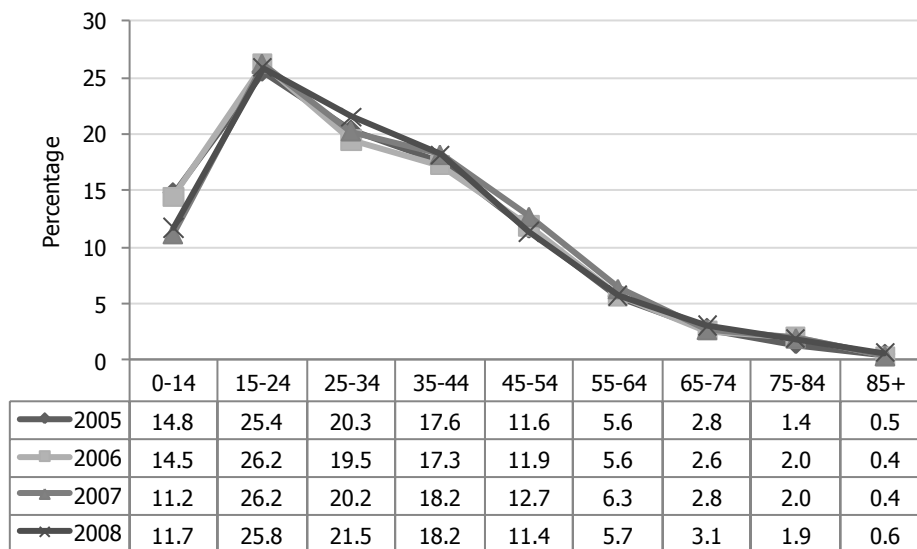


**Figure 6.3.1.2 Overdose cases by gender, 2005–2008 (N=19,542)**

Source: Unpublished data from HIPE

#### Age group

In the four-year period 2005–2008, one quarter of overdoses occurred in those aged 15–24 years, with the incidence of overdose decreasing with age (Figure 6.3.1.3). The pattern was similar for each of the years reported.



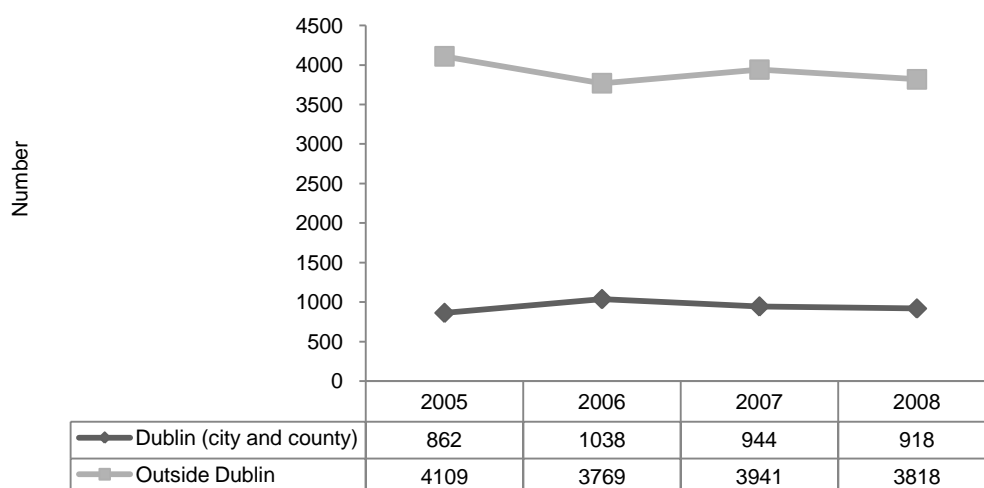
**Figure 6.3.1.3 Overdose cases by age group, 2005–2008 (N=19,542)**

Source: Unpublished data from HIPE

#### Area of residence

In 2008, 26 overdose cases were resident outside of Ireland and 10 cases were recorded as having no fixed abode; these 36 cases were excluded from this analysis. Figure 6.3.1.4 shows the area of residence of cases with an Irish address for the years 2005–2008. One fifth of cases in 2008 were resident in Dublin.





**Figure 6.3.1.4 Overdose cases by area of residence, 2005–2008 (N=18,510)**

Source: Unpublished data from HIPE

### Drugs involved

Table 6.3.1.1 presents the positive findings per category of drugs and other substances involved in **all cases of overdose** in 2008. Non-opioid analgesics were present in 34.8% (1,660) of cases. Paracetamol is included in this drug category and was present in 25% (1,198) of cases. Psychotropic agents were taken in 21.5% (1,025) and benzodiazepines in 20.8% (993) of cases. There was evidence of alcohol consumption in 14.0% (669) of cases. Cases involving alcohol are included in this analysis only when the alcohol was used in conjunction with another substance.

**Table 6.3.1.1 Category of drugs involved in overdose cases, 2008 (N=4,772)**

Drug category	Positive findings per drug category*	
	n	%
Non-opioid analgesics	1660	34.8
Psychotropic agents	1025	21.5
Benzodiazepines	993	20.8
Alcohol	669	14.0
Narcotics and hallucinogens	599	12.6
Anti-epileptic / sedative / anti-Parkinson agents	569	11.9
Other chemicals and noxious substances	316	6.6
Systemic and haematological agents	169	3.5
Autonomic nervous system agents	117	2.5
Cardiovascular agents	110	2.3
Hormones	109	2.3
Systemic antibiotics	92	1.9
Anaesthetics	90	1.9
Gastrointestinal agents	65	1.4
Other gases and vapours	52	1.1
Muscle and respiratory agents	52	1.1
Anti-infectives / Anti-parasitics	40	0.8
Diuretics	38	0.8
Topical agents	24	0.5
Other and unspecified drugs	969	20.3

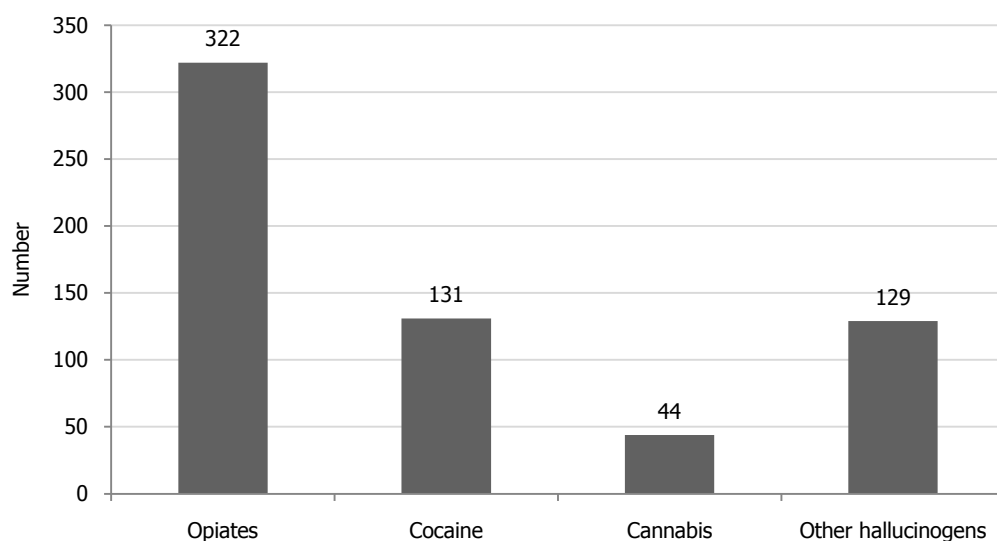
\*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.

Source: Unpublished data from HIPE

### Overdoses involving narcotics or hallucinogens

Narcotic or hallucinogenic drugs were involved in 12.6% (599) of overdose cases in 2008. Figure 6.3.1.5 shows the number of positive findings of drugs in this category by the type of drug. The sum of positive findings is greater than the total number of cases

because some cases involved more than one drug from this category. Opiates were used in over half the cases, cocaine in one fifth and cannabis in 7%.

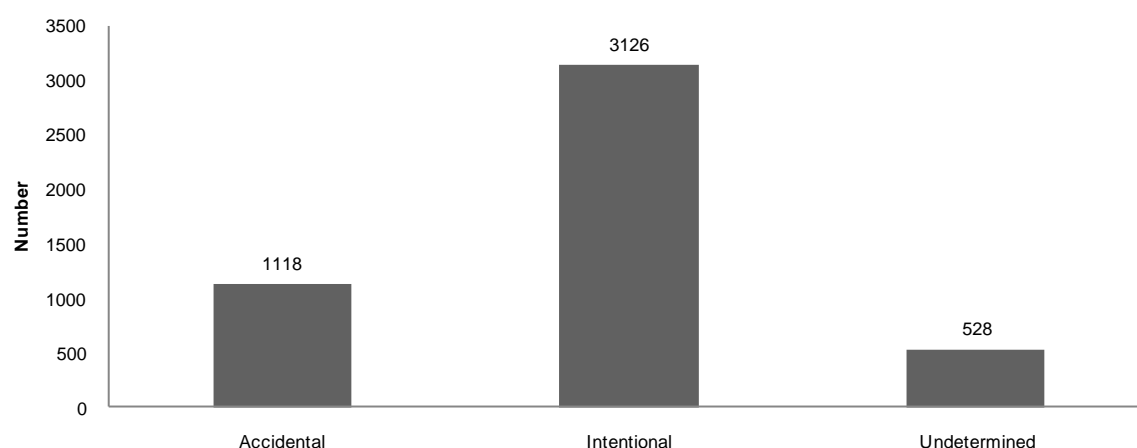


**Figure 6.3.1.5 Narcotics and hallucinogens involved in overdose cases, 2008 (N=599)**

Source: Unpublished data from HIPE

### Overdoses classified by intent

In two-thirds (65.5%) of cases the overdose was classified as intentional (Figure 6.3.1.6).



**Figure 6.3.1.6 Overdose cases by classification of intent, 2008 (N=4,772)**

Source: Unpublished data from HIPE

Table 6.3.1.2 presents the positive findings per category of drugs and other substances involved in cases of intentional overdose in 2008. Non-opioid analgesics were involved in 43.1% (1,346) of cases, psychotropic agents in 25.8% (806) and benzodiazepines in 24.7% (772).

**Table 6.3.1.2 Category of drugs involved in intentional overdose cases, 2008 (N=3,126)**

Drug category	Positive findings per drug category*	
	n	%
Non-opioid analgesics	1346	43.1
Psychotropic agents	806	25.8
Benzodiazepines	772	24.7
Alcohol	476	15.2
Anti-epileptic / sedative / anti-Parkinson agents	461	14.7
Narcotics and hallucinogens	304	9.7
Systemic and haematological agents	96	3.1

Drug category	Positive findings per drug category*	
Other chemicals and noxious substances	84	2.7
Autonomic nervous system agents	77	2.5
Cardiovascular agents	75	2.4
Hormones	70	2.2
Systemic antibiotics	69	2.2
Gastrointestinal agents	50	1.6
Anaesthetics	44	1.4
Muscle and respiratory agents	29	0.9
Anti-infectives / Anti-parasitics	28	0.9
Diuretics	22	0.7
Other gases and vapours	16	0.5
Topical agents	9	0.3
Other and unspecified drugs	576	18.4

\*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.

Source: Unpublished data from HIPE

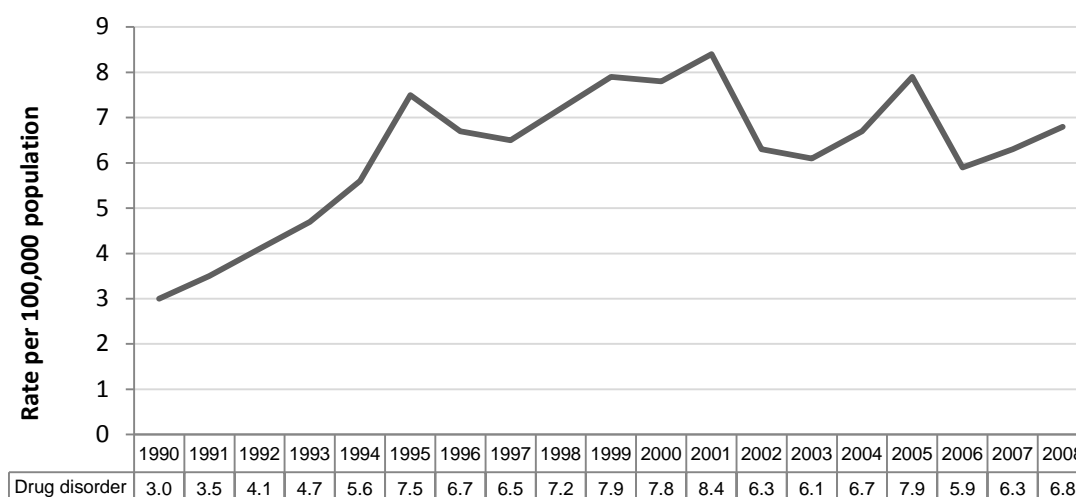
### 6.3.2 Other topics of interest

#### Trends in drug admissions to psychiatric facilities

*Activities of Irish psychiatric units and hospitals 2008* (Daly and Walsh 2009), the annual report published by the Mental Health Research Unit of the Health Research Board, showed that the total number of admissions to inpatient care has continued to fall.

In 2008, 778 cases were admitted to psychiatric facilities with a drug disorder, of whom 289 were treated for the first time. The report does not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate. Figure 6.3.2.1 presents the rates of first admission between 1990 and 2008 of cases with a diagnosis of drug disorder, per 100,000 of the population. 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, 2002 and 2006, 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. The rate increased marginally to 6.8 in 2008. Of the 791 discharges with a drug disorder, 51% spent less than one week in hospital and just under 15% spent more than one month in hospital.



**Figure 6.3.2.1 Rates of psychiatric first admission of cases with a diagnosis of drug disorder (using the ICD-10 three character categories) per 100,000 of the population in NPIRS, 1990–2008**  
Source: Daly and Walsh, 2003; Daly *et al.*, 2004, 2005, 2006, 2007, 2008

### **Chronic illness and multimorbidity among problem drug users: a comparative cross-sectional pilot study in primary care**

Although multimorbidity has important implications for patient care in general practice, limited research has been undertaken on chronic illness and health service utilisation among problem drug users. A study was undertaken to determine chronic illness prevalence and health service utilisation among problem drug users attending primary care for methadone treatment, to compare these rates with matched 'controls' and to develop and pilot test a valid study instrument (Cullen, *et al.* 2009). A cross-sectional study of patients attending three large urban general practices in Dublin, Ireland, for methadone treatment was conducted, and this sample was compared with a control group matched by practice, age, gender and General Medical Services (GMS) status. All patients attending each practice for methadone treatment on 1 July 2008 were eligible for the study.

Data were collected on 114 patients. Fifty-seven patients were on methadone treatment, of whom 52 (91%) had at least one chronic illness (other than substance use) and 39 (68%) were prescribed at least one regular medication. Frequent use of primary care services and secondary care services in the previous six months was observed among patients on methadone treatment and among the control group, although the former had significantly higher chronic illness prevalence and primary care contact rates. The authors conclude that multimorbidity is common among problem drug users attending general practice for methadone treatment. Primary care may therefore have an important role in primary and secondary prevention of chronic illnesses among this population. This study instrument facilitated data collection with minimal inter-observer variation and the authors consider it a feasible option for further work on this issue.

### **Learning and memory deficits in ecstasy users and their neural correlates during a face-learning task**

Research has consistently shown that ecstasy users display impairments in learning and memory performance. In addition, working memory processing in ecstasy users has been shown to be associated with neural alterations in hippocampal and/or cortical regions as measured by functional magnetic resonance imaging (fMRI).

Using functional imaging and a face-learning task, Robert and colleagues investigated neural correlates of encoding and recalling face-name associations in 20 recreational drug users whose predominant drug use was ecstasy, and in 20 controls (Roberts, *et al.* 2009). To address the potential confounding effects of cannabis use by the ecstasy-using group, a second analysis included 14 previously tested cannabis users (Nestor, *et al.* 2010).

Ecstasy users performed significantly worse in learning and memory compared to controls and cannabis users. A conjunction analysis of the encode and recall phases of the task revealed ecstasy-specific hyperactivity in bilateral frontal regions, left temporal, right parietal, bilateral temporal, and bilateral occipital brain regions. Ecstasy-specific hypoactivity was evident in the right dorsal anterior cingulate cortex and left posterior cingulate cortex.

In both ecstasy and cannabis groups, brain activation was decreased in the right medial frontal gyrus, left parahippocampal gyrus, left dorsal cingulate gyrus, and left caudate. These results elucidated ecstasy-related deficits, only some of which might be attributed to cannabis use. These ecstasy-specific effects may be related to the vulnerability of isocortical and allocortical regions to the neurotoxic effects of ecstasy.

### **Lifetime history of substance misuse in first-episode psychosis: Prevalence and its influence on psychopathology and onset of psychotic symptoms**

Substance misuse (drug/alcohol dependence or abuse) in psychotic illness is an increasingly recognised problem. Kamali and colleagues aimed to estimate the prevalence and examine the influence of substance misuse on age at onset of psychosis and psychopathology among patients with first-episode psychosis (Kamali, *et al.* 2009).

One hundred seventy-one consecutive patients with first-episode psychosis were assessed. Substance misuse, age at onset of psychosis and psychopathology were determined using valid instruments. Seventy-seven (46%) patients had a lifetime history of substance misuse and were predominately males, had more positive symptoms, and in the majority of cases (84%) started misusing substances before the onset of psychosis (SM-BP). There was no difference in age at onset between patients with SM-BP and the rest of the sample. Lifetime history of substance misuse is common and may influence psychopathology, but does not appear to influence or bring forward the age at onset of psychotic symptoms.

### **First national report from sexual assault treatment units**

There are currently six sexual assault treatment units (SATUs) in Ireland, located at the Rotunda Hospital (Dublin), South Infirmaries Victoria University Hospital (Cork), Waterford Regional Hospital, Midlands Hospital (Mullingar), Letterkenny General Hospital and Galway (Ballybrit). Clinical reports from each of these units are combined in the first annual SATU report, for 2009 (Eogan 2010).

There were 529 attendances at the six units in 2009; 95% were female and the mean age was 24 years. Half (51%) of all patients who attended had consumed at least four units of alcohol in the 12 hours prior to the incident reported, 8% disclosed that they had taken illegal drugs and 3% were concerned that drugs had been used to facilitate sexual assault. Irish research has shown that alcohol consumption, especially drinking to intoxication, is a feature in a high proportion of rape and sexual abuse cases in Ireland (Hanly, *et al.* 2009); (McGee, *et al.* 2002) and this report further corroborates those findings.

### **Emergencies related to cocaine use**

Illicit drug use can lead to acute reverse reactions leading to admission to emergency departments. Cocaine-related emergencies have been monitored in the USA, but the following is the first such investigation undertaken in Europe. The study investigates patterns of cocaine emergencies in eight European cities in a multicentre cross-sectional study conducted in Barcelona, Budapest, Dublin, Hamburg, London, Rome, Vienna and Zurich (de Millas, *et al.* 2010). The reported frequency differed from city to city, with some emergency centres having less than one case per half year, and some centres having more than one case per month. Patterns of complaints among cocaine users were associated with the psychomotor-stimulant or cardiovascular effects of cocaine. Urine screens and referrals to the addiction services were infrequent. The authors concluded that a closer link between emergency departments and addiction

services would help in guiding problematic drug users towards appropriate treatment at an earlier stage in their addiction.

## 6.4 Drug-related deaths and mortality of drug users

Data on drug-related deaths in Ireland are provided by the NDRDI. Data on directly drug-related deaths (poisonings) in 2008 have been collected and analysed, and these data are described below in Section 6.4.1. Data on indirectly drug-related deaths (non-poisonings) from 1998 to 2007 are described in Section 6.4.3. A more detailed description of drug-related deaths in Ireland is provided in Chapter 12 Mortality related to drug use: a comprehensive approach and public health implications.

### 6.4.1 Drug-induced deaths

In 2008, the number of deaths owing to poisoning (as per Selection D) increased very slightly, from 204 in 2007 to 208 (Table 6.4.1.1, also see Standard Table 6). Since 2003 there has been a steady increase in the number of poisonings reported. It should be noted that annual data previously reported have changed as the database has been updated as new information has become available.

Table 6.4.1.1 Poisonings (Selection D) by year, 1998 to 2007 (N=1474)

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Selection D	115	113	109	127	109	128	173	188	204	208

Source: Unpublished data NDRDI

In 2008, the median age of those dying from poisoning was 34 years and the majority of individuals were aged between 20 and 39 years of age (144, 69.2%). The majority were male (164, 78.8%), although there was a difference between the median age of males (32 years) and of females (38 years). This pattern is similar to findings from previous years and also reflects international trends (see Standard Table 5).

Of the 208 cases of poisoning recorded in 2008, heroin or unspecified opiates accounted for 34 (16.3%) cases, while methadone accounted for 20 (9.6%). This is similar to the pattern reported for previous years. Deaths attributable to polysubstances increased: more than half of all deaths owing to poisoning (124, 59.3%) were attributable to polysubstances, including an opiate, which is higher than in previous years (Health Research Board 2010).

Opiates continued to be associated with the majority of fatal overdoses in 2008, with 180 (86.1%) deaths being associated with opiate use. This is higher than reported for previous years. Deaths as a result of poisoning from cocaine, alone or with another drug, accounted for 27.8% (58) of deaths by poisoning in 2008, which was a decrease compared to 2007, when the proportion was 32.4% (66).

The trends in drug-related deaths in 2008 are similar to the trends seen in the national treatment data for 2008, which show an increase in the number of cases treated for problem opiate use and a slight decrease in the number of cases treated for problem cocaine use (Carew, AM 2010b).

Alcohol and other drugs, including benzodiazepines, non-benzodiazepine sedatives, antidepressants, other prescription medication and over-the-counter medication, continue to contribute significantly to the burden of drug-related deaths in Ireland but are not reported on in this national report. For further information on the national situation, see the most recent publication from the NDRDI (Health Research Board 2010)

## 6.4.2 Mortality and causes of deaths among drug users

See Section 6.4.1, Section 6.4.3 and Chapter 12.

### 6.4.3 Specific causes of mortality indirectly related to drug use

A total of 1,345 deaths by non-poisoning among drug users were recorded between 1998 and 2007. Of the 1,183 cases with a known cause of death, 60.3% (714) were due to trauma and 40% (469) were due to medical causes (Figure 6.4.3.1) (Health Research Board 2010)].

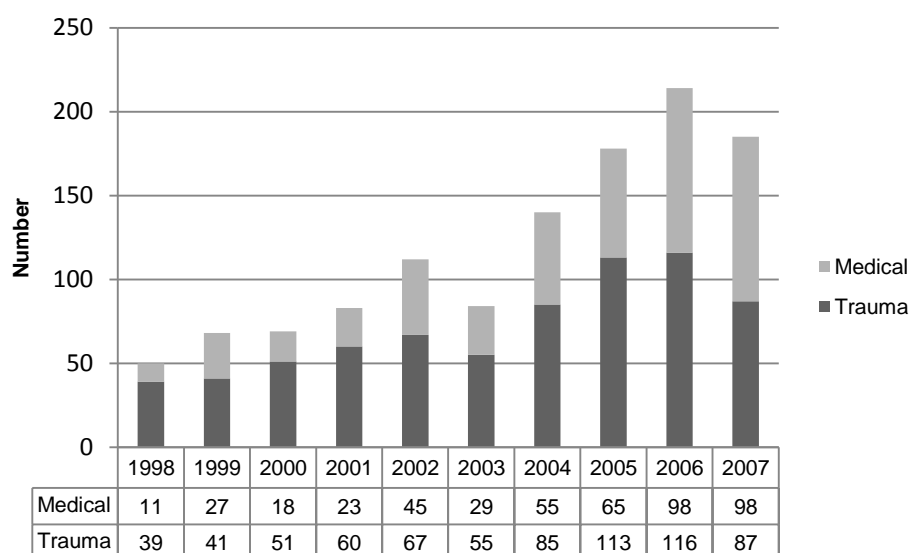


Figure 6.4.3.1 Non-poisoning deaths among drug users, NDRDI 1998 to 2007 (N=1,183)

#### Deaths owing to trauma

The annual number of deaths owing to trauma increased from 39 in 1998 to 116 in 2006, but fell to 87 in 2007 (Figure 6.4.3.1). These figures may be revised when data relating to late inquests become available. Half (50.4%, 360) of those who died from traumatic causes were aged between 20 and 29 years. The median age was 27 years. Almost all (90.1%, 643) were male. The most common causes of death owing to trauma were hanging and RTCs.

#### Deaths owing to medical causes

The annual number of deaths owing to medical causes rose fairly steadily over the reporting period, from 11 in 1998 to 98 in 2007, when it exceeded the number of deaths owing to trauma (Figure 6.4.3.1). The majority of those who died from medical causes were aged between 30 and 44 years. The median age was 39 years. Three-quarters (75.0%, 352) of those who died were male. The most common medical causes of death were cardiac events (25.2%, 118), respiratory infections (17.7%, 83) and liver disease (10.2%, 48).

## 7. Responses to Health Correlates and Consequences

### 7.1 Introduction

This chapter presents new data on preventing drug-related mortality, the management of blood-borne viral infections, and responses to co-morbidity. The public and voluntary sector institutions that have been engaged in the various initiatives described in the following sections are briefly described here.

The purpose of the **Ballyfermot Advance Project** is to support the Ballyfermot Local Drugs Task Force by creating and monitoring specific roles complementary to the delivery of the Task Force plan. It oversees a number of initiatives within the Ballyfermot area to address different needs in relation to drugs and drug use.

The **Ana Liffey Drug Project (ALDP)** is a voluntary organisation offering a low-threshold harm-reduction service in north inner-city Dublin. It works with people experiencing addiction, to minimise the harm that problematic drug use causes them, their families and the wider community. It provides a range of services including a drop-in service, outreach service, family care and case management service, peer-support and literacy tutoring.

The **Health Service Executive (HSE)** is responsible for managing and delivering health and personal social services in Ireland. It supports numerous responses to the health correlates and consequences of problematic drug use.

The **Irish Needle Exchange Forum (INEF)** exists to actively develop, support, and sustain a network of high quality, comprehensive needle exchange and other harm reduction services across Ireland. Membership is open and free.

