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for Drugs and Drug Addiction



**2014 NATIONAL REPORT (2013 Data)
TO THE EMCDDA
by the Reitox National Focal Point**

**IRELAND
New Developments, Trends**

REITOX

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Summary of each chapter

This report, written following European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) guidelines¹ is an overview of new developments and trends in the drugs area in Ireland for 2013 and, in some cases, for the first six months of 2014. 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. High risk 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

Main points from Part A

1. Drug policy: legislation, strategies and economic analysis

New legislative and regulatory measures include: the Health Identifiers Act 2014, which provides the legal basis for individual health identifiers for health service users and unique identifiers for health service providers, the Road Traffic (No.2) Act 2014, which provides for non-technology-based cognitive tests for driver intoxication; and regulations allowing approved medicines containing the active ingredients of cannabis to be prescribed in Ireland. A journal article has examined how legislative and law enforcement responses to the emergence of new psychoactive substances (NPS) and so-called 'head shops' in recent years in Ireland have adversely impacted on academic research on NPS. Future legislative approaches in this area should recognise the potential for academics and forensic service providers to work together. The Criminal Justice Act 1999 created a new offence of possessing controlled drugs having a value of £10,000 (€13,000) or more for sale or supply, which attracted a presumptive sentence of 10 years' imprisonment. A sentencing court may, however, impose a lower sentence where there are mitigating factors that amount to 'exceptional and specific circumstances'. A recent study found that, in addition to consideration of the quantity or value of drugs, other factors influencing sentences under this legislation included the type of controlled drug or drugs, the role of the offender, and the condition of the offender.

To progress the integration of drug and alcohol policies, in October 2013 the government approved an extensive package of measures to deal with alcohol misuse, to be incorporated in a Public Health (Alcohol) Bill. In January 2014 the Department of Health hosted a half-day conference for those working in the drugs and alcohol field to (1) assess how the partnership approach to the delivery of the NDS could be maintained and strengthened, and (2) provide a forum for participants to give their views on how drug and alcohol task forces could integrate alcohol into their work. At the conference, details of a new policy coordination mechanism were announced. Between the Oversight Forum on Drugs (OFD) and the local and regional drugs task forces (LDTFs and RDTFs), a National Coordinating Committee (NCC) for drug and alcohol task forces has been established. It is chaired by a senior official in the Department of Health and comprises representatives of relevant organisations in the statutory, voluntary and community sectors. Replacing the Drugs Advisory Committee, the NCC drives implementation of the NDS at local and regional level. It is responsible for making recommendations to the Minister in relation to the implementation of the NDS.

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

In 2014 the All-Ireland general population survey 2010/2011 reported detailed information on cocaine use. More people than ever before had tried cocaine (including crack) at least once in their lifetime, with the rate at 7% for the adult population in 2010/11, compared to 3% in the 2002/03 survey. However, the proportion of adults who reported using cocaine in the last year (recent use) remained

¹ The EMCDDA 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. www.emcdda.europa.eu/.

stable between 2006/7 and 2010/11 at just under 2%. Half of all cocaine users commenced use before they were 21 years old.

In 2014 the All-Ireland general population survey 2010/2011 also reported detailed information on polydrug use. Polydrug use was defined as concurrent substance use, where a person uses at least two substances within a one-month period. Twenty per cent of all adults had not used any substance within the last month. Women were more likely than men not to have used any substance (23% vs 19%). The most common combination of substances used was alcohol and tobacco (16%), followed by alcohol and other legal drugs (7%), alcohol, tobacco and other legal drugs (2%), and alcohol, tobacco and any illegal drug (2%). Association between use of alcohol and tobacco was high. Users of cannabis, amphetamine-type stimulants (ATS) and cocaine were highly likely to have used other legal and illegal substances.

The Health Behaviour in School-age Children (HBSC) 2010 research programme reported on trends between 1998 and 2010. There was a statistically significant decrease between 1998 and 2010 in the number of young people aged 15 to 17 who reported ever having been drunk. However, gender differences were evident, with an increase in the number of girls reporting ever having been drunk from 24% in 1998 to 26.6% in 2010. There was also a statistically significant decrease between 1998 and 2010 in the percentage of young people aged 15–17 who reported cannabis use in the last 12 months.