The **Mental Health Commission (MHC)** is an independent statutory body established under the Mental Health Act 2001. It is tasked with promoting high standards in the delivery of mental health services in Ireland and ensures the interests of those involuntarily admitted to 'approved centres' are protected.

Written by an 'expert group' and published in 2006, ***A Vision for Change*** set out a comprehensive model of mental health services for Ireland {Expert Group on Mental Health Policy, 2006 #744}. It emphasised the development of mental health services in the community over the next ten years. According to the authors, 'individuals whose primary problem is substance abuse and who do not have mental health problems will not fall within the remit of mental health services'; as a result, the expert group recommended that major responsibility for the care of those with substance abuse (dependence) should lie outside the mental health services, with separate services with their own funding structure within the HSE.

In relation to substance abuse (dependence), the report recommended:

- Mental health services for both adults and children should be responsible for providing mental health services to individuals who have another mental illness in addition to their substance abuse (dependence).
- General adult community mental health teams should care for adults with substance abuse and another mental health problem when the mental health problem is the primary problem.
- Specialist substance abuse mental health teams for adults with complex severe substance abuse and mental disorders should be established. These specialist teams should establish clear links with local community mental health services, and clarify pathways in and out of their services.
- Two additional specialist substance abuse teams for children with substance abuse (dependence) and mental disorders should be established outside Dublin.



- A post of national co-ordinator should be established in the Primary Community and Continuing Care (PCCC) Directorate of the HSE. This co-ordinator should develop standards for the delivery of interventions to address alcohol and drug abuse (dependence) in Ireland and establish how such interventions should be linked to mental health.

The **National Office for Suicide Prevention (NOSP)** was established by the HSE in 2005. Its functions are to oversee the implementation of *Reach Out, the National Strategy for Action on Suicide Prevention*, co-ordinate suicide prevention efforts around the country, and speak regularly with agencies and individuals interested and active in suicide prevention. The NOSP works closely with the HSE Resource Officers for Suicide Prevention.

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

Patients who have overdosed on drugs commonly present to emergency departments, with only the most severe cases requiring intensive care unit (ICU) admission. Such patients typically survive hospitalisation. A study was made of these patients' longer term functional outcomes and recovery patterns (O'Brien, *et al.* 2009). All patients admitted to the 18-bed ICU of a university-affiliated teaching hospital following drug overdoses between 1 January 2004 and 31 December 2006 were identified. With ethical approval, the researchers evaluated the functional outcome and recovery patterns of the surviving patients 31 months after presentation, by telephone or personal interview. These data were recorded as Glasgow outcome score, Karnofsky performance index and present work status.

During the three years of the study, 43 patients were identified as being admitted to the ICU because of an overdose. The average age was 34 years, 72% were male and the mean APACHE II score was 16.7. Of these, 32 were discharged from hospital alive. Follow-up data were collected on all of them. At a median of 31 months follow-up, a further eight had died. Of the 24 surviving, there were 13 unemployed, seven employed and four in custody. The median Glasgow outcome score of survivors was 4.5, their Karnofsky score 80.

Admission to ICU for treatment of overdose is associated with a very high risk of death in both the short and long term. While excellent functional recovery is achievable, 16% of survivors were held in custody and 54% unemployed.

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

### **Needle-exchange services**

In July 2009, the HSE East Coast Area needle-exchange service launched an information leaflet for people who inject drugs (John Craven, personal communication, 2009). The aim of the leaflet is to encourage injectors not to share and never to re-use injecting equipment.

The leaflet includes advice about safer injecting practices and provides guidance on how to look after veins and limit vein damage. It stresses the importance of never sharing drug-taking equipment in order to help prevent the transmission or acquisition of hepatitis and HIV. While the main focus is on injecting drug use, the leaflet states that blood-borne viruses can also be transmitted or acquired by sharing snorting equipment.

Service users are encouraged to seek further advice from needle-exchange services, which are listed in the leaflet, with their opening hours and contact details. Information is also provided on services providing HIV/AIDS prevention, drug treatment and counselling, and the community addiction teams, in the East Coast area. For people seeking treatment and counselling services in other areas, a helpline number is given.

Needle and syringe exchange services were first provided in Ireland in 1989, when five exchanges were established. There are now over 30 exchanges in the country, operating three models of service: fixed-site exchanges, home visit exchanges, and exchanges in public locations. Peer-based, prison-based or vending machine exchange services are not available in Ireland.

The Irish Needle Exchange Forum (INEF) held its inaugural conference at the Malton Hotel, Killarney, Co Kerry, on 5 November 2009 (Keane, M 2010). At the conference, Dr Denis O'Driscoll, chief pharmacist at HSE Addiction Services Dublin Mid-Leinster, and Mr Rory Keane, Regional Drug Co-ordination Unit HSE Mid-West, presented an overview of plans to provide additional needle-exchange services through community pharmacies in 65 new locations across the country. It was envisaged that the services would be targeted to areas outside Dublin and the former Eastern Regional Health Authority. The services proposed would come from a new partnership between the Irish Pharmacy Union (IPU), the Health Service Executive (HSE) and the Elton John Aids Foundation (EJAF). The service would be part-funded by the EJAF for three years, with matching funding by the HSE. The HSE would take responsibility for funding in year four. Needle-exchange services will be provided free in pharmacies and will include both custom-made and standard packs. It was envisaged that the service will exchange new injecting equipment for old, provide sharps bins and advice on safe disposal of used equipment, information on safer-injecting and safe sex practices, and advice on drug use and other health-related issues.

In the second half of 2010, the HSE and the Irish Pharmacy Union commenced recruitment of a National Liaison Pharmacist to supervise and support pharmacists who are participating in the pharmacy-based needle exchange service outside Dublin. These exchanges will be provided in all counties and in most urban areas outside of Dublin. The HSE are in the process of agreeing a fee structure with the IPU in regard to payment for participating community based pharmacists. The Irish Centre for Continuing Pharmaceutical Education training programme on needle-exchange for participating pharmacists commenced on 11 October 2010 and will be completed by 16 November, in time for planned roll-out of the programme at the beginning of 2011. (Joe Doyle, HSE, personal communication, September 2010)

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

As reported in last year's National Report, in January 2007 the HSE established a working group on hepatitis C. The brief of this group was 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 had a national brief. It examined how Ireland could best respond to hepatitis C in the areas of surveillance, education and treatment. The working group commented on how the recommendations of the 2004 report had progressed. The group completed its report, presented it to senior management and is awaiting approval of HSE senior management.

### **Legal highs and head shops: the basic facts**

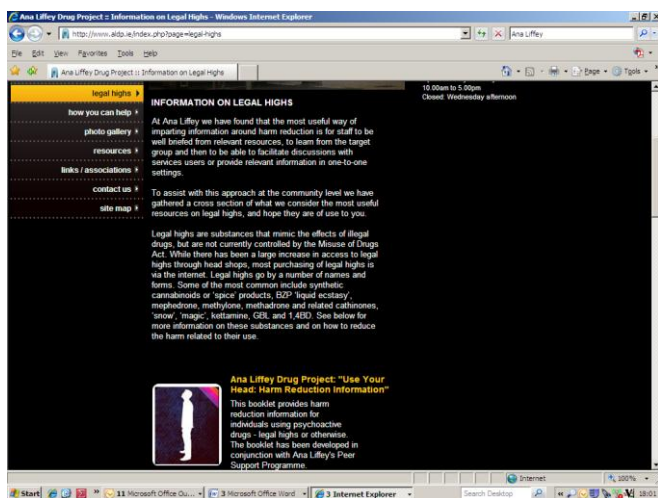
In response to interest among drug workers regarding 'legal high' drugs available in head shops, Ballyfermot Advance Project and The Base youth and child centre in Ballyfermot have produced an information leaflet (Ballyfermot Advance Project and Base Youth and Child Centre 2010).

The leaflet outlines the current legal status and effects of common drugs such as Salvia, Spice, Piperazine, BZP and Kratom. There is also harm reduction information that may be used to advise clients of risks.

Content has been approved by Dr Des Corrigan, chairperson of the NACD, and Dr Bobby Smyth, consultant child and adolescent psychiatrist.

### **Information on what to do if you have side effects from legal highs**

ALDP has developed a web page on legal highs which contains links to published harm reduction information (Ana Liffey Drug Project 2010a). Peer workers at Ana Liffey have produced a booklet, *Use Your Head – Harm Reduction Information – Legal Highs or Otherwise* (Ana Liffey Drug Project 2010b), which provides guidelines on how to minimise harm when taking drugs and how to intervene if someone experiences harm caused by drugs



### SMS service for drug users

On 30 June 2009 the ALDP launched the 'Duck, Dive and Survive' SMS service (Duffin and Galvin 2009). This service enables Ana Liffey to offer real time information on reducing the risks associated with drug use and provide essential health and service-related information. There is a high rate of mobile telephone use among Ana Liffey's clients and this innovative approach adopts this technology to communicate with people who use drugs.

Ana Liffey used the special bursary it received as winner of the New Initiatives category of the Crystal Clear MSD Health Literacy Award 2009 to establish the service.

Information provided by SMS includes:

- changes to opening times of key services,
- advice on overdose risks and prevention, particularly during festive/holiday periods which Ana Liffey suspects are times when overdoses are more likely,
- new trends and dangers relating to illicit drug use – the North Inner City Drugs Task Force will use the SMS service to get key information to service users, and
- information from service users – Ana Liffey works with the service users' 'Peer Support Group' to identify key messages to be sent to their peers.

An example of a group text message sent to people who attended the Ana Liffey project during June 2009 is:

OVERDOSE: Don't panic. Put them in the recovery position, dial 999, ask for an ambulance and stay with them until the ambulance arrives. Ana Liffey: 1800786828

Following feedback from service users, the providers of the service realised that, to be effective, the messages sent must get to the point quickly and should ideally name the issue and the action to be taken. Messages can be no more than 160 characters (including spaces) to allow for the message to be sent in one go. Messages can be personalised by having the person's first name appear at the beginning of the text, but this also uses up text characters.

A total of 2,243 text messages were sent during the first 13 weeks after the launch of the service, and by mid-August, 73 Ana Liffey service users had signed up.

The Swansea Drugs Project (Wales) has followed the example of the 'Duck, Dive and Survive' SMS service and they are establishing an SMS service of their own.

To date, messages have been developed in a reactive way, addressing issues identified by the Ana Liffey team and external issues affecting the client group. A reactive service is necessary, and is one of the strengths of such a mass communication tool. However, the next phase of SMS delivery will involve the development of targeted health campaigns sent at strategic times. This campaign will build on the success of the texts as developed to date.

### **Guide to substance misuse for health professionals**

Sinead O'Mahony Carey (O'Mahony Carey 2008), drug education officer with HSE South, compiled a pocket-sized reference manual, *A guide to substance misuse for medical professionals*. The first section of the guide presents drugs with potential for misuse by category and by type. The major categories of drugs covered include hallucinogens, opiates, stimulants and volatile inhalants. Details of individual drugs are presented under each category, described by street name(s), expected effects, negative or side effects, appearance, method(s) of use, dependency potential, withdrawal symptoms, overdose risk and effects of long-term use. The second section contains information on the signs of drug use. The third section presents an overview of the reasons people use drugs, while section four presents the dangers of drug use. The fifth section presents a summary of Irish law and drug use, and the final section covers the jargon related to drug use. This book is a useful guide for health professionals, counsellors, key workers and social workers who work with drug users.

## **7.4 Responses to other health correlates among drug users e.g psychiatric and somatic co-morbidity**

### **Psychiatric co-morbidity**

In September 2009 the Mental Health Commission (MHC) published the *Report of Joint Working Group on Mental Health Services and the Police 2009* (Mental Health Commission and An Garda Síochána 2009). The authors stated that a considerable proportion of social crises in the community are of a psychiatric nature, involving both adults and children and are often connected not just with mental illness but with a range of other social factors including alcohol and drug abuse. They recommended the urgent implementation of national policy in relation to the document *Vision for Change* and the Primary Care Strategy; the creation of a 24-hour, 7-day a week statutory social work service; expanding training for An Garda Síochána on community and social services, together with mental illness in crisis; joint protocols between the mental health services and An Garda Síochána, and involving users and carers in the drawing up of these protocols; a feasibility study on jointly-staffed crisis intervention teams, made up of mental health personnel and members of An Garda Síochána; and court diversion programmes for dealing with minor criminal matters involving individuals with mental health problems.

In November 2009 the MHC published an analysis of progress towards implementation of *A Vision for Change* by the HSE (Mental Health Commission 2009). The MHC acknowledged that implementation of a complex policy with many recommendations in a system already undergoing significant change was a challenging process. It needs co-ordinated change at system, organisation, programme and practice levels. The MHC stated that the evidence-based requirements for successful implementation were largely missing, and that the HSE's implementation plan should include:

- an overall sense of the HSE vision for mental health services,
- a statement of specific outcomes,
- a map of the steps needed to achieve these outcomes with real targets, timelines, resources and responsible agents clearly described, and
- an outline of the measurable benefits arising from the implementation including the monitoring of the outcomes as they are being achieved.

Published in June 2010, the MHC's annual report for 2009 noted that the fundamental changes to mental health services as recommended in *A Vision for Change*, including the separation of mental health from other mental health services, had still not taken place (Mental Health Commission 2010). The 2009 annual report of the Inspectorate of Mental Health Services, published as part of the MHC's 2009 annual report, noted among 'encouraging developments' in 2009 the appointment of an HSE Assistant National Director with responsibility for the implementation of *A Vision for Change*. While the appointment fell short of a separate national directorate for mental health services, the Inspectorate anticipated that a number of reforms could be achieved on foot of the appointment. The Inspectorate also welcomed the opportunities to progress the development of a separate mental health service provided as a consequence of the HSE's Transformation Programme (see Section 5.3.1 for details of this organisational change programme). Specifically:

- The establishment of a Directorate of Clinical Care and Quality: the Inspectorate anticipated that mental health services would be an integral part of the deliberations of this directorate, whose initial aim is to audit services against practice guidelines on a national basis.
- The integration of the Hospital and Primary Community and Continuing Care (PCCC) divisions: the Inspectorate's report states: 'The 2008 Inspector's Report was concerned at the "lumping" of mental health services into primary care and community services. During 2009, we saw many examples of "raiding of the monasteries" with respect to leakage of mental health resources to other services. Concern was also expressed that mental health services could be almost exclusively delivered at a primary care level. It is to be hoped that, in the new integrated system, especially with the influence of an Assistant National Director for Mental Health, these concerns will be addressed and a more coherent and transparent funding stream for mental health services will be established.' (page 81)

Among areas of concern identified in its 2009 report, the Inspectorate of Mental Health Services noted the following: 'We are concerned by the occupation of scarce CAMHS [Child and Adolescent Mental Health Services] beds by individuals with no diagnosable mental disorder often with social problems with "nowhere else to go". This is inappropriate and potentially damaging to these individuals as well as depriving others of needed beds.' (page 83)

In its report published in June 2010 (Independent Monitoring Group 2010), the independent group set up by the Minister for Equality, Disability and Mental Health, John Moloney TD, to monitor the implementation of *A vision for change* reported that there had been no progress at national level in 2009 regarding the development of mental health services for persons with co-morbid severe mental illness and substance abuse problems.

### **Training programme in dual diagnosis**

The clinical nurse specialist (CNS) in addictions based in the Central Mental Hospital in Dublin has played a key role in developing a pathway of therapeutic group programmes for people with a dual diagnosis of mental illness and substance abuse.

Dual diagnosis is a very recent concept in the Irish mental health service. The concept was highlighted by MacGabhann and colleagues (MacGabhann, *et al.* 2004), who recommended incorporating training for dual diagnosis into undergraduate and continuing education programmes for those working in addiction and mental health services. Because such training is not widely available in Ireland, an innovative five-day training programme was developed by Hanora Byrne, CNS in addictions at the Central Mental Hospital, and Dr Shobha Rani, lecturer in nursing at Trinity College Dublin. The programme has been awarded category 1 approval by An Bord Altranais. The programme development was based on a six-step approach devised by Kern and colleagues (Kern, *et al.* 1998). The six steps are: problem identification needs assessment, objectives, implementation, educational strategies and evaluation.

Analysis of a needs assessment involving 20 psychiatric nurses and 20 probation officers showed that it was clearly necessary to develop a training programme in dual diagnosis.

The main objectives of the programme are to provide information on dual diagnosis and the treatment programmes that can be applied in service delivery. The programme has four modules delivered through lectures, group discussions, role play, video recording and feedback, and vignettes. A workbook has been developed to accompany the delivery of the training.

The first training programme was run on one day a week for five weeks at the end of 2008. It was delivered by the CNS and members of the multidisciplinary teams within the Central Mental Hospital. Participants were assessed using formative evaluation tools, such as questions and answers and three short written assignments. The course was evaluated using the following: pre- and post-test evaluation, daily evaluation by the participants, and a focus group carried out 12 weeks after the course completion.

The programme co-ordinators envisage running an annual one-day refresher course.

### **Review of progress in addressing suicide in Ireland**

A Joint Oireachtas sub-committee<sup>8</sup> was established in 2005 to examine in detail the issue of suicide in Irish society; to engage with those who work in suicide prevention; and to hear evidence from those involved in post-suicide counselling and support. According to the World Health Organization, suicide is among the three leading causes of death worldwide among people in the 15–44-year-old age bracket. In 2004, there were 27.1 deaths/100,000 population among men in Ireland, compared to 6.1 in England. For females the rate was 2.9/100,000 population, compared to 1.7 in England. Youth suicide rates in Ireland are the fifth highest in the European Union.

The sub-committee's report, *The high level of suicide in Irish society*, was published in 2006 (Joint Committee on Health and Children 2006) and accepted for implementation. It provided detailed information on the extent of suicide in Ireland and made 33 specific recommendations on how to address the problem. An updated report by a new sub-committee, published in June 2009 (Joint Committee on Health and Children 2009), reviewed the extent to which these recommendations had been implemented, and identified the obstacles that had prevented their implementation. The recommendations and progress as at mid 2009 were listed in Table 7.2.1 of the 2009 National Report (Alcohol and Drug Research Unit 2009). A brief summary is provided here.

Very limited or no substantial progress was reported on implementing those recommendations dealing with the building of evidence around suicide through research and information gathering. These recommendations include agreement on a national programme of research into self-harm, suicide and suicide prevention and the publishing of suicide research guidelines for donors providing funding.

Similarly little progress was reported regarding recommendations on making more information available to people at risk of suicide, to the general population, to specific groups such as school children, and to groups and individuals who could play a role in suicide prevention such as teachers, voluntary organisations, primary care teams and mental health staff. However, there was some progress in the organisation of consultation with young people and in the provision of information by primary care services to those bereaved by suicide.

More progress was achieved in the development of services such as a pilot fast-track referral systems from primary care to mental health services for suicidal individuals and the development of a service plan for bereavement services. Other recommended services, including a coordinated response from various voluntary agencies working in

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<sup>8</sup> A Joint Oireachtas Committee comprises the select committees of both Houses of the Oireachtas (Parliament), i.e. Senate and Dáil.

the area of suicide bereavement support and a standardized pre-discharge and transfer between mental health services, have not been developed.

The sub-committee that compiled the 2009 report concluded that the few recommendations that had been completed or mostly completed now needed financial resources and political drive in order to develop and implement their findings. The report concluded that immediate change was required to properly address the ongoing serious problem of suicide in Ireland. The National Office for Suicide Prevention needed adequate and sustained funding, a higher level of interagency collaboration, and the requisite political support if it was to have any chance of fully implementing the recommendations made in the 2006 Oireachtas report.

### **Management of neonatal abstinence syndrome: a national survey and review of practice**

O'Grady and colleagues (O'Grady, *et al.* 2009) reviewed the present management of neonatal abstinence syndrome (NAS) in neonatal units in the UK and Ireland. They posted a questionnaire to 235 neonatal units, with telephone follow-up of non-respondents. The response rate was 90% (211/235), and 96% (190/211) of respondents had a formal NAS guideline. The median number of infants treated annually for NAS was six (range 1–100). The method of Finnegan was the most widely used scoring system (52%) for the UK and Ireland combined and 93% for Ireland. Morphine sulphate was the most commonly used first line agent for both opiate (92%) and polysubstance (69%) withdrawal. Phenobarbitone was used as a first line therapy in 62% of units based in Ireland. Dosing regimens varied widely. Units using a maximum daily morphine dose of <400 microg/kg/day were more likely to require the addition of a second agent (76% vs 58%,  $p = 0.027$ ). Phenobarbitone was the drug of choice to treat seizures secondary to both opiate and polydrug withdrawal in 73% and 81% of units, respectively. Fifty-seven (29%) units allowed infants to be discharged home on medication; of these, 58% allowed administration of opiates in the community and in almost half of cases, this was managed by a parent. Mothers on methadone whose serology was positive for hepatitis B and/or hepatitis C were four times more likely to be discouraged from breastfeeding. Over half (55%) of the units had a liaison midwife. The majority of units currently use an opiate as the drug of first choice as recommended. Doses utilised and second agents added vary significantly between units. According to the authors, many of the findings reflect the lack of high-quality randomised studies regarding management of NAS.

### **Alcohol and drug screening of occupational drivers for preventing injury**

A review was undertaken with the objective of assessing the effectiveness of alcohol and drug screening of occupational drivers who operate motorised vehicles, in preventing injury or work-related effects such as sickness absence related to injury (Cashman, *et al.* 2009).

Studies included in this review were selected from among the following: randomised controlled trials (RCTs), cluster-randomised trials, controlled clinical trials, controlled before and after studies (more than three time points to be measured before and after the study) and interrupted time-series (ITS) studies that evaluated alcohol or drug screening interventions for occupational drivers (compared to another intervention or no intervention) with an outcome measured as a reduction in injury or a proxy measure thereof.

Two review authors independently extracted data and assessed study quality. Authors of the included studies were contacted for further information.

The review authors included two interrupted time-series studies conducted in the USA. One study was conducted in five large US transportation companies ( $n = 115,019$ ) that carried passengers and/or cargo. Monthly injury rates were available from 1983 to 1999. In the study company, two interventions of interest were evaluated: mandatory random drug testing and mandatory random and for-cause alcohol testing

programmes. The third study focused only on mandatory random drug testing and was conducted on federal injury data that covered all truck drivers of interstate carriers. Results were recalculated from raw data provided by the study authors. Following re-analysis, it was found that in one study mandatory random and for-cause alcohol testing was associated with a significant decrease in the level of injuries immediately following the intervention (-1.25 injuries/100 person years, 95% CI -2.29 to -0.21) but did not significantly affect the existing long-term downward trend (-0.28 injuries/100 person years/year, 95% CI -0.78 to 0.21).

Mandatory random drug testing was significantly associated with an immediate change in injury level following the intervention (1.26 injuries/100 person years, 95% CI 0.36 to 2.16) in one study, and in the second study there was no significant effect (-1.36/injuries/100 person years, 95% CI -1.69 to 0.41). In the long term, random drug testing was associated with a significant increase in the downward trend (-0.19 injuries/100 person years/year, 95% CI -0.30 to -0.07) in one study, the other study was also associated with a significant improvement in the long-term downward trend (-0.83 fatal accidents/100 million vehicle miles/year, 95% CI -1.08 to -0.58).

The authors concluded that there was insufficient evidence to advise for or against the use of drug and alcohol testing of occupational drivers for preventing injuries as a sole, effective, long-term solution in the context of workplace culture, peer interaction and other local factors. Cluster-randomised trials are needed to better address the effects of interventions for injury prevention in this occupational setting.



## 8. Social Correlates and Social Reintegration

### 8.1 Introduction

The links between social exclusion and drug use in Ireland have been well established (Keane, Martin 2007). Problem drug users in treatment tend to be young and male, have low levels of education and are unlikely to be employed. For a small proportion, around 10%, homelessness and insecure accommodation are persistent problems. In recent times there has been a modest increase in the proportion of other nationalities seeking treatment (Reynolds, *et al.* 2008). Research also shows that there are problems with illicit drug use among socially-excluded groups such as sex workers, homeless people and new communities.

The aim of social reintegration is to empower individuals to plan and pursue alternative activities to those they engaged in when using drugs. It achieves this through providing accommodation, education, training and employment opportunities for recovering drug users.

This chapter presents new data on the social correlates of drug use in Ireland, and describes policy and programmes initiated in the past year to support the social reintegration of recovering drug users. The broad policy approach and funding to support social reintegration are briefly outlined in this section.

The **National Drugs Strategy (interim) 2009–2016 (NDS)** (Working Group on drugs rehabilitation 2007) lists as a priority the implementation of the recommendations contained in the report of the Working Group on Drugs Rehabilitation. It proposes that the recommendations be incorporated in a comprehensive integrated national treatment and rehabilitation service, using a four-tier model approach.

The **Homeless Agency**, a non-statutory agency, jointly funded by the Department of the Environment, Heritage and Local Government (DEHLG) and the Health Service Executive (HSE) to plan, manage and co-ordinate services to tackle homelessness in the Dublin area, has been identified as a key player in developing an integrated national treatment and rehabilitation service for problem drug users. The Agency made a detailed submission to government with regard to the new national strategy on homelessness, *The way home* (Department of the Environment Heritage and Local Government 2008a), which has been described as ‘a blueprint for change’. It is about creating the conditions for change to realise the aim of eliminating long-term homelessness and the need to sleep rough in Dublin: it forms the basis for reorienting homeless services towards a ‘pathways to housing’ approach, also known internationally as the ‘housing first’ policy. The Homeless Agency points out that the housing first policy does not mean ‘housing only’: a variety of services are needed to promote housing stability and individual well-being, using means such as the assertive community treatment model or case management.

The **Community Employment (CE) scheme**, funded by FÁS, the national training and employment authority, includes 1,000 places ring-fenced for recovering drug users. The scheme operates through local projects primarily in LDTF areas, where community and voluntary groups are required to sign service agreements that outline the work programme and the target outcomes for the individuals placed on the CE schemes. The objective is to prepare participants for entry into the labour force, but the outcomes outlined by most projects tend to refer to personal development, improved literacy skills and education capital, and support progression to more specialised training and education, rather than help the individual to find employment.

Acknowledging the CE scheme for helping recovering drug users to develop their personal and employment skills and find a pathway back to work, the NDS suggests that implementation of the **Individual Learner Plan (ILP)** would help to identify participants’ needs and design progression routes towards labour market reintegration.

The development of targeted programmes by FÁS is seen as essential and should be an integral part of the national drugs strategy in the future.

In 2007 the **Family Support Network (FSN)**, established in 2000 under the auspices of Citywide Drugs Crisis Campaign, gained recognition as an autonomous national organisation. It aims to improve the situation of families coping with drug use by developing, supporting and reinforcing the work of family support groups and regional family support networks, by working for positive change in policy and practice and by raising public awareness about the problem of drugs for families and communities. It is funded through the Office of the Minister for Drugs (OMD) and the Family Support Agency of the Department of Social Protection. In addition, over 100 **Family Resource Centres (FRCs)** throughout the country, also funded by the Family Support Agency, while not having a specific remit to tackle problematic alcohol or drug use, provide support to families experiencing such problems.

## 8.2 Social exclusion and drug use

### 8.2.1 Social exclusion among drug users

Early school-leaving among individuals reporting for drug treatment increased between 2004 and 2008 (Carew, A.M. 2010b). The increases are modest, up 1% for all cases entering treatment and less than 1% for new cases (Table 8.2.1.1).

A large number of targeted interventions in high-risk communities, which aim to prevent and/or reduce early school-leaving among at-risk youth, are delivered in schools and in community settings in local drug task force areas, which have been identified in the past on the basis of their acute levels of heroin use. However, as Table 8.2.1.2 shows, early school-leaving among individuals presenting for treatment and reporting opiates as their main problem substance increased by just over 2% for all cases between 2002 and 2007 (Carew, Anne Marie, *et al.* 2009).

The proportion of individuals presenting for drug treatment (including previously treated and new cases), who were also experiencing homelessness, increased between 2004 and 2008 (Table 8.2.1.1). Between 2002 and 2007, the proportion of those presenting for treatment with opiates as their main problem drug and experiencing homelessness almost doubled (Table 8.2.1.2). This data suggests that although the numbers may be small, homelessness among individuals in treatment for problem drug use remains an important issue to tackle.

**Table 8.2.1.1 Socio-demographic characteristics of cases entering treatment, by treatment status, NDTRS 2004–2008**

Characteristics	2004 n (%)	2005 n (%)	2006 n (%)	2007 n (%)	2008 n (%)
<b>All cases entering treatment</b>					
Homeless	197 (4.4)	217 (4.4)	265 (5.1)	279 (4.9)	351 (5.6)
Early school leavers	892 (19.8)	986 (20.2)	1040 (20.0)	1132 (19.9)	1303 (20.8)
<b>Previously treated cases</b>					
Homeless	136 (5.3)	155 (5.6)	156 (5.6)	177 (5.7)	243 (7.0)
Early school leavers	599 (23.4)	685 (24.8)	660 (23.7)	735 (23.8)	871 (25.1)
<b>New cases</b>					
Homeless	52 (2.9)	54 (2.7)	103 (4.6)	90 (3.7)	99 (3.7)
Early school leavers	264 (14.7)	274 (13.9)	339 (15.2)	366 (15.1)	410 (15.4)

Source: Carew, 2010b

**Table 8.2.1.2 Socio-economic characteristics of cases entering treatment who reported opiates as their main problem substance, by treatment status, NDTRS 2002–2007**

Characteristics	2002 n (%)	2003 n (%)	2004 n (%)	2005 n (%)	2006 n (%)	2007 n (%)
<b>All cases entering treatment</b>						

Characteristics	2002 n (%)	2003 n (%)	2004 n (%)	2005 n (%)	2006 n (%)	2007 n (%)
Homeless	91 (3.0)	146 (4.8)	153 (5.3)	171 (5.5)	182 (5.5)	196 (5.5)
Early school leavers	686 (22.3)	712 (23.5)	666 (23.3)	754 (24.4)	779 (23.8)	875 (24.5)
<b>Previously treated cases</b>						
Homeless	61 (2.8)	101 (4.6)	119 (5.6)	133 (5.8)	124 (5.5)	145 (6.0)
Early school leavers	502 (23.0)	514 (23.5)	514 (24.4)	584 (25.6)	564 (25.2)	633 (26.3)
<b>New cases</b>						
Homeless	26 (3.4)	39 (5.1)	26 (4.0)	32 (4.4)	54 (5.9)	42 (4.1)
Early school leavers	165 (21.7)	185 (24.4)	134 (20.5)	149 (20.6)	182 (20.0)	219 (21.2)

Source: Carew *et al*, 2009

## 8.2.2 Drug use among socially excluded groups

### Substance use among children subject to an application for an order of special care

The Child Care Act 1991 provides for a statutory special care scheme, whereby a court can make a special care order if it is satisfied that the behaviour of a child aged between 12 and 17 years poses a real and substantial risk to his or her health, safety, development or welfare. The order of the court involves the detention and secure placement of the child in a special care unit under the management of the HSE. In a recently-published report (Brierley 2010), the author examined data on the characteristics of 70 applications for special care orders in 2007; 59% (n=41) were female and 41% (n=29) were male. The author pointed out that although 'special care units are not intended to deal with children who require medically supervised detoxification for drug misuse...most children who were subject to an application for special care in 2007 had problems in this area. 79% of the applications (n=55) identified alcohol and/or substance misuse as a risk factor, the largest single category against the criteria for 'real and substantial risks to self' '(page 37). The author noted that the nature of the substance misuse was often unclear in the data recorded in the application documentation. To explore this issue further, the author sought to match the limited amount of data in the application documents with information gathered through interviews with social workers (n=41). The collated data suggested the following substances associated 55 applications:

- alcohol use in 45 (28 females; 17 males)
- cannabis use in 34 (19 females; 15 males)
- ecstasy in 15 (12 females; 3 males)
- cocaine in 13 (female = 10; male = 3)
- prescription drugs in 13 (8 females; 5 males)
- heroin in 10 ( 9 females; 1 male)

Regarding the greater proportion of females than males recorded in the data, the author noted that there had been 41 applications for females, with 25 gaining admission, compared to only 29 applications for males, of whom only 7 were admitted. The author observed: 'Special care appears to cater more for the needs of females than the needs of males' (page 106). He also highlighted what appeared to be a significant gap in service provision for children using heroin: 'Those using heroin were less likely to be admitted to special care than those using other substances... this may suggest that children whose behaviour is concerning but who are also misusing heroin are not receiving a sufficiently joined-up service from the various agencies involved' (page 37).

### Homelessness among children subject to an application for an order of special care

In the same report described above regarding substance use among children subject to an application for an order of special care (Brierley 2010), the author also reported that only 38% (5/13) of the applications for special care orders for children at risk of youth homelessness were successful. By November 2009, of the 16 individuals who had either been at risk of homelessness at the time of the application or who had become

at risk of homelessness in the intervening period, 56% (n=9) had overall risk factors that either worsened or were a new feature, and 75% (n=12) had experienced homelessness after the application. According to the author, 'this suggests that the needs of children who are at acute risk who have experienced homelessness are not being addressed adequately' (page vi).

To conclude, the report highlighted the apparent gap in services for children with potentially problematic substance use issues and homelessness. However, these were only two of the many risk factors that these children presented with. According to Brierley, 'When the application [for an order of special care] was made, the combination of risk factors was so acute that in many situations the social work department even feared for the child's life. ...The child's behaviour was perceived as being out of control' (page 57).

### **Substance use among children presenting to the Child and Adolescent Mental Health Service**

In November 2008 a month-long survey of children and young people aged 0–17 seen by the community-based Child and Adolescent Mental Health Service (CAMHS) teams was undertaken (Health Service Executive 2009). This was the first fully comprehensive survey of the age and gender of children and the mental health problems they were presenting with. The primary presentations of 6,629 cases were recorded; only one disorder/problem was entered for each case.

As the data in Table 8.2.2.1 show, the prevalence of substance use among these at-risk young people is quite low, with less than 1% of cases presenting with substance misuse. Drugs played a minor role in cases presenting with drug-induced psychosis (1.2%) and with deliberate self-harm through drug/medications or alcohol overdose (4.6%). Perhaps the low prevalence rates of substance use observed among these children can be explained by reference to the methods of data collection. The CAMHS teams records the primary disorder/problem that each case presented with, meaning that those with substance misuse as a secondary or related issue were not captured in this data set. Also, it is possible that children with substance misuse problems did not present to CAMHS but to other services.

**Table 8.2.2.1: Mental health disorders/problems among children presenting to the CAMHS, November 2008**

<b>Disorder/Problem</b>	<b>Prevalence</b>
Hyperkinetic disorders/problems, e.g. ADHD	1,925 (29.1%) cases
Emotional disorders/problems, e.g. anxiety, depression	1,734 (26.3%) cases
Conduct disorders/problems, e.g. aggression, anti-social behaviour	617 (9.3%) cases
Eating disorders/problems, e.g. pre-school eating problems, anorexia nervosa, bulimia nervosa	159 (2.4%) cases
Psychotic disorders/problems, e.g. manic depressive disorder, drug-induced psychosis	81 (1.2%) cases
Deliberate self harm, e.g. lacerations, drug/medication and alcohol overdose	328 (4.6%) cases
Substance abuse, e.g. drug and alcohol misuse	37 (0.6%) cases
Habit disorders/problems, e.g. sleeping problems	64 (1%) cases
Autistic spectrum disorders/problems	608 (9.1%) cases
Developmental disorders/problems referred to delay in acquiring certain skills such as speech, and social abilities	325 (4.9%) cases
Gender role / identity disorder/problems	10 (0.2%) cases

Source: Health Service Executive, 2009

### **Substance use and related problems among homeless people in Cork**

The Cork Simon Community, which works with homeless people, undertook a health audit of clients using the service in the first week of September 2009 (Cork Simon Community 2009). A total of 183 individuals were supported by services during the week; 86% were male, 87% had a medical card, and 63% were in receipt of a social welfare disability allowance.

Table 8.2.2.2 gives a profile of clients by type of service used, health status and substance use. Individuals using high-support accommodation were more likely to have

a diagnosed physical or mental health condition; this entire group had medical cards, and had the highest proportion of people receiving disability benefit. Rates of alcohol use were relatively high among all service users.

**Table 8.2.2.2 Health profile of users of Cork Simon services, September 2009**

Service	No of clients	Diagnosed physical condition n (%)	Diagnosed mental condition n (%)	Alcohol use n (%)	Drug use n (%)
Emergency Shelter	55	21 (38)	20 (36)	43 (78)	24 (44)
High Support (5 houses)	43	37 (86)	34 (86)	37 (86)	20 (47)
Housing Plus *	79	28 (35)	28 (35)	64 (81)	25 (32)

\*Includes Simon and Galton flats for independent living (38 clients), private rented accommodation (21 clients), council accommodation (7 clients), and 'other' (13 clients)

Source: Cork Simon Community, 2009

In the week of the health audit, 36% (n=20) of the residents in the Emergency Shelter were long-term homeless, defined as being in emergency accommodation for more than six months. All 20 were male; 80% had a medical card; 60% were receiving a disability payment; 55% had at least one diagnosed physical health condition; 55% had at least one diagnosed mental health condition; 90% used alcohol and 55% used drugs; 55% had a diagnosed mental health condition and used alcohol and/or drugs.

During the week of the audit, 16 people were recorded as sleeping rough for at least one night, and six of these were consistent rough sleepers. Fifteen were male; 50% had a medical card; 31% were in receipt of a disability payment; 56% had a diagnosed physical health condition; 44% had a diagnosed mental health condition; 81% used alcohol and 56% used drugs; 44% had a diagnosed mental health condition and used alcohol and/or drugs.

The data paint a picture of homeless people in Cork as having poor physical and mental health, high dependence on social welfare payments, relatively high levels of alcohol and drug use and, for some, unstable accommodation. The relatively high prevalence of substance use among people who are long-term homeless and/or sleeping rough may exacerbate their situation and prolong their experience of homelessness. Individuals presenting with diagnosed mental health conditions who are substance users are also a concern.

On a slightly brighter note, among the people who are being helped with independent living, the outcomes are less severe, as this group reports lower levels of heavy alcohol use and lower levels of drug use and heavy drug use compared to people in emergency accommodation.

### **Health of the homeless in Dublin**

O'Carroll and O'Reilly (O'Carroll and O'Reilly 2008) undertook a census of homeless adults living in temporary accommodation (10 hostels and 12 B&Bs) in north Dublin city in 2005, using an interviewer-administered questionnaire. In total, 356 people were interviewed about their health status, risk behaviours and use of services, and the responses were compared with those given eight years earlier.

Compared to 1997, the census population of 2005 was younger and contained a higher proportion of women. In 2005, a higher proportion was homeless for longer. Women, in particular, were remaining homeless for longer: in 2005, 58% of women reported being homeless for a year or longer, compared to 5% in 1997. In 2005, 69% of respondents had children, with only 20% reporting that the children were currently living with their parents. Depression and anxiety levels had increased since 1997, and there was a sharp increase in morbidity (Table 8.2.2.3).

**Table 8.2.2.3 Socio-demographic profile and health status of homeless people, Dublin, 1997 and 2005**

Characteristic	1997 (n=192)	2005 (n=356)
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Characteristic	1997 ( n=192)	2005 (n=356)
Age (under 45)	70%	81%
Homeless for 1 year or longer	44%	66%
Gender (female)	29%	39%
Drug use (current use or past use)	32%	64%
Morbidity (presence of a mental or physical health problem)	65%	84%
Depression	35%	51%
Anxiety	32%	42%

Source: Adapted from O'Carroll and O'Reilly, 2008

The most significant difference between 1997 and 2005 was that drug addiction had more than doubled and superseded alcohol as the main addiction among the homeless population. In 2005, 48% of those reporting drug use had used or were current users of heroin and 55% had injected heroin; there were high rates of blood-borne infections, such as HIV (6%), hepatitis B (5%) and hepatitis C (36%); and drug and alcohol addiction (39%) was the main reason given for becoming homeless. Access to free healthcare had not increased between 1997 and 2005 and homeless people continued to make greater use of secondary care services than the general population.

### **Risk and protection factors for substance use among young people**

Haase (Haase and Pratschke 2010) estimated drug use among 479 early school leavers and 512 school attendees, aged 16–18 years, and identified risk and protection factors for substance use. Data were collected throughout Ireland during two periods: March–May and September–December 2008. For information on the methodology and data relating to drug use prevalence, see Chapter 2.3.1.

The data showed strong statistical associations between the use of different substances. For both early school-leavers and students attending school, having tried cigarettes was a strong predictor of drinking alcohol and using cannabis. Having drunk alcohol at least once predicted having smoked cigarettes. For students attending school, having used cannabis increased the likelihood of using other drugs and having dabbled in 'other' drugs increased the likelihood of using cannabis.

The authors analysed the relationship between drug use and other factors using multi-level models. The main relationships are highlighted below.

#### **Personal characteristics and attitudes**

Age had a small influence on drug use. Among both school attendees and early school leavers, alcohol consumption increased with age, particularly among those who had reached the age of 18. Gender had no influence on alcohol, tobacco or other drug use. Ethnicity influenced alcohol consumption and cannabis use among early school-leavers. Travellers and non-white ethnic minorities were less likely to use alcohol and cannabis than white Irish early school-leavers. Ethnicity had no influence on alcohol, tobacco, cannabis or other drug use among students attending school.

Low self-concept, or self-esteem, increased the likelihood of smoking cigarettes among early school-leavers and school attendees. Aggressive 'acting-out' behaviour was associated with use of alcohol, cannabis and other drugs among early school leavers and school attendees. Low self-esteem and aggressive behaviour are risk factors for drug use.

Among both early school-leavers and school attendees, having a girlfriend or boyfriend increased the likelihood of smoking cigarettes.

#### **Parents and home**

Parental involvement with and concern for their children were protective factors for alcohol and drug use, although these influences appeared to affect different substance classes in each of the two groups. For school-attending students, parental concern reduced the likelihood of drinking alcohol and the risk of using drugs other than

cannabis. For early school-leavers, parental concern reduced the likelihood of drinking alcohol and using cannabis. Parenting had little effect on smoking in both groups.

Substance use by either parents or siblings increased the risk of a young person using the same substance. If a parent or sibling smoked or used cannabis, there was an increased likelihood that the early school-leaver and school student would smoke cigarettes or use cannabis. If a parent or sibling drank alcohol or used other drugs, there was an increased likelihood that the school attendee would do likewise.

#### Training centre or school

Factors relating to the centre or school attended by the respondent were measured at the individual level and at the level of the educational establishment. The latter data were collected through a separate questionnaire completed by the staff of the school or training centre.

If a school student had a positive relationship with supportive teachers or had a positive school experience, this had a large protective effect, reducing the risk of drinking alcohol, using cannabis or other drugs. However, it had no effect on the likelihood of smoking cigarettes. No protective effects were detected among the early school-leavers attending training centres. From these observations, the authors concluded two things. Firstly, the relationship between these aspects of the school experience and substance use was likely to involve reciprocal effects. Students who had a satisfying and enjoyable school experience were less likely to use substances, and those who did not use substances were more likely to have a good relationship with teachers and school. Secondly, this effect was remarkable by its absence amongst early school-leavers, suggesting that those who had left school early were relatively homogeneous in relation to this characteristic. They were, logically, young people who did not have a good experience at school or a good relationship with teachers.

Small protective effects were identified in relation to the educational establishment. The provision of drug awareness and information sessions for staff working in training centres reduced the likelihood that early school leavers used cannabis or other drugs. Early school-leavers with unmet counselling needs, who attended training centres, reported higher alcohol consumption than those who did not have unmet counselling needs. Within the school sector, the number of substance use classes or information sessions for parents was associated with a lower risk of cigarette smoking among students attending school.

#### Peer group

Substance use among the peer group was a risk factor for both early school-leavers and students attending school. If most of the interviewee's friends smoked cigarettes, drank alcohol, used cannabis or used other drugs, there was a greater likelihood that he or she would do likewise. The authors stated that it was equally possible that young people chose their friends partly on the basis of substance use behaviour or on the basis of factors causally related to substance use.

Smoking cigarettes was not affected by ease of access, indicating that access to cigarettes did not affect smoking rates among early school-leavers and students attending school. Early school-leavers did not report that access to alcohol influenced their alcohol consumption. Interestingly, however, ease of access to alcohol increased the likelihood of drinking alcohol for those still attending school. Use of cannabis and other drugs was significantly higher where access was easier for both early school-leavers and students attending school. Ease of access to alcohol and other drugs (except tobacco) increased consumption and is therefore a risk factor.

#### Neighbourhood

The influence of factors related to the neighbourhood was comparatively small. The neighbourhood relationships identified were not easy to explain and may mask other unanswered questions.

## Conclusion

This study identified a number of risk and protective factors which increase or decrease the risk of using substances among 15–18 year-olds in Ireland. The authors concluded that if attention were focused on factors amenable to change, the most important conclusion would be that both the family (the young person's parents in particular) and the educational institution could have a major impact on the young person's decision with regard to substance use. In addition, access to alcohol and other drugs increases the likelihood of their being used, and this is a factor that society as a whole can address.

## Substance use among children at risk of suicide

McNicholas and colleagues (McNicholas, *et al.* 2010) undertook a study of all children (n=197) presenting to an acute paediatric hospital in Dublin with deliberate self-harm (DSH) or suicidal ideation between 1993 and 2003. The ages of those in the sample ranged from 6 to 16, and three quarters were female. Among the 93% (n=183) who were admitted for DSH, overdose was the method used by 81% (n=160). The study did not discuss the nature of overdose, but 8% (n=16) of the whole sample had ingested alcohol prior to admission. The study found that of the 172 children for whom the time of presentation at the hospital was recorded, 80% (n=137) had presented outside normal working hours, i.e. 9 am to 5 pm, Monday to Friday; 57% (n=98) of those presenting outside normal working hours had presented between 7 pm and 7.30 am. According to the authors, 'These children represent an at-risk group, and were more likely to have consumed alcohol, to have made a suicide attempt, and to have a family history of psychiatric illness compared with children presenting within "normal working hours"...access to an out of hours on-call Child and Adolescent Psychiatry service is essential...' (page 11).

## 8.3 Social reintegration

In line with the recommendations outlined in the report of the Working Group on Drug Rehabilitation (Working Group on drugs rehabilitation 2007), a National Drugs Rehabilitation Framework has been published (Doyle and Ivanovic 2010). Approved by the National Drugs Rehabilitation Implementation Committee (NDRIC), this Framework has been constructed to enhance the provision of rehabilitation services to current and former drug users by creating integrated care pathways (ICPs) with the cooperation of different service providers. It is recognised that service users may present with diverse needs, including treatment, education, vocational training, employment support and accommodation, and that no single agency can cater for all possible needs. An individual care plan will be developed for each service user, and will be delivered by a multi-disciplinary team comprising the necessary range of disciplines and skills drawn from a variety of service providers. Where a service user has complex and multi-faceted needs, a more intensive case management approach may be used. According to the authors of the Framework, 'The provision of rehabilitation pathways is a shared responsibility of the education, training and employment sectors alongside the health, welfare and housing sector, non-governmental organizations, communities, families and the individual themselves' (page 7).

The ICP will comprise four steps, which will be linked to the 4-tier model of service provision:

1. Initial contact (Tier 1 services): Screening and referral, using a brief intervention screening instrument.
2. Initial Assessment and Identification of Appropriate Service (Tier 2 services upwards): Matching person to service – the aim is to determine the seriousness and urgency of the drug/alcohol problem.
3. Comprehensive assessment – key working and care planning (Tier 3 services upwards): Matching services to the person, i.e. identifying appropriate services for service users with more complex needs. Following the comprehensive assessment, a case manager will be identified, who will support the individual on their rehabilitation pathway.



#### 4. Implementation of the care plan to support an individual rehabilitation pathway.

Services drawn from the 4-tier model of service provision will be characterised by the following attributes:

- Settings may include general healthcare, structured drug treatment, community-based specialist addiction services, and residential detoxification and treatment followed by supported step-down accommodation as part of aftercare.
- Services may include information and advice, brief interventions, methadone, harm reduction and therapeutic interventions.
- Target groups may range from those experimenting with drugs to those with drug-related problems and dependence.

The development of a competent workforce in the addiction services will be supported and maintained through the development of a quality standard framework. The national standards for drug and alcohol treatment services that have been agreed by the Health Service Executive (HSE) are the Quality in Alcohol and Drug Services (QuADS) organisational standards. See Chapter 5.x.x for a report on progress in introducing the quality standard framework.

The NDRIC has responsibility for developing national protocols and service-level agreements (SLAs) to facilitate the implementation of the National Drugs Rehabilitation Framework. The NDRIC is currently piloting the integrated care pathway model at regional/local level, with a view to informing the development of the protocols (National Drugs Rehabilitation Implementation Committee 2010). The objectives of the pilot projects are to:

- support the implementation of the National Drugs Rehabilitation Framework and integrated care pathways model in line with the recommendations of the Report of the Working Group on Drugs Rehabilitation,
- build awareness and knowledge of the National Drugs Rehabilitation Framework amongst key stakeholders,
- identify progress in implementation,
- identify gaps in services and drivers/obstacles in respect of implementation,
- assess the initial impact of the Framework, and
- help to clarify roles and inform implementation of the Framework.

#### **8.3.1 Housing**

The Homeless Agency has published a case management guidebook for those working in the area of homelessness and drugs (Homeless Agency Partnership and Progression Routes Initiative 2010) The purpose of the guidebook is to provide comprehensive information, guidance and support to key workers, case managers and line managers working in the field of homelessness and drugs. It is divided into three sections – key support interventions, interagency protocols and listings.

Twelve key support interventions are described, including:

- accommodation/homelessness
- family and current relationships
- early life experience and childhood
- education
- work and job training
- legal issues/offending behaviour
- income and finance
- general physical health
- mental health
- alcohol use
- drug use
- independent living skills

Each of the chapters on support interventions lists the goals to be achieved when working with service users, gives an overview of the context for the services and supports available, and lists key supportive interventions that may be accessed. The guidebook also describes nine case management interagency protocols, including:

- holistic assessment/establishing lead agency
- referral process
- interagency case meetings
- confidentiality and data protection
- gaps and blocks in services
- grievance procedure for service users
- grievance procedure for service providers
- service user disengagement
- positive case closure

### **Accommodation for people in drug treatment**

There is no regular or standardised reporting on the provision of accommodation for people in drug treatment. Where reports are compiled regarding service provision for the homeless, very often they do not explicitly record what proportion of those housed are using drug treatment services. One exception is Merchants Quay Ireland (MQI), which has reported on two initiatives to support people in drug treatment to access appropriate accommodation (Merchants Quay Ireland 2009).

The MQI Integration Programme provides transitional accommodation to drug users who find themselves homeless after completing residential drug treatment. The programme aims to assist in the integration of former drug users into mainstream society by providing opportunities to participate in group and one-to-one therapeutic sessions and activities. Transitional accommodation is provided in two houses for a period of up to six months. Residents are offered one-to-one counselling and support, an aftercare group and a weekly community night with staff. In 2008, there were nine clients residing in one house. Of these, six moved on to longer-term accommodation; two persons relapsed, although both were still reported to be linking in with services; and one remained in the house into 2009. The drug-free aftercare group worked with an average of 6–8 people each week. In the second house, there were six residents in the course of 2008, with five of these moving on to independent accommodation, three taking up further education and two taking up employment. One resident had relapsed but was reported to have re-engaged in treatment.

The MQI Settlement Service supports clients who are seeking to exit homelessness, including those with a history of drug or alcohol problems. The service works with homeless people from a number of settings including rough sleeping, hostels, B&Bs, short-term arrangements with friends/families, and transitional and supported accommodation. A dedicated Settlement Worker works with clients leaving residential drug treatment services who have no home to go to. Methods used to assist users of the MQI Settlement Service to find, access, and sustain appropriate long-term accommodation include assessment interviews, individual support plans, one-to-one key working sessions, group support, personal development and life skills training, advocacy and pre- and post-settlement support.

In 2008 the Settlement Service carried out 86 assessments, and provided support to 96 persons, working with an average of 34 service users each month. Use of services such as money advice services and counselling increased in 2008. The Service also provided assistance with repairing family breakdown among clients and support to access employment, education or vocational training.

### **8.3.2 Education, training**

#### **Development/Education Bursary Fund, Tallaght**

The Tallaght Drugs Task Force (TDTF) commissioned an evaluation of its Development/Education Bursary Fund (Mullan Consulting 2009).