3. Prevention

Among the main developments in environmental prevention, a Public Health (Alcohol) Bill is being drafted, which will include measures to restrict alcohol advertising and introduce minimum pricing for the sale of alcohol. In 2013 the government published a Tobacco Free Ireland policy document, which sets out a framework to protect children and de-normalise smoking and sets a smoking prevalence target of less than 5% by 2025. The government is also drafting legislation to ban the smoking of tobacco in vehicles when any child under 18 years is present.

In school-based substance use prevention, the working group set up to examine substance use education in post-primary schools concluded that multi-element programmes which have whole-school, parent and community support strands, coupled with a harm reduction approach, appear to offer considerable advantages as regards effective substance use education programmes for young people. This is the first time that a harm reduction component has been formally endorsed in school-based substance use education in Ireland. In recognition of the reality that a proportion of students are using legal and illegal substances, the working group recommended that teaching and learning resources used in schools and centres for education aim at reducing, postponing and/or eliminating substance use.

Eighty-eight per cent of primary schools and 93% of post-primary schools that responded to a survey reported having a substance use policy in place. An inspection report on the delivery of Social, Personal and Health Education (SPHE) in post-primary schools noted that the module on substance use is frequently delivered as part of SPHE. When students were surveyed as part of the inspection process, they reported high levels of satisfaction with their learning from the module on substance use, with the vast majority reporting that they learned about reasons for substance use/misuse, and the effects on individuals, families and society.

Published in 2014, a new national policy framework for children and young people sets out five outcomes for children and young people up to the age of 24 to be achieved by 2020: (1) be active and healthy and have physical and mental wellbeing, (2) achieve full potential in all areas of learning and development, (3) feel safe and protected from harm, (4) have economic security and opportunity, and (5) feel connected, respected and contributing to their world.

4. High risk drug use

In April 2014 the Health Research Board published figures on treated problem alcohol use in Ireland between 2008 and 2012. The total number of cases treated for problem alcohol use increased from

7,940 in 2008 to 8,604 in 2011, decreasing to 8,336 in 2012. Of those treated in 2012, 17% reported using at least one other drug, a similar proportion to that observed in previous years.

A study on non-medical use of psychotropic prescription drugs among adolescents (aged 13 to 18 years) in substance use treatment, published in 2013, reported that 68% of the 85 adolescents surveyed reported life-time non-medical use of any of the seven classes of prescription drugs. The most common medication used without a prescription (i.e. diverted use) was sedative/ anxiolytics (62%), followed by sleeping (hypnotic) medication (43%). The paper concluded that non-medical use of prescription drugs is commonplace among adolescents who abuse illicit drugs and that they typically use these prescription drugs for hedonic reasons.

Merchants Quay Ireland (MQI), a national voluntary agency providing services for homeless people and for drug users, reported that in 2012 there were 22,475 visits to its Drug Services and 20,847 needle exchanges, with 3,639 individuals using the services, 558 of whom were new clients.

A study of drug use in Irish prisons published in 2014 reported that the drugs most commonly used by the prison population were cannabis, cocaine powder and benzodiazepines. Oral fluid testing for drug use in the previous 24 to 72 hours showed that 4% had used cannabis, 13% methadone and 11% benzodiazepines. Two-hundred-and-twenty-six prisoners said they were 'doing heroin now'. Among these current heroin users, 75% reported smoking (or chasing the dragon) as their only method of choice, with 13% reporting injecting and 1% snorting as their only method.

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

The key priorities for the HSE's national service plan expected to have an impact on addiction services in 2014 included, inter alia, improving health outcomes for persons with addiction issues, implementing recommendations from the HSE Opioid Treatment Protocol, implementing recommendations with regard to Tier 4 in the residential addiction services report, and finalising the implementation plan for the National Overdose Prevention Strategy.

A review of the pharmacist-patient structured methadone detoxification programme (SDD) in Mountjoy prison between June 2010 and May 2014 showed that, of the 805 prisoners on methadone maintenance treatment, over half were able to reduce their methadone dose significantly using SDD.