Tallaght is situated to the west of Dublin and, according to the 2006 census, has a population of 80,000 people. The community has high levels of unemployment, early school-leaving and local authority housing and in 1997 a local drugs task force, the TDTF, was established to tackle problematic drug use in the area. In 2005, the TDTF established the Development/Education Bursary Fund to target (1) individuals/groups contributing to the work of the TDTF and (2) those recovering from drug addiction and returning to education.

Mullan Consulting undertook a review of the relevant background documents, consulted with TDTF personnel and associated stakeholders, and conducted a telephone survey with 47 individuals who had secured funding through the bursary fund. The review of documentation revealed that from 2006 to 2009, an average of 43% of people granted funding for education were recovering drug users, and an average of 55% were either working or volunteering in a local drugs agency. Among participants in the telephone survey, 36% identified themselves as recovering drug users when they applied for funding. The documentation review also revealed that the average grant per individual from 2006 to 2008 was €1,500; in 2009 this was reduced to just over €1,000.

The information on the impacts and benefits of the course are not reported by target group, so the specific benefits that may have accrued for recovering drug users are not known. Among the 47 individuals granted funding who were interviewed by telephone, 64% completed their education course and 32% were on schedule to complete. The overwhelming majority reported that the course they had undertaken had met their needs. Sixty per cent had progressed to other training or education, in some cases from certificate/diploma level to degree level. In terms of progression to employment, 28.6% had retained their job, 12% had secured what was their first ever job or first job in a long time, and 26% had obtained a 'better job'. When asked to comment on their overall experience of their return to education, 82.6% rated it as having had a very positive impact. The authors noted, 'a number of recovering users commented upon the importance of the course in terms of getting them out into the real world' (page 37). Finally, there was unanimous agreement among all non-grantees consulted that participation in education and training is a progression route for stabilised and recovering drug users. One of the recommendations of the report is that recovering drug users should remain the fund's priority target group.

A similar training and education bursary fund operates in most local and regional drugs task force areas. The target groups that can avail of funding include recovering drug users. However, in most cases, the criteria for application stipulate that funding will be allocated to individuals wishing to pursue education through the Diploma in Drug and Alcohol Studies. While this approach benefits those who want to work in the addiction field, recovering drug users who wish to pursue education and employment outside the addiction field will not benefit.

### **Vocational training supported by FÁS**

FÁS, the national training and employment authority, is responsible for providing 1,000 ring-fenced drugs rehabilitation places on its Community Employment (CE) Scheme, to facilitate the vocational training needs of recovering drug users. A specially-convened working group recently developed a set of nine revised conditions to improve the operation and accessibility of the scheme (Eamonn Carey, FÁS, personal communication). The revised conditions include:

- Age of entry reduced to 18.
- Only participants identified as in rehabilitation referred for a place on the special CE Scheme. (Family members/relatives affected by drugs may be eligible under the normal CE eligibility for a place as a Support Worker.)
- Participants eligible for up to 3 years, based on annual renewal contracts.
- Supervisor to participant ratio 1:7.
- Access to quality-assured recognised certification recommended but up to 30% non-accredited activities allowed, pending periodic review.

Other enhancements introduced by FÁS, which may assist drugs rehabilitation include:

- FÁS has piloted a module on drug awareness as part of its CE Supervisors Development Programme (Level 6 FETAC Award) (Miriam Conway, FÁS, personal communication).
- A number of CE schemes that provide drugs rehabilitation places operate a pre-CE initiative, in recognition of the fact that participants may need to stabilise themselves and in order to determine levels of commitment, motivation and readiness for recovery.
- In addition to the 1,000 ring-fenced places, FÁS has a policy of positive integration of participants into mainline training.

Data from the MQI 2008 annual report illustrate the levels of activities and progression for some participants engaged in vocational training through FÁS (Merchants Quay Ireland 2009) Training and Work Programmes are provided by MQI in partnership with FÁS through the FÁS CE Scheme to prospective drugs workers, clients and post-treatment service users. The programme provides participants with skills that enable them to access employment. In 2008, 124 persons participated in CE programmes at MQI. Fifty-three completed their FÁS placement at MQI, and of these, 17 (28%) secured permanent employment, and two (4%) moved into full-time further education; 20 (38%) completed an MQI residential- or community-based drugs intervention programme as part of their CE project.

### **8.3.3 Employment**

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

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

### 9.1 Introduction

This chapter presents the most recent statistical data on drug-related crime in Ireland. It also describes policies and programmes initiated in the past year to prevent drug-related crime both in the community and in prisons as well as research studies on drug-related crime, prevention and prison. In this section the data sources and types of drug-related crimes in Ireland are described, and the approaches to preventing drug-related crime, both in the community and in prisons, are also briefly outlined.

Since 2006 reporting crime statistics has been the responsibility of the Central Statistics Office (CSO). The CSO data are derived from the Garda Síochána computerised PULSE system (Police Using Leading Systems Effectively).

The vast majority of drug offences reported come under one of three sections in the Misuse of Drugs Act (MDA) 1977: section 3 – possession of any controlled drug without due authorisation (simple possession); section 15 – possession of a controlled drug for the purpose of unlawful sale or supply (possession for sale or supply); and section 21 – obstructing the lawful exercise of a power conferred by the Act (obstruction). Other MDA offences regularly recorded relate to the importation of drugs (section 5), cultivation of cannabis plants (section 17) and the use of forged prescriptions (section 18).

Driving under the influence of drugs (DUID) has been a statutory offence in Ireland since the introduction of the 1961 Road Traffic Act. The principal legislation in this area is contained in the Road Traffic Acts 1961 to 2002. Section 10 of the Road Traffic Act 1994 prohibits driving in a public place while a person is under the influence of an intoxicant to such an extent as to be incapable of having proper control of the vehicle. Intoxicants are defined as alcohol or drugs and any combination of drugs or of drugs and alcohol. Although penalties for driving under the influence of alcohol are graded according to the concentration of alcohol detected, the law does not set prohibited concentrations for drugs. Neither does it distinguish between legal and illegal drugs. Tests to identify the level of impairment can only take place where there is a reasonable suspicion that an offence is being committed.

In reading the tables in this chapter, please note that **‘relevant proceedings’** refer to the legal proceedings, such as prosecution, taken in relation to an offence as it was originally recorded in the PULSE system. **‘Proceedings’** is a list of charges and proceedings which do not necessarily relate to an offence as originally recorded in the PULSE system.

Over and above the ‘inherent’ drug crimes, that is crimes under the Misuse of Drugs Acts or the Road Traffic Acts, ‘non-inherent’ drug crimes are also recorded in Ireland, for example acquisitive crime to pay for drugs, crimes of intimidation and violence inflicted by drug gangs, money laundering, smuggling or other finance-related crimes, or public nuisance. However, they are not reported in this chapter as it is not possible to separate those associated with the operation of the illicit drug market from those not associated with illicit drugs.

Crime prevention in Ireland proceeds on several fronts. Tackling community disadvantage is one important approach. Disadvantage in communities is recognised as a risk factor in contributing to, among other things, the spread of drug-related crime. A wide range of national initiatives exist to tackle disadvantage and its consequences, including community and local development programmes, the RAPID and CLAR programmes, and targeted urban regeneration projects. These initiatives all contain components relating specifically to illicit drugs. Specifically in relation to the drug problem, in 1998 local drugs task forces (LDTFs) were established in areas identified

as having the highest concentrations of drug misuse; without exception, these areas were all also experiencing high levels of disadvantage. The purpose of the LDTFs is to co-ordinate local action plans in relation to curbing local supply as well as treatment, rehabilitation, education and prevention. A central feature of the LDTFs is that as well as co-ordinating the provision of services locally, they also allow local communities and voluntary organisations to participate in the planning, design and delivery of services.

Diversion is another important means of seeking to prevent crime including drug-related crime – both before, and after, a crime has been committed. Garda Youth Diversion Projects are local community activities which work with children. These projects aim to help children move away from behaving in a way that might get them or their friends into trouble with the law. In 2005 the Irish Youth Justice Service (IYJS) was established to develop a co-ordinated partnership approach among agencies working in the youth justice system, to improve service delivery in the system through diversion, restorative justice, rehabilitation and detention as a last resort. Garda (Irish police force) statistics show that the types of offence committed by children under the age of 18 years are primarily theft, alcohol-related offences, criminal damage, assault, traffic offences, drugs possession, public order offences and burglary. The Garda Juvenile Diversion Programme is used to deal with children under 18 years of age who have committed offences, including alcohol-related and drug possession offences. This programme exists across the country and is included as part of the Children Act 2001. First established on a pilot basis in 2001 the Drug Treatment Court is a specialised District Court which offers long-term court-monitored treatment, including career and education support, to offenders with drug addictions as an alternative to a prison sentence. The idea is that by dealing with the addiction, the need to offend is no longer present.

Finally, individuals and communities are encouraged to participate in helping to prevent and/or detect crime. For example, the Customs Drugs Watch Programme, first launched in 1994, encourages those living in coastal communities, maritime personnel and people living near airfields to report unusual occurrences to Customs. Under the Garda Síochána Act 2005, Joint Policing Committees (JPCs) have been established in local authority areas to bring together public representatives, representatives of local authorities, the Garda Síochána and representatives of the voluntary and community sectors to assess levels of crime and anti-social behaviour, including that related to alcohol use and illicit drug use, and to make recommendations as to how to prevent and address such problems. The JPCs are empowered to establish local policing fora (LPF), to deal specifically with drugs and associated issues such as estate management and anti-social behaviour. In September 2008 a Dial-to-Stop Dealing campaign was launched and operates nationwide; individuals and communities affected by drug dealing are urged to pass information by dialling a confidential number.

The presence of drugs in prisons led the Irish Prison Service (IPS) to develop a policy based on three underlying principles (Irish Prison Service 2006):

- the presence of drugs in prison will not be tolerated;
- prisoners will be encouraged and supported to develop a responsible attitude to drugs, both while in prison and following release, through a range of measures including education and counselling; and
- prisoners who are addicted to drugs or have other medical problems caused by the misuse of drugs will be offered every reasonable care and assistance.

In the accompanying strategy the IPS lists two aims in relation to illicit drugs in prisons: (1) to eliminate the supply of drugs into prisons, and (2) to provide prisoners with a range of opportunities which encourage them to adopt a drug-free lifestyle, before and after release, thereby reducing demand for drugs.

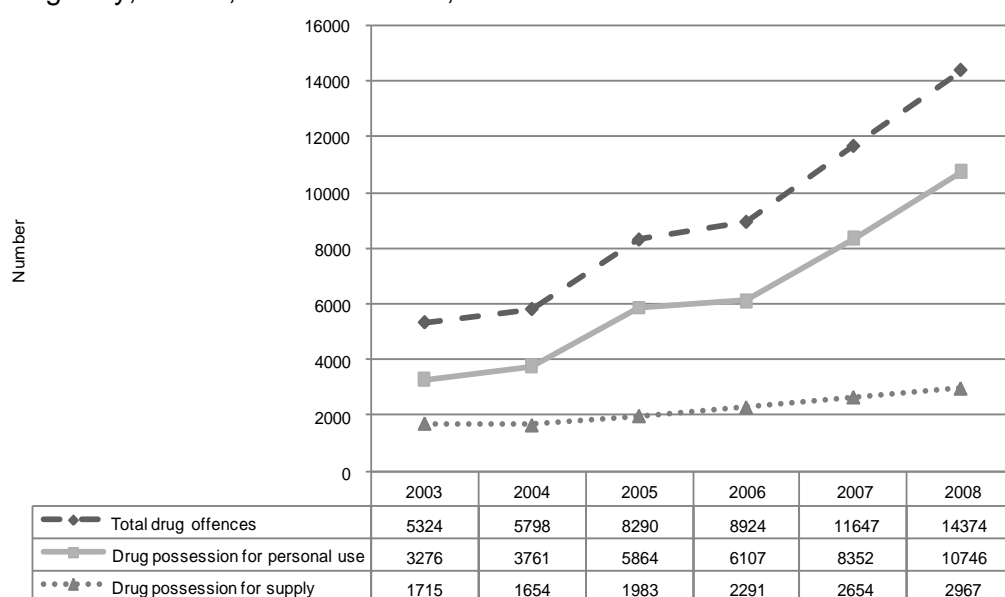
The Probation Service works in partnership with communities, local services and voluntary organisations to reduce offending and to make communities safer. It funds

and supports organisations and projects providing drug treatment to offenders, as well as other important services such as employment placement, accommodation, education and training, restorative justice initiatives. Probation Service staff in the community and in prisons may refer clients to these community-based projects, to enhance their re-integration and resettlement as positive, contributing members of their communities.

## 9.2 Drug-related crime

### 9.2.1 Drug law offences

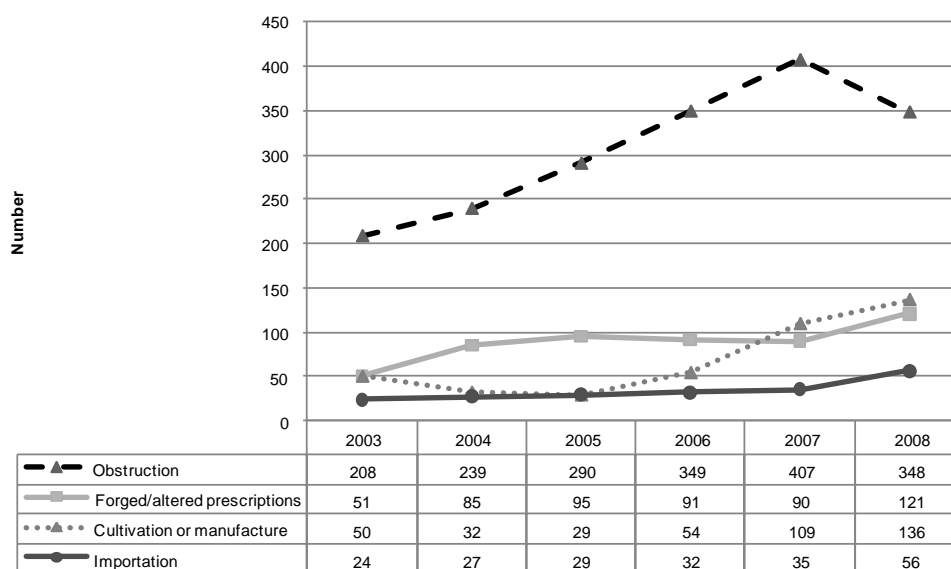
Figures 9.2.1.1 and 9.2.2.2 show trends in proceedings for drug offences from 2003 to 2008. As can be seen from Figure 9.2.1.1, criminal proceedings for the possession of drugs for personal use (simple possession) continue to increase. Possession offences accounted for almost 75 % of total drug offences (n = 14,374) in 2008. The sharp upward trend in total drug offences since 2003 is largely accounted for by the increase in simple possession offences. Proceedings for drug supply continued to increase marginally, from 2,654 in 2007 to 2,967 in 2008.



**Figure 9.2.1.1 Trends in relevant legal proceedings for total drug offences, drug possession for personal use and for supply, 2003–2008**

Source: CSO 2008, 2009, unpublished data from CSO, July 2009

Figure 9.2.2.2 shows trends in legal proceedings for a selection of other drug offences between 2003 and 2008. Although the offence of obstructing the lawful exercise of a power conferred by the Misuse of Drugs Act, 1977 (s21) continues to be the largest category, proceedings for such offences decreased in 2008, following a steady increase since 2003. Obstruction offences often involve an alleged offender resisting a drug search or an arrest or attempting to dispose of drugs to evade detection. In 2008 there was an increase in the number of proceedings for drug importation and forging a prescription to obtain drugs in a chemist or pharmacy. Proceedings for the cultivation or manufacture of drugs have continued to increase since 2005. In 2005 there were 29 proceedings for such offences. In 2008, the number of proceedings for drug cultivation/manufacture more than quadrupled to 136 proceedings. It is unclear whether this increase reflects a genuine growth in the commission of such offences or whether it reflects a greater concentration of law enforcement on detecting such offences.



**Figure 9.2.2.2 Trends in relevant legal proceedings for selected drug offences, 2003–2008**

Source: CSO 2008, 2009, Personal communication, Central Statistics Office, July 2009

In July 2009 the Courts Service annual report for 2008 was released (Courts Service 2009). It reported among other matters that drug offence cases before the District Court had increased by 58% – to 15,658 from 9,870 in 2007 – and that 18% of cases before the Circuit Court were for drug offences.

Data on prosecutions for the offence of driving under the influence of drugs (DUID) for 2008 and 2009 are not available.

## 9.2.2 Other drug-related crime

A report on drug and alcohol use in the Midland region was published in May 2010 (Lyons, Suzi, *et al.* 2010b). The study was commissioned by the Midland Regional Drugs Task Force. The aim of the study was to establish an evidence base for drug-related issues in the Midland region and to inform the development of appropriate response strategies. The study used information from several different sources, including national drug prevalence data, the National Drug Treatment Reporting System (NDTRS) and the CSO. Interviews and focus groups were also conducted with key informants (e.g. service providers, drug users, family members) in four selected communities in the region. The study findings included evidence of drug crime, such as drug markets, in the region. A partnership approach involving all the key stakeholders was one strategy highlighted by the study to tackle this problem.

The issue of gun crime in Ireland was the subject of an article in the *British Journal of Criminology* (Campbell 2010). The article identified a clear link between the illicit drug market and an increase in gun crime. Comparing the percentage of murders and manslaughters in Ireland, England and Wales the author found that 'proportionally speaking, between twice and five times as many homicides involving guns occur in Ireland' (page 415). She also cited police statements and media reports which indicated that many firearms-related deaths occurred among those involved (or at least suspected of being involved) in the illegal drugs trade. In asserting the link between guns and the trade in illicit drugs the author highlighted the fact that drugs and guns were often imported together and the view of the Customs Service that the rise in the detection and seizure of illicit firearms being imported was linked to the increased level of violence involved in drug trafficking and smuggling. The author concluded that policy responses to gun crime needed to consider the link between masculinity and gun crime and also the link between poverty, the illicit drug market and gun crime. An adequate and comprehensive response to gun crime, she concluded, 'should be cognisant of the link to poverty and the drug market and incorporate educational rather than legal approaches alone' (page 429). Targeted psychology programmes for 'at risk' young



men to address the violent expression of masculinity which underlies much gun crime and targeted policing at high-risk areas where gun violence takes place are necessary. These should, according to the author, be coupled with an increase in economic equality and a holistic educational approach. Such measures, she concluded, would be more effective in reducing gun crime than increasing prison sentence lengths or abrogating the rights of accused people.

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

In July 2009 the IYJS published *Designing effective local responses to youth crime: a baseline analysis of the Garda Youth Diversion Projects* (Irish Youth Justice Service 2009). The first part of an improvement programme for Garda Youth Diversion Projects, this baseline analysis provided a qualitative profile of youth crime in each locality and analysed the way that Garda Youth Diversion Projects impact upon youth offending. Currently there are 100 projects located around the country, representing a €13 million investment annually in youth crime prevention.

In February 2010, at the IYJS's second biennial conference, Barry Andrews TD, Minister for Children and Youth Affairs, launched the online learning community YJforum for those working on Garda Síochána Youth Diversion Projects. This web-based forum provides an opportunity for practitioners working in the youth justice system to share their experiences and work together to strengthen the system.

### **9.4 Interventions in the criminal justice system**

#### **9.4.1 Alternatives to prison**

Drug Treatment Court to continue operating

In May 2010, the Minister for Justice and Law Reform, Dermot Ahern TD, published a review by his department of the Drug Treatment Court (DTC) which has been operating in Dublin since 2001 (Department of Justice Equality and Law Reform 2010b).

According to the department's press release (Ahern 2010): 'Participants who engage with the programme have reduced rates of recidivism and improved health, education and social skills, which impact positively on the participants and the community.

However, the review also confirmed that the DTC, as currently operating, is not dealing with sufficient numbers of participants and programme completion rates are very low.'

The press release quoted Minister Ahern: 'Drug treatment courts can make an important contribution as a restorative justice measure but international studies also indicate they need to evolve and develop on an ongoing basis. This review stems from my concern about the very low throughput of participants in the DTC programme, despite the dedicated team attached to the Court and considerable goodwill on the part of all the agencies involved. I am pleased therefore that the report has identified a number of recommendations which should lead to a marked improvement in the programme's throughput and effectiveness.'

The review sought to ascertain why so few people were going through the DTC, how throughput could be increased and whether further expansion was desirable given poor results thus far. It identified the following costs and outcomes:

- Average annual justice sector cost for the years 2001–2009 was €300,000.
- A total of 374 people were referred in the nine-year period, of whom 174 were deemed unsuitable (90% of whom were outside the DTC catchment area).
- Twenty-nine people have graduated from the programme (14% of 200).
- Involvement in the court led to significant reduction in offending.
- Estimated weekly cost of DTC per offender in 2008 was €320.
- Weekly cost of a prison space in 2008 was €1,783.

The press release continued: 'The review identifies particular issues to be addressed in terms of the management and operation of the DTC which, when implemented will, it concludes, enable the DTC to fulfil its potential in terms of the numbers participating in the programme and increasing the numbers who successfully complete it. The review recommends that, having implemented the recommendations, the DTC should continue its operations for a further two years with an interim assessment to consider if the improvements are being achieved.' The review identified the following reasons for the low number of referrals to the DTC:

- Eligibility criteria exclude offenders aged under 18, those from outside the defined catchment area, and those whose offences involve violence.
- Offenders can only be referred to the DTC when they have pleaded guilty and/or have been convicted of certain offences where a prison sentence is likely.
- Judges/solicitors are unaware of the DTC as an option.
- There is a lack of management support and resources.

The press release concluded: 'The DTC operates on a multi-agency basis and all the agencies involved have confirmed their continued commitment to support the work of the Court. The Courts Service has agreed that the administration of the project will now be led by the Chief Clerk of the Dublin Circuit and District Courts, supported by a designated Deputy Chief Clerk who will be appointed shortly. The review also recommends the establishment of an Advisory Committee to oversee the project. This will be chaired by the Courts Service and made up of senior staff members of the Garda Síochána, the Health Service Executive, the Probation Service and the City of Dublin Vocational Educational Committee, and will consider the entry requirements to the programme, expectations of participants and measures of success and how the numbers of participants in the programme can be increased quickly. The Committee will also look at the questions of research into the work and effectiveness of the DTC process and examine how third-level institutions might assist the Court in this work.'

### **Restorative Justice**

The National Commission on Restorative Justice which was established to consider the potential for a restorative perspective on crime and criminal justice to be introduced in Ireland published its final report in December 2009 (National Commission on Restorative Justice 2009). The Commission defined restorative justice in the following terms: 'Restorative justice is a victim-sensitive response to criminal offending, which, through engagement with those affected by crime, aims to make amends for the harm that has been caused to victims and communities and which facilitates offender rehabilitation and integration into society' (page 20). Models of restorative justice favoured by the Commission include family conferencing, victim-offender mediation and reparation panels. The precise model adopted should, according to the Commission, be determined by the circumstances of each case. The Commission concluded that the establishment of a national system of restorative justice which targets cases involving custodial sentences of up to three years' imprisonment has the potential to divert some offenders from a custodial sentence. Although the Commission does not identify a definitive range of offences for which restorative justice would be applicable, many of those imprisoned for drug-related offences receive custodial sentences of less than three years duration.

The Commission on Restorative Justice also concluded that the Probation Service should be the lead agency in implementing any wider application of restorative justice. The Annual Report of the Probation Service for 2009 provides information on the various community-based drug services which receive funding support through the Probation Service (Probation Service 2010).

#### **9.4.2 Other interventions in the criminal justice system**

According to the 2009 annual report of the Revenue Commissioners (Revenue Commissioners 2010) the Revenue's Customs Drug Law Enforcement (CDLE) has put in place strategic and operational drugs enforcement plans; furthermore, additional

resources have been deployed. CDLE's response to the threat posed by drug smuggling includes promoting co-operation, exchange of intelligence and proactively profiling drug-trafficking networks with the relevant national and international law enforcement agencies, along with effective operational interventions. The CDLE's capacity to counter smuggling was enhanced during 2009 by the commissioning of a second Revenue Customs Cutter, *RCC Faire*, and the deployment of a second X-ray container scanner. The new scanner will be mainly deployed around Dublin Port, while the other scanner has been redeployed and will be managed from Rosslare. The complement of detector dog teams has been increased to thirteen.

The Department of Justice and Law Reform has launched the second discussion document as part of the consultation process to develop a White Paper on crime (Department of Justice Equality and Law Reform 2010a). The White Paper, due to be completed in 2011, will provide a high-level statement of government policy, its rationale and the strategies to give effect to that policy. The process of consultation involves the publication of thematic discussion documents. The first discussion document, published in July 2009, was entitled *Crime prevention and community safety* and invited submissions on a range of subjects such as: reducing opportunities for crime; developing locally based partnerships; preventing first-time criminality among those most at risk; and reducing re-offending. The process of consultation also involved regional seminars and meetings with key stakeholders. The second discussion document, *Criminal sanctions*, considered the purpose of sanctions, non-custodial sanctions, imprisonment, and sentencing policy and practice, and was published in February 2010.

In February 2010 Policing Priorities 2010 were announced by the Minister for Justice, Equality and Law Reform, Dermot Ahern TD. In addition to the continuing fight against gangland crime (including targeting drug trafficking and low-level street dealing), the Minister has prioritised security, and policing communities (including adopting a low tolerance to alcohol- and drug-related anti-social behaviour and youth crime). The policing priorities set by the Minister are reflected in the Garda Síochána Policing Plan for 2010 (An Garda Síochána 2010).

In June 2010, Pat Carey TD, Minister for Community, Equality and Gaeltacht Affairs (with responsibility for the National Drugs Strategy) announced his intention to extend the Dial to Stop Drug Dealing Campaign across local and regional drugs task forces (Carey, P 2010, 6 June). Speaking at the presentation of certificates to graduates of the TURAS programme in the Canal Communities Local Drugs Task Force area, Minister Carey said:

'The benefits of the Dial-to-Stop Drug Dealing are manifold. Since the campaign has been in operation, well over 6,000 calls have been made to the line, resulting in over 1,800 reports to the Garda. In addition to this obvious benefit, the campaign has given communities and individuals a sense of empowerment and a feeling that they can make a difference and help stop the spread of drug misuse in their communities'. He continued, 'I hope to be in a position to extend the phone-line and provide additional funding for promotional materials in the coming weeks. Officials in my Department will be in contact with local and regional drugs task forces with a view to maximising the impact of the campaign.'

## **9.5 Drug use and problem drug use in prisons**

Prevalence data regarding drug use and problem drug use in Irish prisons are not routinely collected. The Inspector of Prisons includes his findings with regard to drug and alcohol use in prisons in his reports.<sup>9</sup>

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<sup>9</sup> The Office of the Inspector of Prisons is a statutory, independent office established under the Prisons Act 2007. The key role assigned to the Inspector is to carry out regular inspections of the 14 prisons in the

In a report of an inspection in 2008–2009 of Castlerea Prison, which serves Connacht and counties Longford, Cavan and Donegal, the Inspector of Prisons stated that he had reason to believe that, contrary to the views expressed by prison management and medical staff, the use of illicit drugs and alcohol by prisoners in Castlerea Prison was cause for serious concern. The prison authorities did acknowledge that the use of prescription drugs was a serious problem:

‘I was informed that the abuse of prescription medication is a serious problem particularly addiction to sleeping tablets. I was further informed that prisoners are on prescribed sleeping tablets before entering Castlerea Prison, either from other prisons or from the community. It is the policy of the medical unit in Castlerea Prison not to prescribe sleeping tablets to prisoners unless exceptional circumstances justify their use. ... The management of Castlerea Prison conducted a survey of 230 prisoners and found that 57% of those surveyed were on prescribed high dependency mind altering drugs’ (Reilly 2009b) (paras. 5.40–41).

With regard to drug use in Irish prisons in general, the Inspector of Prisons reported in his annual report for 2008:

‘I uncovered evidence of illicit drug use in our prisons. During my inspection of Loughan House Open Centre (2008) I found that of the 553 prisoners transferred there from other prisons in 2007, 529 were selected for drug testing. Those not selected were elderly or prisoners with other medical complaints. 12.48% of those selected refused or failed to be tested. A refusal or failure was deemed by management for the purpose of their statistics as a positive finding. Of those tested, 31.76% tested positive for illicit drugs. Taking those who tested positive and those who either refused or failed, the percentage testing positive in 2007 was 44.24%. (The most common drug was cannabis). Given that this is supposed to be a coterie of prisoners who are drug free this is a matter of serious concern and suggests that the overall level of drug abuse in our prisons is very high. This prompts the observation that drugs were available in the closed prisons that these prisoners came from. The prisons from which transferred prisoners tested positive were Castlerea, Wheatfield, Midlands, Limerick, St. Patrick’s Institution, Mountjoy, Portlaoise and Cloverhill’ (Reilly 2009a) (para. 10.3).

The Inspector recommended that the IPS consider introducing mandatory testing of all prisoners in all prisons in order to get a clear picture of the extent and nature of drug use in the prison population, and to enable planning to deal with the problem.

Unpublished data obtained from the IPS regarding the results of the mandatory drug testing programme, as carried out in Irish prisons in 2009, indicates that, excluding methadone, between one-tenth and two-fifths of those screened tested positive for at least one drug. For more details, see Section 4.4.1.

The National Advisory Committee on Drugs (NACD) is currently in the process of commissioning a study to estimate the prevalence of drug use, including intravenous drug use, among the prisoner population in Ireland. For more details, see Section 9.6.3 below.

With regard to security in prisons to eliminate the supply of contraband items, primarily mobile phones, drugs and weapons, the IPS annual report for 2009 (Irish Prison Service 2010) reported on the roll-out of further security measures, to supplement those announced in the IPS strategy *Keeping drugs out of prisons* (Irish Prison Service 2006), which included stricter visiting arrangements, examination of incoming mail, search procedures, drug testing of prisoners, and enhanced perimeter security. The new measures included the following:

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State and to present his report(s) on each institution inspected as well as an Annual Report to the Minister for Justice and Law Reform.

- Operational Support Units: now operating in all closed prisons (excluding the Training Unit and Arbour Hill). These Units act as dedicated search teams, the first responders to any alarm or incident, the designated control and restraint team for cell removals and relocations and the on-call fire pickets. They are also responsible for gathering and collating intelligence information in the prison.
- Security screening: now fully operational for all staff and visitors entering all closed prisons (except the Training Unit and Arbour Hill). Every visitor and member of staff is required to pass through an airport-style walk-through detector before being granted access to the prison. In addition, x-ray scanners screen all hand bags, briefcases, packages, coats, etc.
- A Canine Unit (i.e. drug detection dog unit): operational in all prisons in 2009, comprising 31 staff.

With regard to mobile phones, the IPS reported in its 2009 annual report that a pilot scheme using technology to prevent the use of mobile phones in prisons had begun in 2007, was extended in 2008 with the introduction of inhibitors designed to prevent the use of 3G phones, and testing and evaluation continued in 2009. A Body Orifice Security Scanner (BOSS) chair, which is used to scan prisoners for contraband secreted in their body cavities, has also now been introduced in all prisons. It was piloted in Cloverhill Prison, and in its annual report for 2008, the Cloverhill Prison Visiting Committee (Cloverhill Prison Visiting Committee 2009) reported that its use had reduced mobile phone trafficking into the prison by 39%.

Regarding prisoner safety, the 2009 IPS annual report stated that on 4 December 2009, 760 people were serving sentences for drug offences, an increase of 34% on the 2008 figure of 567. During the whole year, there were 814 incidents of violence among prisoners, including some very minor incidents, an increase of 56 since 2007 (759). The IPS commented, ‘...attacks by prisoners on prisoners are not usually random acts of violence – they are related to matters on the outside – such as drug debts, gang rivalries, etc’ (Irish Prison Service 2010) (p. 28). In his annual report for 2008, the Inspector of Prisons (Reilly 2009a) suggested that internal factors also threatened the provision of safe and secure custody for prisoners including overcrowding, boredom, the reduced availability of illicit drugs, which led to irritability among prisoners, and the use of drugs by prisoners, which increased levels of aggressiveness.

## **9.6 Responses to drug-related health issues in prisons (and other custodial settings)**

### **9.6.1 Drug treatment**

The 2009 IPS annual report states that drug treatment continues to be one of the biggest issues facing the Irish prison health services (Irish Prison Service 2010). Those who present with a history of problem opiate use are offered detoxification if it is clinically indicated, or stabilisation on methadone as a treatment option. As a matter of policy, those who are already on methadone when committed can continue to receive this treatment for the duration of their sentence.

The number of prisoners on methadone maintenance treatment increased by 20% between 2008 and 2009. There was a 10% increase in the number of people new to treatment. Over 20% of those on the Central Treatment List (CTL), i.e. clients receiving methadone treatment, in 2009 were treated within the IPS, and 31% of all new entrants on the CTL in 2009 were treated within the IPS. Since 2008, pharmacists have provided the methadone treatment in Mountjoy and in the Dóchas Centre. Provision of treatment plays an important part in reducing drug-related deaths.

In 2009, 1,130 prisoners underwent detoxification treatment, and there were approximately 1,500 prisoner contacts per month with the addiction counselling services (both drug and alcohol). The report noted the benefit of the multidisciplinary

approach to the care of drug-using prisoners in Mountjoy prison, which aims to provide a personalised therapeutic relationship.

The IPS offers a range of care and rehabilitation services to inmates, including those with drug and alcohol problems. These services include education, vocational training, and psychological and spiritual services, which aim to improve re-integration into the community on release. The IPS also continues to work to enable prisoners at risk of homelessness to access appropriate accommodation on release through partnership with voluntary and statutory services in the community.

### **9.6.2 Prevention and reduction of drug-related harm**

International research has found an increased risk of mortality among prisoners within the days and weeks following their release from prison (Binswanger, *et al.* 2007). Many of these deaths are drug related and the increased mortality risk is thought to be caused by the altered tolerance to drugs which an individual may develop while in prison (Jones, *et al.* 2002) (Seymour, *et al.* 2000). A recently published paper based on data from the National Drug-Related Deaths Index (NDRDI) for the years 1998–2005 examined the relationship between date of release from prison and drug-related death (Lyons, Suzi, *et al.* 2010a). This was the first study of its kind in Ireland.

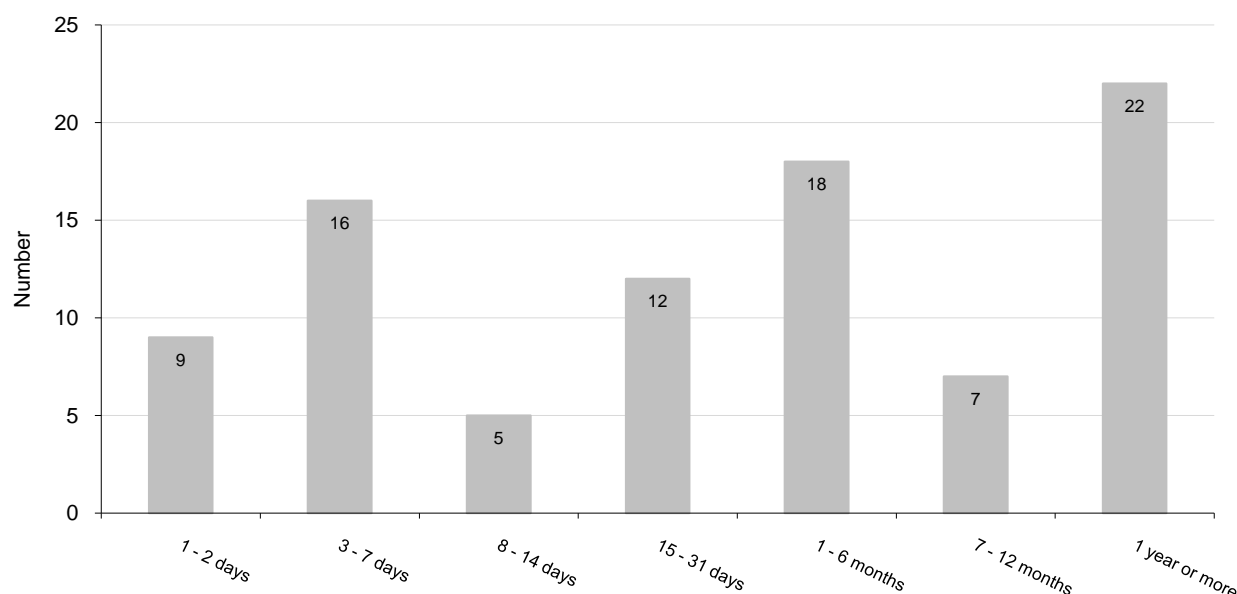
#### **Profile of cases examined**

Between 1998 and 2005, 2,442 drug-related deaths were recorded on the NDRDI. One hundred and thirty of the individuals who died had a documented history of imprisonment. Of the 130 individuals, 105 were not in prison at the time of death. The analysis presented in this article is based on these 105 individuals, of whom:

- the majority (93, 88.6%) were male;
- most (69, 65.7%) were aged between 20 and 29 years (median age 29 years);
- the majority (88, 83.8%) were unemployed;
- 21 (20.0%) were living in unstable accommodation, and 10 (9.5%) were homeless;
- 64 (61.0%) had a history of injecting, and 36 (34.3%) were injecting at the time of death;
- 11 (10.5%) had a blood-borne viral infection recorded in their history, of whom five were co-infected with two or more viruses.

#### **Time between release from prison and death**

Of the 105 individuals, 89 had a known date of release (Figure 9.6.2.1). Of these, nine (10.1%) died on day one or day two, and 16 (18.0%) died between day three and day seven. Almost half (42, 47.2%) of the 89 deaths occurred within the first month of release.



**Figure 9.6.2.1 Time between release from prison and death (N=89), NDRDI 1998–2005**

#### Deaths by poisoning within the first month of release

Of the 42 deaths within the first month of release, 38 were due to poisoning, and 18 of those who died were injecting drugs at the time of their death. Of the 14 deaths involving a single drug, 11 involved an opiate, mainly heroin and/or methadone (Table 9.6.2.1). Of the 24 deaths involving polysubstances, 23 involved an opiate (in addition to one or more other substances).

**Table 9.6.2.1 Substances involved in deaths by poisoning within the first month of release from prison (N=38)**

Substance	n (%) <sup>*</sup>
Heroin	19 (50.0)
Methadone	18 (47.4)
Benzodiazepines	11 (28.9)
Antidepressants	6 (15.8)
Stimulants <sup>†</sup>	7 (18.4)
Other <sup>‡</sup>	11 (28.9)

<sup>\*</sup> The sum of percentages in this column exceeds 100% as most deaths involved more than one substance.

<sup>†</sup> Includes cocaine and methamphetamine.

<sup>‡</sup> Includes non-benzodiazepine sedatives, unspecified opiates, analgesics containing an opiate compound, anti-psychotics, non-opiate analgesics, alcohol, solvents, cardiac and all other types of medication, including over-the-counter products.

The findings of this study are consistent with those of international studies in this area. The number of cases reported in this study is likely to be underestimated, as history of imprisonment is not routinely recorded in the NDRDI data sources. The study highlights the need for education and awareness among prisoners and their families and friends about the risk of overdose in the days and weeks following release. Many of these deaths are preventable and the findings of the study support the need for an overdose prevention strategy.

### 9.6.3 Prevention, treatment and care of infectious diseases

The National Advisory Committee on Drugs (NACD) is commissioning a study to estimate the prevalence of drug use, including intravenous drug use, among the prisoner population in Ireland in order to determine the need for drug treatment and harm reduction (including needle exchange) services in Irish prisons.

The objectives of the study are to:

- describe the nature, extent and pattern of consumption for different drugs among the prisoner population when in the community and when in prison,
- describe methods of drug use, including intravenous drug use, among the prisoner population,
- estimate the prevalence of blood-borne viruses among the prisoner population and to identify associated risk behaviours, and
- measure the uptake of individual drug treatment and harm reduction interventions (including hepatitis B vaccination) when in the community and when in prison.

The study will be jointly funded by the NACD and the IPS and the tender will be awarded in the fourth quarter of 2010 (National Advisory Committee on Drugs 2010).

A consultant-led infectious disease service has been contracted from St James's Hospital to provide treatment to prisoners who suffer from infectious diseases, including Hepatitis C and HIV. The development of this service has demonstrably decreased the number of prisoners transferred to St James's Hospital Guide Clinics for screening and treatment. It has also been effective in increasing compliance with complicated drug regimes and improving patient outcomes. The IPS in collaboration with St James's Hospital are finalising arrangements to introduce a hepatitis C virus treatment service to selected Dublin prisons (Irish Prison Service 2010).

#### **9.6.4 Prevention of overdose-risk upon prison release**

Provision of treatment plays an important part in reducing drug-related deaths. The 2009 IPS annual report stated that the service continued to face challenges in securing places in methadone clinics in the community for prisoners on methadone who were to be released (Irish Prison Service 2010).

### **9.7 Reintegration of drug users after release from prison**

In May 2010, the Irish Penal Reform Trust (IPRT) published a report *'It's like stepping on a landmine...' – Reintegration of prisoners in Ireland* (Martynowicz and Quigley 2010). The IPRT is an independent non-governmental organisation which campaigns for the rights of people in prison and the reform of penal policy.

The study, conducted between October 2009 and February 2010, consisted of a literature review, a number of semi-structured interviews with service providers (in the statutory and non-statutory sectors), a questionnaire completed by service providers throughout Ireland, and two focus groups with ex-prisoners in Dublin. The report lists the aims of the study:

- to review national and international practice and policy (including human rights standards) relating to reintegration,
- to identify barriers to reintegration of ex-prisoners in Ireland,
- to map, as far as possible, available services and identify possible gaps in service provision, and
- to make recommendations for development of future policy and practice.

The study found that, although 'significant progress has been made in recent years in integrating post-release services ... by the Irish Prison Service and its partners, there remains a less than uniform approach to the provision of necessary services in individual prisons and access to support is dependent on the facility in which the prisoner finds his- or herself' (page 3). Service provision also varies between different areas of the country. The study also found that the unstructured use of Temporary Release, often used to alleviate pressure on overcrowded prisons and to make spaces available to new prisoners, impacts negatively on preparation for release. The study found that prisoners are sometimes given no more than a few hours' notice before being released, and some are released when outside services are unavailable, on Friday evenings or at the weekend for example.



The report notes some positive developments in recent years, such as the development of a system of Integrated Sentence Management (ISM) in some prisons, and wider provision of drug counselling services, including those provided in Dublin by Merchants Quay Ireland. The IPRT makes a number of recommendations arising from the findings of the study, including the following:

- The IPS should provide appropriate access and facilities for practitioners working with prisoners on drug and alcohol addictions, including the provision of facilities ensuring confidentiality and a therapeutic environment for service users.
- All prisons should provide drug-free landings.
- The IPS, in partnership with relevant service providers, should ensure arrangements are made for prisoners to continue drug and alcohol addiction treatment upon release when required.
- The government should make the introduction of spent convictions legislation a priority in 2010, to assist prisoners in entering employment post release.

The authors state that during the research it became clear that they would not be able to address many of the issues which arose, including the specific needs of children and young people leaving custody, or of foreign national prisoners, and the needs of families who support prisoners during custody and upon release. The IPRT plans to follow-up on these issues in the near future.

## 10. Drug Markets

### 10.1 Introduction

There is no systematic, comprehensive information available on illicit drug markets in Ireland. However, there are several information sources which give indications of the nature and size of the market.

Prevalence surveys may ask respondents about their access to illicit drugs and about the availability of various drugs. For example, the **all-Ireland general population drug prevalence survey**, described in detail in Section 2.1 above, asks respondents how they obtained individual substances (who from and under what circumstances), where did they obtain them (in what type of location) and how easy were they to obtain. The **European School Survey Project on Alcohol and Other Drugs (ESPAD)**, also described in detail in Section 2.1 above, contains a question, the answer to which indicates the perceived availability of some illicit substances – ‘How difficult do you think it would be for you to get each of the following (cannabis, amphetamine, ecstasy)?’. The above studies are not reported in every National Report.

Data on drug seizures by **Customs Drug Law Enforcement (CDLE)** and the **Garda Síochána** provide insights into the origins of drugs being brought into Ireland, and the nature of the market in terms of supply and availability. However, these data must be treated with caution as the number of drug seizures in any given period can be affected by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of traffickers to law enforcement activities.

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

For policing purposes Ireland is divided into six regions, each of which is commanded by an Assistant Commissioner. The six regions are:

- Dublin Metropolitan Region
- Northern Region
- Western Region
- Eastern Region
- Southern Region
- South Eastern Region

Each region is divided into divisions commanded by a Chief Superintendent, and each division is then divided into districts commanded by a Superintendent, who is assisted by a number of Inspectors. The districts are divided into sub-districts, each normally the responsibility of a Sergeant.



**Map 10.1.1 Irish Garda regions and divisions**

The **Forensic Science Laboratory (FSL)** provides impartial scientific evidence following examination of crime scenes, including seizures of drugs. However, not all drugs seized by the law enforcement agencies (the Garda Síochána or Customs Drug Law Enforcement) are necessarily analysed and reported on by the FSL. For example, if no individual is identified in relation to the drug seizure, and no prosecution takes place, the drugs may not be sent for analysis and may be destroyed. Moreover, drug purity data are not collated in a systematic way at different market levels in Ireland. The primary function of the FSL in this area relates to supporting the criminal justice system, and not to research. Only a very small proportion of drugs seized are tested to ascertain the percentage purity.

## **10.2 Availability and supply**

### **Study of Illicit drug market in Ireland**

The first comprehensive study of the Irish illicit drug market is currently being completed by the Health Research Board. The aims of the study are to:

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

The study, a joint publication of the Health Research Board and the National Advisory Committee on Drugs, employed a range of research methods.

#### **10.2.1 Perceived availability of drugs, exposure, access to drugs e.g. in general population, specific groups/places/settings, problem drug users**

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

### **10.2.2 Drugs origin: national production versus imported**

The origins of drugs vary according to drug type. Although there has been no specific research conducted on trafficking routes into Ireland, its proximity to the UK renders it vulnerable to transit from there, and the proximity of the southern coast of Ireland to the Iberian peninsula exposes it to the supply of cannabis resin originating in Morocco and cocaine originating in the Andean peninsula. Both cannabis resin and cocaine, according to the UNODC, sometimes enter Western Europe through Ireland. It is widely reported by gardaí and the media that many known Irish drug dealers are resident in Spain, which also facilitates the development of links between suppliers of cannabis and cocaine and drug dealers resident in Ireland (O'Keeffe, Cormac 2005). Finally, Ireland's long western Atlantic coastline renders it vulnerable to trafficking from the south and central Americas. It is also important to recognise that seizures made in Irish waters are sometimes not destined for the Irish market but are destined for the UK or elsewhere in mainland Europe. In recent years some of the largest cocaine seizures in Europe have been made off the south-western coast of Ireland (Burke 2008).

The following information with regard to individual drugs was supplied by Customs Drug Law Enforcement (CDLE unpublished data, July 2010).

#### **Cannabis**

South Africa continues to be the main source for herbal cannabis. In all sectors local profiling and national /international intelligence continue to be the dominant triggers. There has been an increase in the detections of herbal cannabis sent through the post. Herbal cannabis seems to have overtaken resin in what appears to be a seesaw annual trend year on year. The trend in domestic cultivation of cannabis continues to intensify; over the past 18 months there has been a noticeable increase in detections of sapling cannabis plants and seeds. As a result of these detections, joint operations between Custom and An Garda Síochána have led to a number of seizures of cannabis plants with evidence of cannabis cultivation.

#### **Cocaine**

South America continues to be the main source for cocaine but there is continuing evidence of West African countries, e.g. Benin and Senegal, becoming distribution hubs for the European market. There has also been a marked increase in detections of cocaine swallowers coming through the airport.

#### **Heroin**

Heroin continues to be high risk through our ports. The trend of utilising deep concealment methods continues.

CDLE also states: 'Due to the economic downturn and scarcity of criminal funding we have seen evidence that Organised Crime Groups are resorting more frequently to the 'little but often' technique.' This relates to the use of drug couriers to transport small quantities of drugs frequently. This method, it is reported, is particularly evident in passenger drug couriers by air and postal and air freight packages. It is also reported that there has been a continued increase in seizures of medicinal products such as Zolpiclone and Diazepam. CDLE believes that 'this could indicate a move by drug gangs into the medicinal market which is quite lucrative'. A Memorandum of Understanding has been signed between Revenue and the Irish Medicines Board aimed at improving co-operation and the sharing of intelligence in relation to this development (CDLE personal communication, July 2010).

### **10.2.3 Trafficking patterns, national and international flows, routes, moduli operandi; and organisation of domestic drug markets**

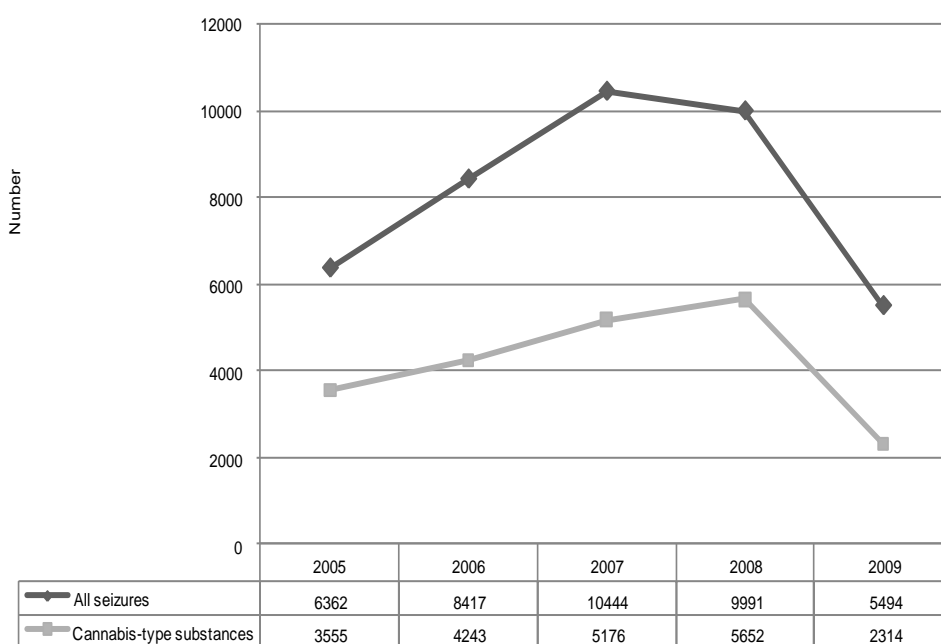
See National Report 2009 for most recent information (Alcohol and Drug Research Unit 2009).

## 10.3 Seizures

### 10.3.1 Quantities and numbers of seizures of all illicit drugs

The number of drug seizures in any given period can be affected by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of traffickers to law enforcement activities. However, drug seizures are considered indirect indicators of the supply and availability of drugs. See standard table 13 Number and quantity of seizures of illicit drugs.

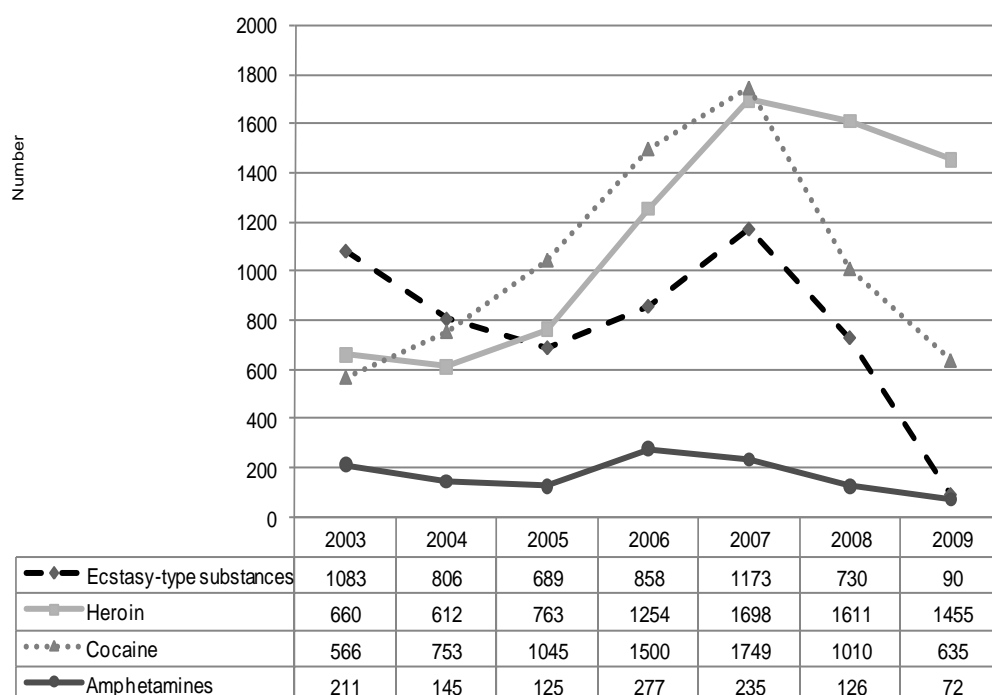
Cannabis seizures account for the largest proportion of all drugs seized. Figure 10.3.1.1 shows trends in cannabis-related seizures and total seizures between 2003 and 2009. The total number of drug seizures increased between 2005 and 2007. In 2008 the total number decreased and in 2009 the number decreased further. This decrease in total seizures in 2009 can partly be explained by the significant decrease in cannabis-type substances seized. Cannabis-related seizures decreased by just over 59%. In 2009 there were fewer reported cannabis seizures ( $n = 2,314$ ) than there were in 2005 ( $n = 3,555$ ). Although, as explained in section 10.1 above, not all drugs seized by law enforcement are necessarily analysed and reported by the Forensic Science Laboratory, it is difficult to know if the reduction in cannabis-related seizures reflects a decline in cannabis use or a reduction in law enforcement activity. However, it should be noted that drug offence prosecutions reported in section 9.2, most of which are cannabis-related, have continued to increase.



**Figure 10.3.1.1 Trends in the total number of drug seizures and cannabis seizures, 2005–2009**

Source: Central Statistics Office 2008, 2009, 2010

The reduction in the total number of reported seizures in 2009 shown in Figure 10.3.1.1 may also be explained by a reduction in the number of seizures of other drugs since 2008. Figure 10.3.1.2 shows trends in seizures for a selection of drugs, excluding cannabis, between 2003 and 2009. There has been a significant decline in seizures of cocaine, heroin and ecstasy-type substances since 2007. In 2007 there were 1,173 ecstasy-type substances seized, and in 2009 this figure was 90; in 2007 there were 1,749 cocaine seizures, while in 2009 there were 635. In 2007 there were 1,698 heroin seizures while in 2009 there were 1,455 heroin seizures. It appears that the significant reduction in total drug seizures reported in 2009 can be explained primarily as the result of a reduction in seizures of cannabis and cocaine.



**Figure 10.3.1.2 Trends in the number of seizures of selected drugs, excluding cannabis, 2003–2009**

Source: Central Statistics Office 2008, 2009, 2010

\* Includes MDMA, MDEA, and DOB

Table 10.3.1.1 shows the particulars of all drugs seized in 2009 that were reported on by the Forensic Science Laboratory (FSL). As noted in Section 10.1 above, not all drugs seized by law enforcement agencies (the Garda Síochána and Customs Drug Law Enforcement) are necessarily analysed and reported by the FSL.

**Table 10.3.1.1 Particulars of drugs seized during 2009, and analysed by the Forensic Science Laboratory (unpublished data, Central Statistics Office, 2010)**

Drug	Quantity	No. Cases
Alprazolam	38,414.5 tablets	42
Amphetamine	36,508.358 grams	72
BK-MBDB	4 tablets	2
Bromazepam	22 tablets	3
BZP ***	309,236.5 tablets, 4,371 grams, 2,360 capsules	348
Cannabis	572,333.348 grams	981
Cannabis resin	1,538,226.236 grams	1109
Cannabis plants*	3,750 plants	224
Chlorpheniramine **	333 tablets	4
Clonazepam	54 tablets	2
Cocaine	118,259.360 grams	635
CPP **	107 tablets	2
Diamorphine (Heroin)	78,668.357 grams	1455
Diazepam	114,158 tablets, 3.222 gram	270
Dihydrocodeine	790 tablets	9
Ecstasy MDMA	18,711 tablets, 3,288.496 grams	90
Flunitrazepam (Rohypnol)	152 tablets	7
Fluoxetine**	15 tablets 5 capsules	2
Flurazepam	339 capsules, 50 tablets	34
Ketamine	1.231 grams	2
Khat	Plant samples	2
Lignocaine**	106,147.501 grams	20
Lorazepam	41,524 tablets	14
LSD	1,122 squares	4
Mescaline	9 plants	3
Methandienone**	21 capsules, 711 tablets	11
Methadone	2014 mls	15
Methylamphetamine	1,119.929 grams	25

Drug	Quantity	No. Cases
Nitrazepam	23 tablets	1
Oxymetholone**	72 tablets	5
Prazepam	4 tablets	1
Sildenafil**	37 tablets	9
Stanozolol**	106 tablets, 20 mls	4
Temazepam	5 tablets	5
Triazolam	168 tablets	7
Zolpidem**	36 tablets	8
Zopiclone**	76,821 tablets	67

\*The number of cannabis plants does not reflect the total number detected as only a sample of the plants are sent for analysis.

\*\*These drugs were not controlled under the Misuse of Drugs Acts, 1977 & 1984.

\*\*\* BZP was controlled on 31 March 2009.

### **10.3.2 Quantities and numbers of seizures of precursor chemicals used in the manufacture of illicit drugs**

Data on precursor chemical seizures are included in Table 10.3.1.1.

### **10.3.3 Number of illicit laboratories and other production sites dismantled; and precise type of illicit drugs manufactured there**

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

## **10.4 Price/purity**

### **10.4.1 Price of illicit drugs at retail level**

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

### **10.4.2 Price/potency of illicit drugs**

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

### **10.4.3 Composition of illicit drugs and drug tablets**

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

## Part B: Selected Issues

### Summary of selected issues

#### **11. Selected issue: history, methods and implementation of national treatment guidelines**

The first move to standardise treatment for drug dependence in Ireland coincided with the public health scare in the mid 1980s regarding the spread of HIV/AIDS, and the recognition that risky practices associated with injecting drug use were contributing to the spread of HIV infections. Guidelines for the prescription of methadone were first issued in 1987.

The current methadone treatment protocol (MTP), adopted in 1998, covers the statutory and regulatory issues around methadone prescribing and dispensing and does not deal with any clinical or treatment guidelines *per se* (buprenorphine is not currently available in Ireland). Guidelines specifically for general practitioners and for pharmacists managing opiate users in the primary care setting have been drawn up. Guidelines have also been developed for drug treatment in prison settings, and for clinicians prescribing benzodiazepines. The MTP was reviewed in 2002, and a further review was initiated in mid 2010.

A study in 2005 of drug users' experiences of the Irish health services revealed many problems, including negative or discriminatory attitudes and treatment by health care staff. This finding led to steps to ensure that, in future, the opinions of drug users would be sought and taken into account when planning and delivering services, including the MTP. A study of Irish GPs' attitudes to the MTP in 2006 found that the vast majority thought it beneficial to patients.

#### **12. Mortality related to drug use: a comprehensive approach and public health implications**

This chapter is based on NDRDI data for the years 1998–2007.

Between 1998 and 2007 there were 3,465 drug-related deaths and deaths among drug users in Ireland. Of these deaths, 2,120 were due to poisoning and 1,345 were due to traumatic or medical causes (non-poisoning). Over the reporting period, the annual number of deaths by poisoning increased from 178 in 1998 to 274 in 2007. A study of positive toxicology reports of drug users who died owing to trauma between 1998 and 2005 showed that in many cases, more than one substance was present. The same study also looked at the history of drug use among those who died from medical causes between 1998 and 2005. This showed that the majority of drug users who died of medical causes had a history of opiate use, probably reflecting the long-term effects of problem drug use on a person.

For each death recorded by the NDRDI, any history of a blood-borne virus, including HIV, is documented if such data are recorded. However, this information is not always available. In total, between 1998 and 2007 there were 84 deaths where the individuals were HIV positive and 19 deaths where AIDS/HIV was in some way implicated in the death. The HPSC reported 84 AIDS deaths during the same period. Small numbers over the 10-year period make it difficult to discern trends.

Data from the NDRDI illustrate the total burden of mortality related to drug use in Ireland. The upward trend in deaths both by poisoning and by non-poisoning has both immediate and longer term implications and requires appropriate public health strategies.



## 11. History, methods and implementation of national guidelines

### 11.1 Introduction

The first move to standardise treatment for drug dependence in Ireland coincided with the public health scare in the mid-1980s regarding the spread of HIV/AIDS, and the recognition that risky practices associated with injecting drug use were contributing to the spread of HIV infections. This recognition saw a shift towards a decentralised network of drug treatment centres and satellite clinics, accessible and acceptable to potential service users, which provided a range of both harm reduction options, including substitution treatment, needle exchange and outreach services, and treatment options (Butler 2002a) (Butler 2002b). This shift to a dispersed and more complex system of responses to problem drug use meant that the maintenance of a consistent standard of service was more challenging than before.

In 1987 the Medical Council, a statutory body tasked with promoting and better ensuring high standards of professional conduct and professional education, training and competence among registered medical practitioners, issued guidelines for the prescription of controlled drugs under the Misuse of Drugs Act 1977 (Expert Group on the establishment of a protocol for the prescribing of methadone 1993) (Appendix B).

In 1993, following a recommendation by the National AIDS Strategy Committee, the Minister for Health convened an Expert Group on the Establishment of a Protocol for the Prescribing of Methadone. This 'expert group' comprised personnel from the Drug Treatment Centre, the Eastern Health Board, the Irish College of General Practitioners, Merchants Quay (a voluntary drug treatment service provider) and the Department of Health. It was assisted by the Pharmaceutical Society of Ireland (PSI) and the Irish Pharmacy Union (IPU).<sup>10</sup> The Expert Group published a report setting out a protocol for the management of drug users in primary care (Expert Group on the establishment of a protocol for the prescribing of methadone 1993). Endorsing the Medical Council's guidelines, published 6 years earlier, the protocol covered the prescribing of methadone, the registration of drug users and the licensing of general practitioners to treat drug users.

Between 1996 and 1998 a series of reports endorsed the 1993 methadone prescribing protocol and called for the formal adoption of national guidelines. The Ministerial Task Force on Measures to Reduce the Demand for Drugs (Ministerial Task Force on Measures to Reduce the Demand for Drugs 1996), whose reports formed the basis for Ireland's first national drugs strategy in 2001, recommended that the GP/Pharmacist methadone prescription/dispensing scheme should continue to be expanded, evaluated and strictly regulated. In its policy document on drug misuse published in 1996, the PSI acknowledged the valuable role played by methadone treatment in the management of opiate addiction. It encouraged pharmacists to participate in methadone dispensing in accordance with specific guidelines, which were in agreement with the recommendations in the Protocol and with Department of Health policy. In 1997 the Irish College of General Practitioners (ICGP) published a report by a task group on drug misuse, which recommended that general practitioners become involved in the treatment of opiate misusers in their own local communities. It also recommended that methadone treatment as described in the 1993 Protocol should continue as a valid form of treatment for opiate dependence.<sup>11</sup>

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<sup>10</sup> The Pharmaceutical Society of Ireland is the regulator of pharmacy in Ireland. The Pharmacy Act 2007 dissolved the old Pharmaceutical Society of Ireland (established in 1875) and re-established it as a statutory body. The Irish Pharmacy Union is the professional, representative body for community pharmacists.

<sup>11</sup> The executive summaries of the PSI's 1997 policy document on drug use and the ICGP's 1998 task group report on drug misuse are both included in the appendices to the report of the Methadone Treatment Services Review Group (1998).

In 1997 a Methadone Treatment Services Review Group was set up to consider the arrangements in place for the management and care of heroin dependent drug misusers by general practitioners and pharmacists in Ireland and to advise the Minister on the approach to be taken in the future. The Review Group concluded that methadone, as part of a comprehensive programme of care, was still a valid treatment for opiate-dependent persons. It recommended that services should be developed using the 1993 Protocol for the Prescribing of Methadone; that methadone should be available free of charge to all persons undergoing methadone treatment for opiate dependence; and that the methadone treatment protocol scheme should be available nationally. Recommendations were also made on the type and concentration of methadone to be used, on the roles of general practitioners and pharmacists, and on the relationships between treatment centres, general practitioners and pharmacists.

The Review Group also recommended that the methadone monitoring scheme should be placed on a statutory basis by the making of regulations under Section 5 of the Misuse of Drugs Act 1977 (Methadone Treatment Services Review Group 1998).

On foot of the Methadone Treatment Services Review Group's report, the Methadone Treatment Protocol (MTP) was drafted and activated when the Misuse of Drugs (Supervision of Prescriptions and Supply of Methadone) Regulations, 1998 (S.I. No. 225/1998) were published.

To ensure compliance with the MTP, the ICGP and PSI have both published treatment guidelines, which are described in Sections 11.2.1 and 11.2.2. The review process for the MTP is described in Section 11.3.1.

## **11.2 Existing national guidelines: narrative description of existing guidelines**

The current methadone treatment protocol covers the statutory and regulatory issues around methadone prescription and dispensing and does not deal with any clinical or treatment guidelines per se (Methadone Prescribing Implementation Committee 2005).

Appendix A (dated 1993) provides a brief summary of good practice in relation to methadone prescribing. It suggests that methadone should be started at a low dose (dose not specified) and supervised daily. For withdrawal, it recommends starting on 30 to 40 mg and reducing by 5 mg increments. It recommends methadone for pregnant women. There are also recommendations around providing comprehensive medical, social and psychological care for the client on methadone. In relation to benzodiazepines, the protocol states that they can be useful in the short term but GPs participating in the methadone programme need to be aware of the potential for abuse of these drugs.

Guidelines have been developed for managing opiate users in the primary-care setting – specifically for general practitioners (GPs) and for pharmacists. Guidelines have also been developed for drug treatment in prison settings, and for clinicians prescribing benzodiazepines. These are all described in the following sections.

### **11.2.1 Management of opiate users in the primary care setting**

In January 2008, the ICGP published revised guidelines for working with opiate users in primary care (Irish College of General Practitioners 2008). The guidelines were revised by a representative group of GPs who had experience in managing the care of individuals with an opiate misuse problem. Service users were not involved in developing these guidelines. The document deals only with methadone as a substitution treatment; buprenorphine is not currently available in Ireland (a small pilot project with regard to the use of buprenorphine in substitution treatment is ongoing (Alcohol and Drug Research Unit 2009)).

The review of the guidelines drew on available international evidence and guidelines, including the NICE guidelines, 'Methadone and Buprenorphine for Managing Opioid

Dependence', which contain recommendations based on 'current practice that has evolved over the years' (National Institute for Health and Clinical Excellence 2007).

The document has 11 sections:

1. Methadone Treatment Protocol
2. Aims and objectives of treatment
3. Assessment and management options
4. Detoxification
5. Methadone treatment
6. Special groups and substitute prescribing
7. Drug-related deaths and overdose
8. Other problems
9. Management of other drugs of misuse
10. Blood-borne viruses in opiate users
11. Non-methadone alternative therapies

Notable features of these treatment guidelines are the following:

#### After initiation assessment

The document states that not every client will be suitable for treatment in primary care, for example those with a history of violent behaviour, polysubstance addiction or a psychiatric problem.

#### Commencing methadone

The starting dose should be no more than 30 mg daily, with consumption supervised daily at this stage.

#### Stabilisation/destabilisation

It is recommended that the dose be increased by no more than 10 mg at a time until the client is stable. Usually clients stabilise on doses between 60 and 80 mg. On the clinical judgement of the doctor, supervision of consumption may be gradually reduced from daily, to thrice weekly, then twice weekly etc. However, for amounts larger than 80 mg, the guidelines state that it may be 'prudent' to continue with twice-weekly supervision because of the risk of overdose.

With regard to destabilisation, advice is provided on how to respond to the early signs of destabilisation. The guidelines recommend that management of the client should be supportive rather than punitive.

#### Pregnancy

A short section on pregnancy emphasises the need to stabilise the woman's drug use during pregnancy. If necessary, the woman should be offered admission to an in-patient unit for stabilisation on methadone (pregnant women receive priority for inpatient admission).

#### Use of sedation

The guidelines recommend that the current good-practice guidelines for the prescription and use of benzodiazepines (The Benzodiazepine Committee 2002) (Department of Health and Children 2002) be followed when prescribing benzodiazepines (see section 11.2.4 below). They specify that benzodiazepine prescriptions should be reviewed monthly (to avoid dependence) and that there should be regular communication between the client's different treatment providers to ensure benzodiazepine prescriptions are not duplicated.

#### Detoxification/withdrawal

The guidelines state that detoxification/withdrawal from methadone is more likely to be successful if psycho-social support is available. However, the type and location of the support, and the role of the GP in this process, are not outlined. They recommend that,

in negotiation with the client, small reductions (amount not specified) are more likely to be successful when aiming to reduce or come off prescribed methadone.

#### Use of sedation in withdrawal

The guidelines recommend that benzodiazepines should not be prescribed for opiate users to help reduce withdrawal symptoms. They state that there is no evidence of benefit to the client and there is a risk that the tablets may be abused or diverted. If a client is on benzodiazepines, it is recommended that a detoxification from benzodiazepines be conducted before commencing the methadone detoxification.

### **11.2.2 Management of service provision to opioid misusers by pharmacists**

As part of their overall guidance manual, the PSI has included a short section on the management of service provision to opioid users (The Pharmaceutical Society of Ireland (Standards and Practice Unit) 2008). The section lists the criteria under which the pharmacist should operate. Any pharmacist providing methadone should:

- be aware of, and comply with relevant legislation,
- ensure that persons are not stigmatised and confidentiality is maintained when they use the service,
- ensure the appropriate protocols, facilities and resources are available to safely deliver the service, and
- ensure all staff are properly trained to manage the programme.

In particular, the document states that the pharmacist should draw up a written protocol with the person receiving methadone maintenance. This protocol should set out what is expected from both parties, standards of behaviour, confidentiality and how the treatment is to be provided. Specific procedures such as the storage of the drugs or maintaining records are also outlined, and the importance of good communication between the pharmacist and client is emphasised.

### **11.2.3 Drug treatment clinical policy in the Irish Prison Service**

In January 2008 the Irish Prison Service (IPS) published a comprehensive drug treatment clinical policy (Irish Prison Service 2008). The document was created by the IPS, based on European methadone guidelines, but it does not give the names or designations of those who contributed. There is no time line or date given for evaluation or review of the document.

The policy contains a detailed section on methadone treatment, outlining the background and rationale for methadone treatment, as well as the clinical management of a prisoner on methadone and the logistics of dispensing. Specifically, it includes:

- clinical interdisciplinary care planning,
- methadone treatment guidelines,
- assessment – treatment plans and treatment goals (induction, maintenance and detoxification),
- criteria for treatment priority,
- use of methadone – ordering and dispensing, and
- administration and recording of methadone.

#### Methadone treatment

The policy outlines the processes necessary for methadone treatment under different circumstances, including when a prisoner is already on methadone, when treatment is to be initiated in prison, and when a prisoner on methadone is due to be released.

The document states that in general the initial starting dose should be between 10 and 20 mg. The document also states that if there is considerable tolerance to opioids, the starting dose could be between 25 and 40 mg but cautions that, if there is any doubt, it is better to start on a lower dose. Normally, an individual will stabilise on 60–120 mg per day.

### Withdrawal and detoxification

As set out in these guidelines, the policy of the IPS is to offer detoxification to clients who have a history of drug use unless they are (1) already on methadone maintenance treatment, (2) HIV positive, or (3) pregnant.

The document states that evidence shows that the slower the reduction of the methadone dosage the greater the likelihood of successfully coming off methadone treatment (dosages not specified). It recognises psychological support along with aftercare as critical in this process.

The lofexidine detoxification and alcohol withdrawal guidelines have been adapted from The Maudsley Protocols. Guidelines for the use of naltrexone, as part of an overall programme of addiction treatment, along with psycho-social support, are outlined in the document. The guidelines state that naltrexone should only be prescribed by a medical person experienced in its use. The use of injectable naloxone for reversing accidental opiate overdose is not covered.

### Pregnancy

Pregnant women are specifically mentioned in the document. Objectives in the care of pregnant women are:

- stabilisation of mother's drug use,
- retention of mother in obstetric and drug treatment service and ensuring adequate support and through care in the community,
- delivery of a full-term baby with healthy birth weight,
- avoidance of *in utero* exposure to HIV/hepatitis,
- minimisation of the occurrence of neonatal abstinence syndrome, and
- promotion and support for positive physical health, mental health and social wellbeing throughout and after pregnancy.

The document states that during pregnancy it is advisable to stabilise the woman on methadone, rather than attempt to detoxify. However, if a woman wishes to detoxify during her pregnancy, it is recommended that it should be done after the 12<sup>th</sup> week of pregnancy but before the 32<sup>nd</sup> week, to reduce the risk of premature labour.

### Psychological care

The policy devotes a chapter to the importance of the psychological and social aspects of drug treatment. The guiding principles are case management and care plans and a therapeutic and supportive environment within the prison.

### Other issues

Issues around blood-borne viruses, including testing, clinical management and immunisation, are also addressed in the policy. The document states that the misuse of benzodiazepines is an endemic problem in the Irish prison population and provides policies and guidelines around assessment of dependence, prescribing and detoxification.

The document states that an interdisciplinary team will provide treatment for problem cocaine use on an individual basis. There is a range of treatments available including counselling and cognitive behavioural therapy, along with appropriate referrals to medical or psychiatric services as necessary.

The document also states that it is the policy of the IPS, in accordance with the standard prevailing in the community, to develop a dual diagnosis service for those patients with addiction problems and mental health problems.

#### **11.2.4 Good practice guidelines for the prescription and use of benzodiazepines**

In December 2002 the Minister for Health and Children, Micheál Martin TD, launched the Report of the Benzodiazepine Committee (The Benzodiazepine Committee 2002)

and its Good Practice Guidelines for Clinicians (Department of Health and Children 2002).

The Benzodiazepine Committee was set up by the Minister in June 2000 to 'examine the current prescribing and use of benzodiazepines; to consider recommendations on good prescribing and dispensing practice, paying particular attention to the management of drug misusers'. The Committee comprised doctors working in addiction, with input from psychiatrists and others working in the area of addiction around the country. The Committee made no recommendations for evaluation of the report or review of the success of the guidelines.

The report envisaged the continued use of benzodiazepines as versatile and valuable drugs in clinical medicine, for example in treating insomnia, epilepsy, muscle spasms, some forms of anxiety, panic and pre-surgical stress. They anticipated that fostering rational prescribing practices for these drugs would reduce the prevalence of inappropriate use, the number of patients who become dependent on them, and consumption by known opiate users.

The report made 24 recommendations including the introduction of a monitoring system to inform GPs of their prescribing patterns and to allow appropriate action where there is a suspicion of irresponsible prescribing. The report signalled the need for greater awareness among professionals (including all hospital and institutional healthcare providers and pharmacists) and the general public about the use of benzodiazepines and made a number of recommendations in this area.

The report also recommended ongoing evaluation and monitoring of the use and misuse of benzodiazepines in Ireland, particularly in the private sector, among older people and drug users attending drug treatment clinics.

The good practice guidelines recommend GPs to critically and urgently review their current level of benzodiazepine prescribing, regard the prescription of benzodiazepines to opioid users (and other drug users) as an exceptional rather than a routine clinical decision, and routinely advise patients dependent on opioids that the concurrent use of benzodiazepines greatly increases the risk of overdose. The guidelines outline four methods for benzodiazepine withdrawal/ detoxification.

## **11.3 Implementation process**

### **11.3.1 Methadone Treatment Protocol and associated guidelines**

In 1997 the Department of Health and Children set up the Methadone Treatment Services Review Group to assess the use of methadone in the treatment of heroin dependence. Membership of this Review Group was similar to that of the 1993 Expert Group, and reflected the various agencies with a role in the provision of services for drug misusers, including the Department of Health, the then Eastern Health Board, the ICGP and the PSI. Representatives from the Merchants Quay Project, Department of General Practice in University College Dublin, and the IPU also participated in the meetings of the Review Group.

The Review Group examined the existing protocols for good practice in the prescribing and dispensing of methadone and pointed to appropriate controls that could be put in place. It also set out the basis on which methadone treatment should continue to be developed and recommended a concise framework for the future operation of the Scheme. The framework was enshrined in statutory regulations introduced in 1998 (see Section 11.1).

### **11.3.2 Methadone Prescribing Implementation Committee, 2002**

A Methadone Prescribing Implementation Committee, comprising representatives from the then Eastern Regional Health Authority, the seven health boards outside the eastern region, General Medical Services (Payments) Board, the ICGP, the PSI and the Department of Health and Children was subsequently established to oversee the implementation of the 1998 MTP. In 2002 this committee commenced a review of the implementation of the MTP (Methadone Prescribing Implementation Committee 2005).

Submissions were received from 46 interested parties and were analysed to identify themes and recommendations were made to address the themes identified, which included the following:

#### **Representation on the Methadone Prescribing Implementation Committee**

A number of submissions identified the need to invite representatives from the community, service users, the voluntary sector, the Drug Treatment Centre Board, the former Area Health Boards and the Irish Psychiatric Association on to the committee. The committee agreed to invite representatives of the Drug Treatment Centre Board, the former Area Health Boards and the Irish Psychiatric Association to be represented on the committee.

#### **The regulations**

Several submissions requested revisions to the prescribing of methadone. None of these suggestions were taken on board as it would have meant re-writing the regulations.

#### **Clients' experiences of methadone treatment services**

Clients attending methadone treatment programmes requested that all clients should participate in their treatment plan, stable clients should not need to attend weekly, individual appointment times should be given to clients, clients continuing to use drugs chaotically should be treated separately from more stable clients, and the issue of privacy with respect to urinalysis should be addressed. The committee recommended that it would be more appropriate to address these issues through the service users' charter in each HSE area.

#### **General practitioners**

A number of submissions stated that there was a need to take a co-ordinated approach to methadone treatment outside the HSE Eastern Region and to increase the recruitment of level 1 and level 2 general practitioners throughout the country. The committee stated that it would review the role of the National General Practitioner Co-ordinator to ensure greater support to the areas outside the Eastern Region. A small number of general practitioners requested an increase in the number of clients that a practitioner was permitted to treat. The committee stated that it would deal with such requests on an individual basis. It was suggested that training on treating opiate misuse be included in undergraduate and postgraduate medical training. In addition, it was suggested that specialist methadone training should continue and that completion of such training should be one of the criteria for GMS posts in deprived areas. These ideas were welcomed by the committee and were to be recommended to the relevant authorities. It was also suggested that general practitioners be given the resources to comply with the requirements of the National Drug Treatment Reporting System. Such compliance is a condition of the general practitioners contract negotiated in 2003.

#### **Pharmacists**

Pharmacists requested joint training with other health professionals, which the committee considered a useful suggestion. The need to increase the recruitment of pharmacists was raised. The committee recommended the employment of a liaison pharmacist for the HSE areas outside the Eastern Region. Some pharmacists requested routine hepatitis B vaccination; this is available free from the HSE to all participating pharmacists and their staff. Pharmacists and clients raised the issue of security and privacy in pharmacies. The committee reported that these issues were

outside their remit as they had resource implications, and noted that grants were available through the HSE for upgrading premises. Some pharmacists reported that a regular client might present to a pharmacy without a prescription and the pharmacists experienced a dilemma: to follow the regulations, or to fulfil their duty of care to the client. The committee took a pragmatic view, stating that the pharmacist should provide the previously prescribed treatment, document the experience and ensure the client seek an up-dated prescription as soon as possible. Actions should be taken to prevent this practice being repeated on a regular basis.

#### Co-ordination between services and continuity of care for clients

According to the text of the submissions, the lack both of co-ordination between psychiatric services and drug treatment services and of continuity of care between prison services and drug treatment services needed to be addressed. The committee agreed with these statements and welcomed the establishment of a national committee to develop protocols for transfer of clients between the prison services and the HSE. The committee stated that structures should be developed to ensure that clients on methadone treatment who require psychiatric treatment are not at a disadvantage.

### 11.3.3 External review of MTP, 2010

In June 2010 an external review of the MTP was initiated to maximise the provision of treatment, to facilitate appropriate progression pathways (including exit from methadone treatment where appropriate) and to encourage engagement with services. The HSE has commissioned Professor Michael Farrell, Professor of Addiction Psychiatry and Director of Postgraduate Medical Education in the Institute of Psychiatry London, to carry out the review, in conjunction with Professor Joe Barry, Professor of Population Health Medicine, Trinity College Dublin. Submissions have been invited from interested parties, including the community and voluntary sectors.

The terms of reference for the review are to:

- review the MTP with regard to maximising provision of treatment including detoxification, stabilisation, and rehabilitation,
- review the MTP with regard to clinical governance and audit,
- review the MTP with regard to effectiveness of referral pathways,
- review the MTP with regard to the enrolment of GPs, the training of GPs, the criteria for Level 1 and Level 2 GPs, and the GP co-ordinator role,
- review the MTP with regard to urinalysis testing – its appropriateness and efficacy;
- engage with the Department of Justice with regard to the prescribing of methadone in Garda stations, and
- review the MTP with regard to data collection, collation and analysis.

### 11.3.4 Drug treatment policy in Irish prisons

To date there has been no evaluation of the new policy in prisons.

### 11.3.5 Benzodiazepines

Action 41 the *National Drugs Strategy 2001–2008* (Department of Tourism Sport and Recreation 2001), tasked the Department of Health and Children with overseeing implementation of the recommendations in the report on benzodiazepines (Section 11.2.4). Speaking at the launch of the report on 10 December 2002, the Minister for Health and Children said, ‘The co-operation of key players from a wide spectrum of sectors will of course be pivotal in helping to realise this objective. I am confident that this co-operation together with a heightened public awareness of the risks inherent in inappropriate use will result in a reduction in misuse and dependency in this country.’

No formal evaluation of the success of the guidelines has been conducted. In 2009 the Steering Group that drafted the *National Drugs Strategy (interim) 2009–2016* (Department of Community Rural and Gaeltacht Affairs 2009) stated that the implementation of the recommendations had been slow and that several important



issues still needed to be addressed. These included a review of the benzodiazepine regulatory framework which deals with monitoring and application of sanctions. The Steering Group noted that while there had been improvements in the system to monitor prescribing within the public health system, prescribing in the private sector still needed to be tackled. It called for the Irish Medicines Board to review both the regulatory system and the implementation of the guidelines.

Although no formal evaluation has been conducted, several studies have examined benzodiazepine use in Ireland. A study published in 2009 (Flynn 2009) Flynn, 2009 #1266} noted that, in spite of the introduction of the guidelines seven years previously, the Irish health service had doubled the amount spent on tranquillisers and sedatives. The author stated that there was significant incorrect prescribing and distributing of these drugs. Long and colleagues (Long, J and Lyons 2009) reported that the misuse of tranquillisers and sedative drugs (mainly benzodiazepines) was common among the Irish population, while benzodiazepines were implicated in 30% of drug-related deaths in Ireland between 1998 and 2005 (Lyons, Suzi, *et al.* 2008).

#### **11.3.6 Drug users' views on the health services**

A collaborative piece of action research was published in 2005 which sought to identify the issues encountered by drug users in their dealings with the Irish health services (O'Reilly, *et al.* 2005). Focus groups were held with 25 drug users from Dublin city. The study revealed many problems, including negative or discriminatory attitudes and treatment by health care staff.

The study dealt with issues to do with drug treatment, particularly methadone maintenance treatment. Some participants felt that GPs were reluctant to take on drug users and, since GPs are gate keepers for medical cards, this created obstacles to health care. Concerns in relation to treatment services included privacy and confidentiality, and a consequent reluctance to enter counselling. Another theme to emerge was the perceived need to develop a more holistic, individual-centred approach to the multi-faceted problems being encountered by users. A broad consensus came out of the focus groups that methadone was not the whole answer to these complex issues.

One of the expected outcomes of the study was that the opinions of drug users would be considered by the health service in future. Since then, the Union for Improved Services Communication and Education (UISCE) has joined the Methadone Prescribing Implementation Committee.

#### **11.3.7 GPs' perceptions of implementing the Methadone Treatment Protocol (MTP)**

Almost one-third (32%) of opiate users prescribed methadone substitution are cared for in private general practice in Ireland. In light of this information, the ICGP conducted a postal survey in 2006 to determine the attitudes of Irish GPs to the MTP (Delargy 2008).

A questionnaire was sent to 600 GPs who were recorded on the ICGP's drug misuse database as having received training in the management of methadone clients. Just under 35% (207) responded. It is notable that 247 GPs had patients on the Central Treatment List at the time of the study.

Almost half of the GPs who responded were aged between 46 and 60 years and 29% were female. Two out of every three practices were situated in an urban area. Just over two-fifths of the GPs said that illicit drugs were a major problem in their practice area; the majority of these GPs practised in an urban location. Ninety-two per cent confirmed that they had attended special training in methadone treatment.

Of the 207 GPs who completed the questionnaire, 72% were providing patients with methadone treatment at the time of the survey. Over half had 10 or fewer patients. Only 35 prescribing doctors or their staff did not want any more patients. Forty-six GPs were willing to take more patients, which suggested that there was capacity to transfer suitable clients to a normal health care environment.

The vast majority of GPs thought that the MTP was beneficial to patients, though some said that methadone was addictive and difficult to get off.

The types of training that GPs considered most useful were small locally-based continuing education networks, individual mentoring, and distance learning.

The additional services most desired by GPs were addiction counselling, in-patient detoxification and rehabilitation beds, and employment schemes.

#### **11.4 Comparison of treatment guidelines with WHO guidelines**

Within each section above, where relevant, each item of the WHO questionnaire is alluded to. In general, comparison of the three Irish treatment guidelines dealing with methadone (Irish College of General Practitioners 2008) (Irish Prison Service 2008, Methadone Prescribing Implementation Committee 2005) with the WHO questionnaire revealed only limited congruences as the approach adopted in the Irish guidelines differs from that adopted by the WHO. However, since the start of methadone treatment in Ireland, there have been positive changes in response to previous studies and reviews, such as including services users in the MPIC committee, and the current review of Ireland's methadone treatment protocol is regarded as timely.

## **12. Mortality related to drug use: a comprehensive approach and public health implications**

### **12.1 Introduction**

Measuring the number of drug-related deaths and deaths among drug users is one of the key indicators used to monitor the consequences of problem drug use. Drug use can lead to premature death owing to a range of different causes. These include direct drug-related deaths (referred to as poisonings in this report) and indirect drug-related deaths (referred to as non-poisonings).

The National Drug-Related Deaths Index (NDRDI) is an epidemiological database which records cases of death by drug and alcohol poisoning and deaths among drug users and those who are alcohol dependent in Ireland.

Before the NDRDI, information on drug-related deaths in Ireland had been provided by the General Mortality Register (GMR), which is maintained by the Central Statistics Office (CSO). However, these data were felt to be an under-estimation, especially by families of substance users (Long, J., *et al.* 2005). This belief was supported by a study in 2001 which found that the annual numbers of opiate-related deaths recorded by the Dublin coroners were consistently higher than those reported by the GMR (Byrne, R. 2001, Byrne, R. 2002). Furthermore, deaths as an indirect result of drug use had not been systematically documented, although there had been a number of small-scale studies looking at this phenomenon in Dublin city and county (Long, J., *et al.* 2005). Families of substance users in Dublin (through the Family Support Network) had been advocating for some years for a mechanism to measure accurately the extent of premature death among drug users.

The NDRDI was established in September 2005 to comply with Action 67 of the 2001–2008 National Drugs Strategy (Department of Tourism Sport and Recreation 2001). The aim was to put in place a mechanism for accurately recording the number of drug-related deaths in Ireland, to enable the State to respond in a timely manner. The objectives of the NDRDI are to:

- provide accurate information on drug- and alcohol-related deaths and deaths among drug users and among those who are alcohol dependent, and
- assist in identifying and prioritising areas for intervention and prevention, and to measure the effects of such interventions.

To ensure completeness, the NDRDI records data from four sources: the Coroner Service, the acute hospital sector, those prescribed methadone and the GMR. Data were collected retrospectively from 1998 onwards and data in Fonte have been updated to reflect this change (see Standard Table 5). The information from the NDRDI means that for the first time both directly and indirectly drug-related deaths in Ireland can be examined.

To date, two trends papers have been published using NDRDI data, the first reporting trends in drug-related deaths and deaths among drug users in Ireland between 1998 and 2005 (Lyons, Suzi, *et al.* 2008), and the second reporting trends in deaths among drug users in Ireland from traumatic and medical causes between 1998 and 2005 (Lynn, *et al.* 2009). In 2010, a web-based report on drug-related deaths and deaths among drug users in Ireland in 2006 and 2007, including an update on previously published figures for the years 1998–2005, was uploaded (Health Research Board 2010).

### **12.2 Recent follow-up mortality cohorts studies among PDUs**

There have been no mortality cohort studies conducted in Ireland. There is one pertinent study, the Research Outcome Study in Ireland (ROSIE), which recorded death as an outcome among problem opiate users (Comiskey, Catherine, *et al.* 2008).

Commissioned by the National Advisory Committee on Drugs in 2002, ROSIE was a prospective longitudinal study of problem opiate users who entered treatment in Ireland, examining the outcome of different treatment modalities over a period of three years. One of the variables collected was information on mortality, using information obtained from the participants' contacts and the GMR.

The study recruited 404 opiate users aged 18 years or over entering treatment at inpatient facilities (hospitals, residential programmes and prisons) or in outpatient settings (community-based clinics, health board clinics and general practitioners). The opiate users selected were entering treatment for the first time, or were returning to treatment after having been absent for a period. At the end of three years, 97% of those initially recruited were followed up. Overall, six participants had died and the mortality rate was calculated as 1.5% (95% CI 0.5% to 3.2%). Cause of death was not recorded.

## 12.3 Cause specific mortality among drug users (1998 to 2007)

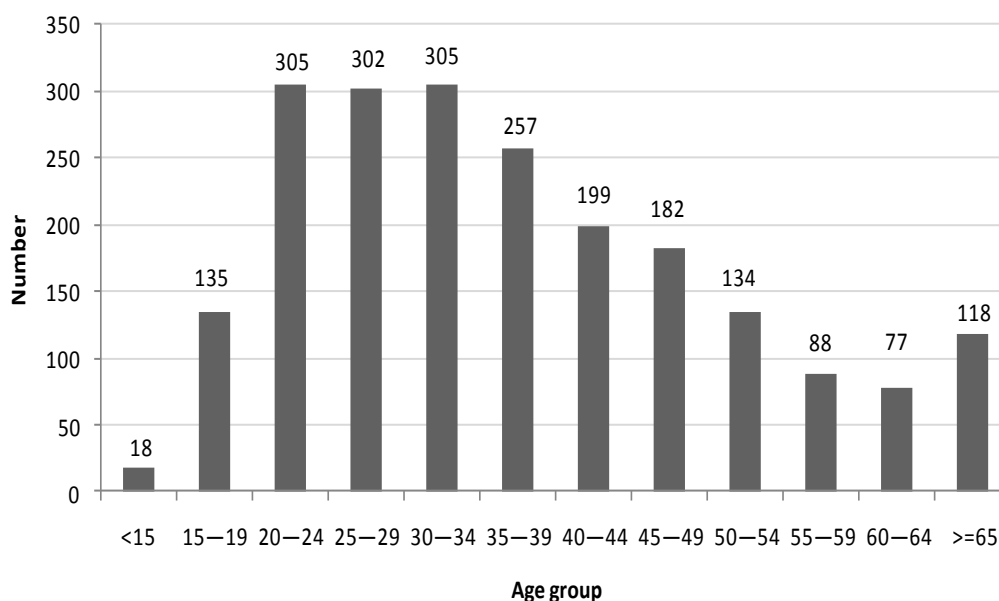
### Poisonings

Between 1998 and 2007 there were 3,465 drug-related deaths and deaths among drug users in Ireland (Health Research Board 2010). A drug user is defined in this analysis as an individual who has a history of drug dependency or of non-dependent abuse of drugs and/or other substances. Of these deaths, 2,120 were due to poisoning and 1,345 were due to traumatic or medical causes (non-poisoning) (Table 12.3.1). Over the reporting period, the annual number of deaths by poisoning increased from 178 in 1998 to 274 in 2007.

**Table 12.3.1 Drug-related deaths, by year of death, NDRDI 1998–2007 (N=3,465)**

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
All deaths	242	271	261	277	338	297	365	447	491	476
Poisoning ( n=2120)	178	187	182	178	211	185	207	248	270	274
Non-poisoning (n=1345)	64	84	79	99	127	112	158	199	221	202

Over two thirds (68%) of all deaths by poisoning were male. The median age was 34 years, with the majority of cases aged between 20 and 40 years (Figure 12.3.1).



**Figure 12.3.1 Deaths by poisoning, by age group, NDRDI 1998–2007 (N=2,120)**

Opiates, frequently heroin and methadone, were implicated in 55% of all deaths by poisoning (Table 12.3.2). Prescription medication, especially benzodiazepines, and over-the-counter medication were implicated in many of the deaths by poisoning. Just over half of all poisonings involved polysubstances.

**Table 12.3.2 Drugs involved in deaths by poisoning, NDRDI 1998–2007 (N=2,120)**

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total	%
All deaths* †	178	187	182	178	211	185	207	248	270	274	2120	100
Heroin	29	48	37	48	46	28	29	48	66	63	442	20.8
Methadone	43	37	40	28	39	34	40	43	60	50	414	19.5
Other opiates**	39	35	45	54	47	48	65	67	55	55	510	24.1
Cocaine	5	5	5	8	14	10	19	36	52	63	217	10.2
MDMA	4	8	8	6	10	11	13	10	6	11	87	4.1
Benzodiazepines	78	72	73	55	71	62	76	80	113	113	793	37.4
Alcohol‡	35	43	38	38	57	49	63	65	53	77	518	24.4
Antidepressants	32	34	41	40	47	44	51	54	43	40	426	20.1
Other prescription drug §	38	37	35	18	33	37	41	37	39	60	375	17.7
Non-opiate analgesics	12	17	11	16	16	11	12	22	13	16	146	6.9
Other¶	14	17	13	13	21	14	9	21	21	24	167	7.9

\* Includes Selection D poisonings and also other types of poisonings collected at the national level.

† Numbers and percentages in columns do not add up to totals shown in this row because individual deaths may be attributable to more than one drug or substance.

\*\* Includes unspecified opiates and analgesics containing an opiate compound.

‡ Alcohol is recorded only when it contributes to a polysubstance death.

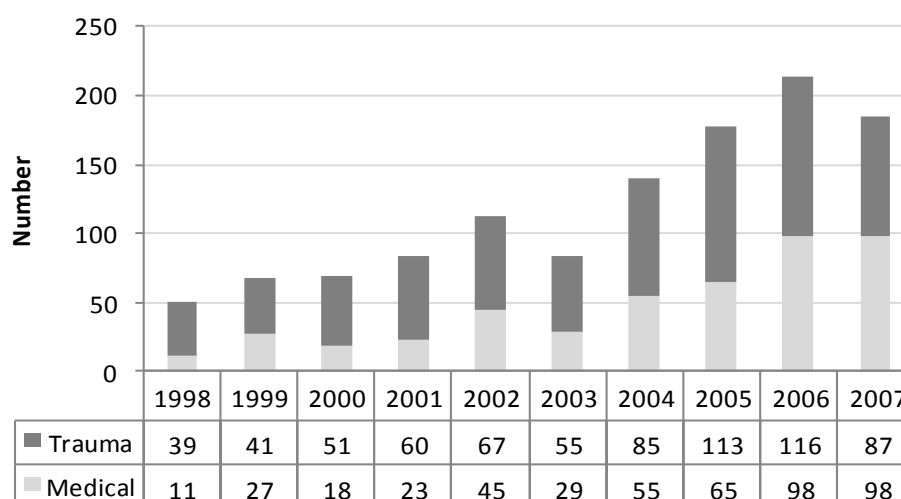
§ Includes non-benzodiazepine sedatives, anti-psychotics, cardiac and all other types of medication, including over-the-counter medication.

¶ Includes solvents, insecticides, herbicides, barbiturates, other amphetamines, hallucinogens, cannabis and other chemicals.

## Non-poisonings

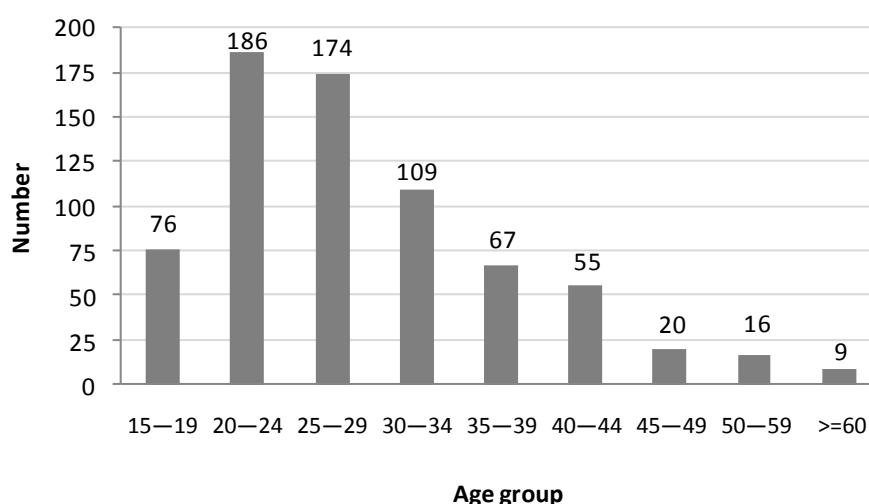
Data from the NDRDI showed that between 1998 and 2007 there was a total of 1,345 indirectly drug-related deaths among drug users in Ireland (Health Research Board 2010). For this analysis drug user is defined as an individual who has a history of drug dependency or of non-dependent abuse of drugs and/or other substances. This analysis included illegal and also legal substances (e.g. benzodiazepines) if appropriate. Of those cases with a known cause of death (n=1,183), 714 (60.3%) were owing to trauma and 469 (39.6%) were owing to medical causes (Figure 12.3.2). The

annual number of deaths owing to trauma increased from 39 in 1998 to 116 in 2006, but decreased to 87 in 2007.



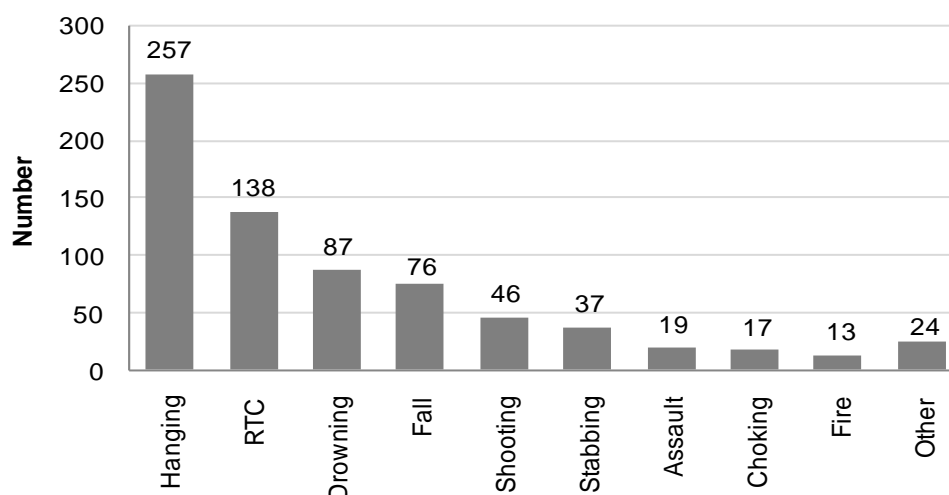
**Figure 12.3.2 Deaths not by poisoning among drug users, NDRDI 1998–2007 (N=1,183)**

Half (360, 50.4%) of those who died from traumatic causes were aged between 20 and 29 years (Figure 12.3.3). The median age was 27 years. Almost all (643, 90.1%) of those who died were male.



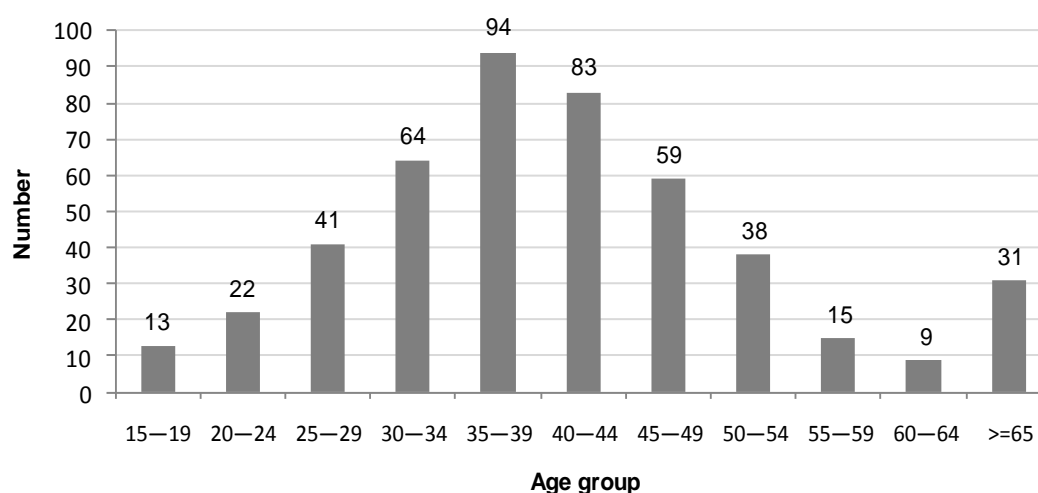
**Figure 12.3.3 Deaths among drug users owing to trauma, by age group, NDRDI 1998–2007 (N=714)**

The most common causes of death owing to trauma were hanging and road traffic collisions (RTCs) (Figure 12.3.4).



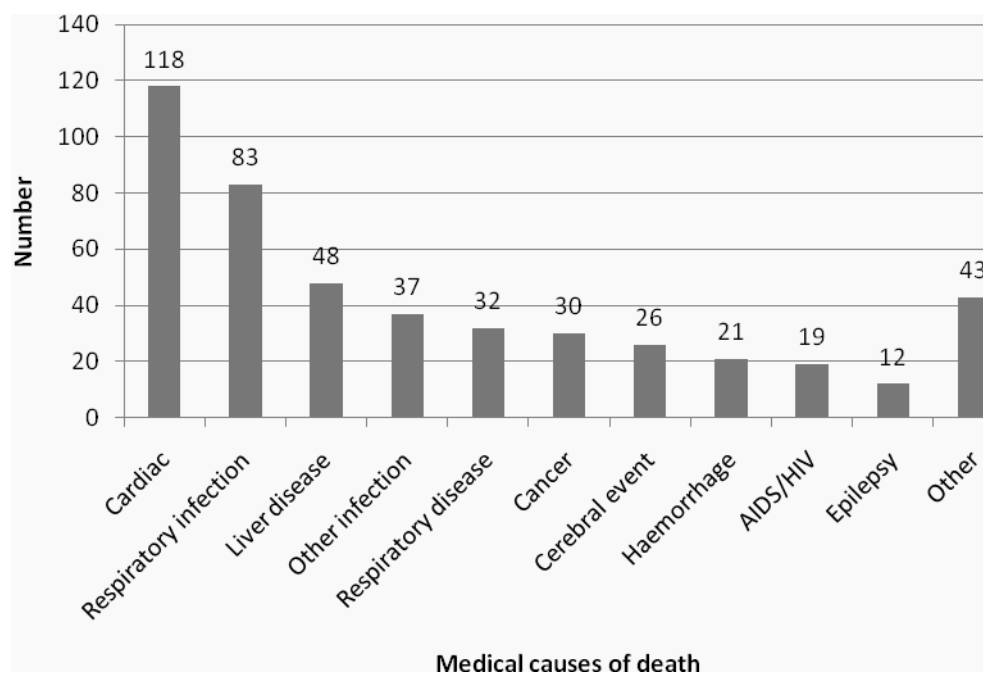
**Figure 12.3.4 Deaths among drug users owing to trauma, by type of death, NDRDI 1998–2007 (N=714)**

Between 1998 and 2007, the annual number of deaths owing to medical causes rose steadily, from 11 in 1998 to 98 in 2007 (Figure 12.3.2) (Health Research Board 2010). The majority of those who died from medical causes were aged between 30 and 44 years (Figure 12.3.5) and the median age was 39 years. Three-quarters (352, 75.0%) of those who died were male.



**Figure 12.3.5 Deaths among drug users owing to medical causes, by age group, NDRDI 1998–2007 (N=469)**

Analysis of the data showed that the most frequent medical causes of death were cardiac events (118, 25.2%), respiratory infections (83, 17.7%) and liver disease (48, 10.2%) (Figure 12.3.6).



**Figure 12.3.6 Deaths among drug users owing to medical causes, by type, NDRDI 1998–2007 (N=469)**

The previous report on traumatic deaths using NDRDI data for 1998 to 2005 had already noted that these data were consistent with data from the UK, suggesting ‘that the risk of traumatic death in drug users decreases after the age of 25, to be replaced by an increased risk of death from a pre-existing medical condition (often drug-related) in later life (Webb, *et al.* 2003). The NDRDI data on deaths among drug users show a similar pattern. Overall, those who died from medical causes were older than those who died from traumatic causes. However, it should be noted that the majority of all cases of death by non-poisoning died prematurely, well before their peers.’ (Lynn, *et al.* 2009)

#### **Correlation between toxicology and traumatic death (NDRDI 1998 to 2005 deaths)**

The toxicology of drug users who died owing to trauma between 1998 and 2005 was analysed (Lynn, *et al.* 2009). A positive toxicology report was available for 412 (86.5%) of these cases. In many cases, more than one substance was present. When these cases were analysed by type of death (Table 12.3.3), the results showed that:

- Alcohol was present in nearly three-fifths (241, 58.5%) of deaths.
- Cannabis was the illicit drug most commonly found (227, 55.1%).
- Cannabis (40, 67.8%), opiates (24, 40.7%) and cocaine (18, 30.5%) were found in the greatest proportions among deaths owing to violence (shooting, stabbing or assault).
- MDMA (ecstasy) (26, 28.6%) was found in the greatest proportion among the deaths owing to RTCs.

**Table 12.3.3 Positive toxicology in trauma cases among drug users, by type of death, NDRDI 1998–2005**

	All trauma deaths	Hanging	RTCs <sup>§</sup>	Drowning	Fall	Violence*	Other trauma
	Number (%)						
Positive toxicology cases †	412	147	91	53	32	59	30
Alcohol	241 (58.5)	82 (55.8)	50 (54.9)	40 (75.5)	22 (68.8)	35 (59.3)	14 (46.7)
Cannabis	227 (55.1)	75 (51.0)	60 (65.9)	26 (49.1)	12 (37.5)	40 (67.8)	14 (46.7)
Benzodiazepine	127 (30.8)	47 (32.0)	22 (24.2)	20 (37.7)	11 (34.4)	20 (33.9)	7 (23.3)
Opiate‡	121 (29.4)	39 (26.5)	21 (23.1)	6 (11.3)	10 (31.3)	24 (40.7)	21 (70.0)



	All trauma deaths	Hanging	RTC§	Drowning	Fall	Violence*	Other trauma
Cocaine	87 (21.1)	36 (24.5)	15 (16.5)	7 (13.2)	6 (18.8)	18 (30.5)	5 (16.7)
MDMA	62 (15.0)	10 (6.8)	26 (28.6)	10 (18.9)	5 (15.6)	9 (15.2)	~
Antidepressant	31 (7.5)	17 (11.6)	~	7 (13.2)	~	~	~
Other substance**	75 (18.2)	32 (21.8)	10 (11.0)	11 (20.7)	8 (25.0)	7 (11.9)	9 (30.0)

§ Road traffic collision

\* Includes deaths owing to shooting, stabbing or assault.

† This is a multi-response table taking account of up to 10 substances present on toxicology report. Therefore, numbers and percentages in columns may not add up to totals shown as individual cases may have more than one drug or substance present on their toxicology report.

‡ Includes methadone, heroin, morphine, distalgesic, tramadol or codeine.

\*\* Includes antihistamines, barbiturates, unspecified amphetamines, other chemicals, antiepileptics and non-benzodiazepine anxiolytics, non-opiate analgesics, local anaesthesia, antipsychotic drugs.

~ Cell contains less than five cases

There is a body of evidence linking psychiatric illness as a co-morbid condition with an increased risk of suicide (Baldacchino and Corkery 2006, Darke, Shane, *et al.* 2009, Health Service Executive, *et al.* 2005). The NDRDI does not analyse deaths by intent (accident, misadventure, suicide etc) but the presence of prescription drugs such as antidepressants and benzodiazepines in those cases where death was by hanging or drowning suggests that some people may also have had a psychiatric illness.

The analysis showed that almost two thirds of those who died owing to a RTC were positive for cannabis (note, the RTC category includes drivers, passengers and pedestrians). This underlines the need for more reliable statistics on drink/drug driving, although currently there is no reliable system of road-side testing for the presence of drugs in a driver (EMCDDA 2009).

Research has shown that drug misuse, frequently also involving alcohol, increases the risk of violence leading to homicide (Darke, S, *et al.* 2007, Shaw, *et al.* 2006). As shown in Table 12.3.3, many of those who died owing to violence were positive for both drugs and alcohol.

### Correlation between history of drug use and medical cause of death (NDRDI 1998 to 2005)

History of drug use among those who died from medical causes between 1998 and 2005 was analysed (Table 12.3.4) (Lynn, *et al.* 2009). The results showed that:

- The majority (180, 66.7%) of drug users who died of medical causes had a history of opiate use.
- Two fifths (13, 41.9%) of those who died of liver disease had a history of alcohol dependency.
- Approximately half of all deaths among cocaine users (12/26) and cannabis users (24/52) were due to a cardiac event.

**Table 12.3.4 History of drug use in cases of death from medical causes, NDRDI 1998–2005**

Substance used	All medical deaths	Cardiac	Respiratory infection	Liver disease	Other infection	Respiratory disease	AIDS /HIV	Other medical cause
	Number (%)							
All cases*	270	67	48	31	24	19	12	69
Alcohol	78 (28.9)	11 (16.4)	17 (35.4)	13 (41.9)	6 (25.0)	6 (31.6)	~	20 (29.0)
Cannabis	52 (19.3)	24 (35.8)	7 (14.6)	~	~	6 (31.6)	~	14 (20.3)
Benzodiazepine	10 (3.7)	~	~	~	~	~	~	~
Opiate†	180 (66.7)	36 (53.7)	38 (79.2)	21 (67.7)	23 (95.8)	11 (57.9)	10 (83.3)	39 (56.5)
Cocaine	26 (9.6)	12	~	~	~	~	~	5 (7.2)

	All medical deaths	Cardiac (17.9)	Respiratory infection	Liver disease	Other infection	Respiratory disease	AIDS /HIV	Other medical cause
MDMA	7 (2.6)	~	~	~	~	~	~	~
Other substance†	13 (4.8)	~	~	~	~	~	~	6 (8.7)

\*This is a multi-response table taking account of illicit use of up to six drugs. Therefore numbers and percentages in columns may not add up to totals shown as individual cases may use more than one drug or substance.

† Includes heroin, morphine, codeine, street methadone, unspecified opiate-type drug, other opiate analgesic.

‡ includes hallucinogenic substances, other stimulants and volatile inhalants, prescription and over-the-counter medication.

~ Cell contains less than five cases.

Many of those who died from medical causes were opiate users, probably reflecting the long-term effects of problematic drug use on a person. Research shows that cocaine can cause vascular disease, including heart disease (Karch 2002), and approximately one in five of those who died from a cardiac event were known to have used cocaine.

## 12.4 Risk/protective factors among PDUs

In 2009, an Irish university received funding for a study which aims to identify risk factors associated with mortality among clients receiving methadone (Dr Grainne Cousins, personal communication, Royal College of Surgeons). This study is still at an early stage and will use a variety of data sources, including data from the NDRDI. It will be several years before the results are published.

## 12.5 Complementary sources with drug-related mortality information

### 12.5.1 AIDS related deaths

In Ireland, surveillance data show that the most common probable route of transmission for HIV is sexual contact. The proportion of cases where injecting drug use is the probable route appears to be falling, from 20% in 2004 to 9% in 2009 (Health Protection Surveillance Centre 2010).

In Ireland, the number of deaths among AIDS cases appears to have been steadily falling over the past decade, down to two in 2009 (Table 12.5.1) (Health Protection Surveillance Centre 2010). However, the national Health Protection Surveillance Centre (HPSC) notes that this figure must be interpreted with caution as there is known to be under-reporting and late reporting (especially in more recent years), the impact of which is unknown. Additionally, the probable route of transmission is not known for these deaths.

**Table 12.5.1 HIV infections, AIDS cases and deaths among AIDS cases by year of diagnosis/death, 1998–2009**

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
HIV infections	120	190	290	299	364	401	358	326	353	391	404	395
AIDS	18	25	13	26	35	39	44	42	42	34	35	33
Deaths among AIDS cases	11	17	10	6	6	4	8	8	8	6	3	2

Source: HPSC, 2010

For each death recorded by the NDRDI, any history of a blood-borne virus, including HIV, is documented if such data are recorded in the coronial records, hospital or GMR data. However, this information is not always available. In total, between 1998 and 2007 there were 84 deaths where the individuals were HIV positive and 19 deaths where AIDS/HIV was in some way implicated in the death. The HPSC reported 84 AIDS deaths during the same period. Small numbers over the 10-year period make it difficult to discern trends.

### 12.5.2 Public health perspectives

The number of drug-related deaths in Ireland has increased year on year over the past decade, reflecting the increasing number of people taking drugs (National Advisory Committee on Drugs and Drug and Public Health Information and Research Branch 2009a). The majority of drug-related deaths owing to both poisoning and non-poisoning occur among people aged between 20 and 44 years, meaning that drug use is contributing to the burden of premature mortality among the Irish population. Analysis of the data on deaths by non-poisoning recorded in the NDRDI has meant that for the first time a more complete picture of the effects of drug use on drug users is available.

Public health has been defined as ‘the science and art of preventing disease, prolonging life and promoting health through organised efforts of society’ (The Committee into the Future Development of the Public Health Function 1998). Although the issues around drug-related deaths are complex, public health measures can be introduced that will help to reduce the burden of premature mortality among drug users.

For poisonings, strategies such as timely access to treatment, reduction of supply, and education and health promotion measures, can help to reduce the burden. As over half of all deaths owing to poisoning have involved polysubstances, this issue should be prioritised within education and health promotion. The first trends paper on the NDRDI data stated that, ‘The number of deaths as a result of poisoning indicates the most significant response required is a strategy to address overdoses, including actions to deal with overdose cases in a proactive manner at all levels including family, community health services, gardaí and government’ (Lyons, Suzi, *et al.* 2008). In the 2009–2016 National Drugs Strategy, Action 40 calls for the development of a National Overdose Prevention Strategy and a co-ordinated response to the rise in deaths indirectly related to substance abuse (Department of Community Rural and Gaeltacht Affairs 2009). The HSE has convened a committee to develop this strategy.

The second trends papers on the NDRDI data highlighted the public health issues around deaths by non-poisoning: ‘One-fifth of deaths among drug users that were due to trauma [between 1998 and 2005] were the result of RTCs, and almost half of these cases were driving at the time of death. This finding supports the position of the Road Safety Authority, which claims that one of the main causes of death on Irish roads is impaired driving due to the consumption of alcohol and/or drugs (both prescription and non-prescription) (Road Safety Authority 2007). The Road Safety Authority has campaigned for more reliable statistics on the incidence of drink/drug driving, and for expansion of the forensic analysis programme to ascertain the true incidence of driving under the influence of substances. However, there is currently no reliable road-side test for drugs.’ (Lynn, *et al.* 2009)

The NDRDI does not analyse data according to intent (suicide, accident, misadventure or homicide). However, international research has shown there is a strong association between substance abuse and risk of suicide (Darke, S, *et al.* 2007, Darke, Shane, *et al.* 2009, Farrell, *et al.* 1996, Guaglio, *et al.* 2001). Many of the deaths by non-poisoning, specifically those owing to hanging or drowning, had positive toxicology for antidepressants, suggesting co-morbidity among this group. Many of these cases were male with a median age of 27 years. National figures show that young men are over-represented in national suicide statistics (Health Service Executive, *et al.* 2005, Walsh 2008). The NDRDI trends paper on deaths by non-poisoning stated that, ‘Overall, the data from the NDRDI support the argument that substance misuse is related to suicide. One of the objectives of the National Strategy for Action on Suicide Prevention is to raise awareness of the association between alcohol and/or substance abuse and suicidal behaviour. There is a need for increased awareness of cases with dual diagnosis (an individual who has both a mental health issue and a substance misuse problem) given that a proportion of those who died as a result of hanging or drowning were in treatment for substance dependency at the time of their death.’ (Lynn, *et al.* 2009)

The long-term detrimental effects of drug use also have public-health implications. Data from the NDRDI have shown that many of those who have died from traumatic causes were younger than those who died from medical causes; this is similar to findings in the UK (Webb, *et al.* 2003) (Lynn, *et al.* 2009). Two thirds of those who died from medical causes were opiate users. The correlation of history of drug use and medical causes has shown the probable impact of opiate use through deaths owing to HIV/AIDS or liver disease, deaths from cardiac events among those with a history of cocaine use, and liver disease among those with a history of alcohol dependence. Linked to this is the need to support harm reduction strategies to help prevent blood-borne viruses.

Finally, alcohol features strongly in deaths by both poisoning and non-poisoning. For example, between 1998 and 2007, alcohol was implicated in almost a quarter of all deaths by poisoning (and only as part of a polysubstance poisoning). Between 1998 and 2005, alcohol was the substance most commonly found in the toxicology of those who died owing to trauma. Many of the drug users who died from medical causes were known to be alcohol dependent. As well as public health strategies to reduce alcohol-related harm, these data underline the need to integrate alcohol treatment with drug treatment services in Ireland.

Data from the NDRDI illustrate the total burden of mortality related to drug use in Ireland. The upward trend in deaths both by poisoning and by non-poisoning has both immediate and longer term implications and requires appropriate public health strategies.

## Part C

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### 13.2 List of relevant databases available on internet

- Central Statistics Office interactive tables Census 1996, 2002 and 2006  
[www.cso.ie](http://www.cso.ie)
- Hospital In-Patient Enquiry scheme data 2000–2008  
[www.esri.ie/health\\_information/hipe/](http://www.esri.ie/health_information/hipe/)
- National Drug Treatment Reporting System interactive tables 2004–2008  
[drugsandalcohol.ie](http://drugsandalcohol.ie)

For descriptions of relevant databases not currently available on-line, see introductions to chapters 5, 6, and 7.

### 13.3 List of relevant internet addresses

<http://aldp.ie>  
<http://addictionireland.ie>  
<http://attorneygeneral.ie>  
<http://www.citywide.ie>  
<http://clondalkindrugstaskforce.ie>  
<http://corkldtf.ie>  
<http://www.cso.ie>  
<http://www.courts.ie>  
<http://dialtostopdrugdealing.ie>  
<http://www.dewf.ie/>  
<http://www.dnedrugstaskforce.ie>  
<http://www.dohc.ie>  
<http://www.drugs.ie>  
<http://drugsandalcohol.ie>  
<http://www.drugpolicy.ie>  
<http://www.dwec.ie/walktall/index.html>  
<http://www.education.ie>  
<http://www.esri.ie>

<http://www.fesat.ie>  
<http://www.fsn.ie>  
<http://www.garda.ie>  
<http://www.gov.ie>  
<http://www.healthpromotion.ie>  
<http://www.hepinfo.ie>  
<http://www.hpsc.ie>  
<http://www.hrb.ie>  
<http://www.hse.ie>  
<http://www.iccl.ie>  
<http://www.icgp.ie/>  
<http://www.ihrc.ie>  
<http://inef.ie>  
<http://iprt.ie>  
<http://www.irishprisons.ie>  
<http://www.iyjs.ie>  
<http://www.justice.ie>  
<http://www.mhcirl.ie>  
<http://www.mrdtf.ie>  
<http://www.mqi.ie>  
<http://www.mwrdtf.ie>  
<http://www.nacd.ie>  
<http://www.nicdtf.ie>  
<http://www.ndublinrdtf.ie>  
<http://www.nosp.ie/index.html>  
<http://nsrf.ie>  
<http://nuigalway.ie/hbsc/>  
<http://www.nwdrugtaskforce.ie>  
<http://www.omc.gov.ie>  
<http://www.oireachtas.ie>  
<http://www.pobail.ie>  
<http://www.poisons.ie>  
<http://www.probation.ie>  
<http://www.nuim.ie/rosie/>  
<http://www.slan06.ie>  
<http://www.swrdtf.ie>  
<http://www.tallaghtdtf.ie/index.php>  
<http://www.taoiseach.ie>  
<http://www.tcd.ie/childrensresearchcentre/>  
<http://www.wrdtf.ie>



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- Figure 12.3.5 Deaths among drug users owing to medical causes, by age group, NDRDI 1998 to 2007 (N=469)

Figure 12.3.6 Deaths among drug users owing to medical causes, by type, NDRDI 1998–2007 (N=469)

### 14.3 List of maps

Map 10.1.1: Irish Garda regions and divisions

### 14.4 List of legislation

#### Acts

Children Act 2001 (No 24 of 2001)  
Criminal Justice (Money Laundering and Terrorist Financing) Act 2010 (No 6 of 2010)  
Criminal Justice (Psychoactive Substances) Act 2010 (No 22 of 2010)  
Criminal Procedure Act 2010 (No 27 of 2010)  
Garda Síochána Act 2005 (No 20 of 2005)  
Health (Miscellaneous Provisions) Act 2009 (No 25 of 2009)  
Housing (Miscellaneous Provisions) Act 1997 (No 21 of 1997)  
Housing (Miscellaneous Provisions) Act 2009 (No 22 of 2009)  
Irish Child Care Act 1991 (No 17 of 1991)  
Proceeds of Crime Act 1996 (No 30 of 1996)  
Road Traffic Act 1961 (No 24 of 1961)  
Road Traffic Act 1994 (No 7 of 1994)  
Road Traffic Act 2002 (No 12 of 2002)  
Road Traffic Act 2010 (No 25 of 2010)

#### Statutory Instruments

European Communities (Road Haulage and Road Passenger Transport Operator's Licences) (SI No. 318 of 2009)  
Irish Medicines Board (Miscellaneous Provisions) Act 2006 (Commencement) Order 2007 (SI No. 194 of 2007)  
Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2007 (SI No. 201 of 2007)  
Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order 2010 (SI 199 of 2010)  
Misuse of Drugs (Amendment) Regulations 2010 (SI 200 of 2010),  
Misuse of Drugs (Designation) (Amendment) Order 2010 (SI 201 of 2010)  
Misuse of Drugs (Exemption) (Amendment) Order 2010 (SI 202 of 2010)  
Misuse of Drugs (Amendment) Regulations 2007 (SI No. 200 of 2007)  
Misuse of Drugs (Supervision of Prescriptions and Supply of Methadone) Regulations, 1998 (SI No. 225/1998)

#### Bills

Communications (Retention of Data) Bill 2009 (No 52 of 2009)  
Criminal Justice (Forensic Evidence and DNA Database System) Bill 2010 (No 2 of 2010)  
Criminal Justice (Public Order) Bill 2010 (No 7 of 2010)  
Non-Medicinal Psychoactive Substances Bill 2010 (No 18 of 2010)  
Planning and Development (Amendment) Bill 2010 (No 10 of 2010)  
Proceeds of Crime (Amendment) Bill 2010 (No 30 of 2010)  
Spent Convictions Bill 2007 (No 48 of 2007)

### 14.5 List of abbreviations

ACC	Anterior Cingulate Cortex
ADRU	Alcohol and Drug Research Unit
AIDS	Acquired Immunodeficiency Syndrome

ALDP	Ana Liffey Drug Project
AUDIT	Alcohol Use Disorders Identification Test
BBV	Blood Borne Virus
BITC	Business in the Community Ireland
BZP	Benzylpiperazine
CAB	Criminal Assets Bureau
CAMHS	Child and Adolescent Mental Health Service
CDLE	Customs Drug Law Enforcement
CE	Community Employment
CNS	Clinical Nurse Specialist
COFOG	Classification of the Functions of Government
CRDT	Compulsory Random Drug Testing
CSO	Central Statistics Office
CTC	Coolmine Therapeutic Community
CTL	Central Treatment List
DAIRU	Drugs and Alcohol Information and Research Unit (DHSSPS, NI)
DAIS	Drugs/AIDS Information System
DES	Department of Education and Science (before March 2010)
DES	Department of Education and Skills (since March 2010)
DEHLG	Department of the Environment, Heritage and Local Government
DEIS	Delivering Equality of Opportunity in Schools
DHSSPS	Department of Health, Social Services and Public Safety
DMR	Dublin Metropolitan Region
DSH	Deliberate Self Harm
DoHC	Department of Health and Children
DTC	Drug Treatment Court
DTCB	Drug Treatment Centre Board
DTF	Drugs Task Force
DCEGA	Department of Community, Equality and Gaeltacht Affairs (since March 2010)
DCRGA	Department of Community, Rural and Gaeltacht Affairs (before March 2010)
DUID	Driving Under the Influence of Drugs
ECAS	European Comparative Alcohol Study
ED	Electoral Division
EJAF	Elton John AIDS Foundation
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESL	Early School Leavers
ESPAD	European School Survey Project on Alcohol and Other Drugs
ESRI	Economic and Social Research Institute
EU	European Union
FÁS	Foras Aiseanna Saothair (Training & Employment Authority)
FAQ	Frequently Asked Question
FESAT	European Foundation of Drug Helplines
FMRI	Functional Magnetic Resonance Imaging
FRC	Family Resource Centre
FSL	Forensic Science Laboratory
FSN	Family Support Network
GLEN	Gay and Lesbian Equality Network
GMS	General Medical Services Payment Board
GNDU	Garda National Drugs Unit
GP	General Practitioner
GYDP	Garda Youth Diversion Project
HBSC	Health Behaviour in School-aged Children Survey
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HIPE	Hospital In-Patient Enquiry scheme
HPSC	Health Protection Surveillance Centre
HRB	Health Research Board

HSCL	Home School Community Liaison
HSE	Health Service Executive
ICD	International Classification of Diseases
ICDT	Inchicore Community Drug Team
ICGP	Irish College of General Practitioners
ICU	Intensive Care Unit
ICP	Integrated Care Pathway
IHRC	Irish Human Rights Commission
ILP	Individual Learning Plan
INEF	Irish Needle Exchange Forum
IPRT	Irish Penal Reform Trust
IPU	Irish Pharmacy Union
IPS	Irish Prison Service
ISM	Integrated Sentence Management
ITS	Interrupted time-series
IYJS	Irish Youth Justice Service
JPC	Joint Policing Committee
LCDP	Local and Community Development Programme
LDTF	Local Drugs Task Force
LGBT	Lesbian, Gay, Bisexual and Transgender
LHO	Local Health Office (of the Health Service Executive)
LOD	Limit of Detection
LPF	Local Policing Fora
MAOC-N	Maritime Analysis and Operational Centre – Narcotics
MCIDI	Munich-Composite International Diagnostic Interview
MHC	Mental Health Commission
MDA	Misuse of Drugs Act
MDT	Mandatory Drug Testing
MTP	Methadone Treatment Protocol
MQI	Merchants Quay Ireland
NACD	National Advisory Committee on Drugs
NDS	National Drugs Strategy
NDRDI	National Drug-Related Deaths Index
NDRIC	National Drugs Rehabilitation Implementation Committee
NDST	National Drugs Strategy Team
NDTRS	National Drug Treatment Reporting System
NESF	National Economic and Social Forum
NGO	Non Governmental Organisation
NIAC	National Immunisation Advisory Committee
NMPDU	Nursing and Midwifery Planning and Development Unit
NPIC	National Poisons Information Centre
NPIRS	National Psychiatric Inpatient Reporting System
NSP	National Service Plan (of the Health Service Executive)
NUI	National University of Ireland
OFD	Oversight Forum on Drugs
OECD	Organisation for Economic Co-operation and Development
OMC	Office of the Minister for Children
OMCYA	Office of the Minister for Children and Youth Affairs
OMD	Office of the Minister for Drugs
PCCC	Primary, Community and Continuing Care
PCR	Polymerase Chain Reaction
PCRS	Primary Care Re-imbursement Service
PDV	Phocine Distemper Virus
PHIRB	Public Health Information and Research Branch
PPLS	Post-Primary Longitudinal Study
PSI	Pharmaceutical Society of Ireland
PPSN	Personal Public Service Number
PQ	Parliamentary Question
PULSE	Police Using Leading Systems

QFI	Quality Framework Initiative
QuADS	Quality in Alcohol and Drug Services
RAPID	Revitalising Areas by Planning Investment and Development
RCPI	Royal College of Physicians of Ireland
RCSI	Royal College of Surgeons in Ireland
RCTs	Randomised Control Trials
RDTF	Regional Drugs Task Force
RIS	Rehabilitation/Integration Service
ROSIE	Research Outcome Study in Ireland
SATU	Sexual Assault Treatment Unit
SAOL	Service Provision for Women with Addiction Problems
SBP	Schools' Business Partnership
SCP	School Completion Programme
SDS	Severity of Dependence Scale
SLÁN	Survey of Lifestyle, Attitudes and Nutrition in Ireland
SMS	Short Message Service
SPHE	Social, Personal and Health Education
STTC	Senior Traveller Training Centre
STI	Sexually Transmitted Infection
TCD	Trinity College Dublin
TD	Teachta Dála (Member of Parliament)
TDI	Treatment Demand Indicator
TDTF	Tallaght Drugs Task Force
TR	Temporary Release
UCC	University College Cork
UCD	University College Dublin
UISCE	Union for Improved Services Communication and Education
UK	United Kingdom
UNODC	United Nations Office on Drugs and Crime
VEC	Vocational Education Committee
VTOS	Vocational Training Opportunities Scheme
WHO	World Health Organization
WRDTF	Western Regional Drugs Task Force
WSE	Whole School Evaluation
YPFSF	Young People's Facilities and Services Fund