TDI data showed that in 2013, 8,684 cases entered treatment, an increase of 981 cases compared to 2012. The majority were male (72.9%) and the mean age was 29 years, similar trends to 2012. As in previous years, opiates (mainly heroin) were the most common main problem drug reported by cases entering treatment (51.3%). The reduction in the proportion and number of cases treated for cocaine as a main problem substance continued, whereas the number of cases entering treatment for cannabis as their main problem substance continued to increase. There were 9,640 clients registered for methadone treatment (including those receiving methadone in prison), again only a very small increase since 2012. The proportion of clients receiving treatment from GPs has increased slightly, from 35% in 2009 to 40% in 2013. The number of cases among the Traveller community seeking treatment for problem drug and alcohol use increased by 163% between 2007 and 2010. However, this number is likely to be under-estimated. Alcohol was the most common problem substance, while the number seeking treatment for opiates increased by 291%. Traveller women reported high rates of problem opiate use and injecting behaviours. The findings present a major cultural issue and challenge to Traveller health services and, given the high level of sharing, this has implications for the delivery of needle exchange services.

6. Health correlates and consequences

In 2013, 18 new diagnoses of HIV were injecting drug users (IDUs). This was similar to the number diagnosed in the previous four years (ranging from 13 to 23 cases since 2010). Among the IDUs newly diagnosed with HIV infection, 83% were co-infected with hepatitis C (HCV).

There was an 18% decrease in hepatitis B (HBV) notifications in Ireland in 2013 compared to 2012, with only one new acute cases of HBV infection among IDUs. There was also an 18% decrease in HCV notifications in Ireland in 2013 compared to 2012. The decreasing HCV notifications and

increasing median age is indicative of a reduced incidence of HCV in the population. Injecting was the predominant risk factor for 372 of the new cases and the average age was 38 years.

The annual report from the Rotunda Maternity Hospital for 2012 showed a total of 89 deliveries to mothers attending the drug liaison midwife, of whom 76 were HBV positive, 70 were HCV positive, 31 HIV positive and 18 tested positive for syphilis. Fourteen babies were admitted to the neonatal unit with neonatal abstinence syndrome.

A study on drug use in Irish prisons published in 2014 reported a prevalence of HCV of 13% among the general prison population and 42% among IDUs. The prevalence of HBV among the prison population was 0.3%, and 19% among IDUs; the prevalence of HIV among the prison population was 2%, and 6% among IDUs.

Other reports described in Chapter Six include studies of opiate-induced neonatal abstinence syndrome; non-fatal overdoses and drug-related emergencies admitted to Irish hospitals; admissions to Irish psychiatric units and hospitals of cases with a drug disorder (ICD-10 Code F11–19, F55); mephedrone-induced uvulitis; and methaemoglobinaemia secondary to amyl nitrate use.

In 2012, there were 181 deaths owing to poisoning recorded in Ireland by the National Drug-Related Deaths Index (NDRDI). This represents a decrease compared to 2011, when 232 such deaths were recorded.

7. Responses to health correlates and consequences

It was reported that a pharmacy-based needle exchange programme, rolled out in 2011 in 42 pharmacies and extended to 71 pharmacies by the end of 2012, had provided pharmacy-based needle exchanges to an average of 360 individuals each month in 2012. As a consequence, the number of individual drug users using sterile injecting equipment had increased by 188%, from 199 in January 2012 to 573 in December 2012. In total, 10,601 needle exchange transactions were completed in 2012.

A qualitative study of youth mental health and substance misuse disorders in two deprived urban areas, published in 2014, highlighted the progressively deteriorating symptoms experienced by young people as their addiction became a full-time occupation. It outlined the need for interventions which enhance early identification and treatment of mental health and substance use disorders in young people living in deprived urban areas.

A report outlining a holistic approach to supporting families with complex challenges is also described.

8. Social correlates and social reintegration

The proportion of early school-leavers in treatment increased slightly in 2012, compared to 2011; there was also an increase in the proportion of new cases. The proportion of both all cases in treatment and new cases entering treatment who reported being in employment is reducing. Drug use was reported in research among socially-excluded groups, including early school-leavers, people in prison, female prisoners, homeless people, the traveller community and among people living in disadvantaged communities.

A pilot study to assess the implementation of a framework to support the rehabilitation and reintegration of recovering drug users reported that, overall, the 14 service users interviewed felt supported; they highlighted the positive role of care planning in helping them to set recovery goals. The views of service providers highlighted the need for better access to services for clients, including housing, education and employment, and for improved inter-agency working. Recent major shifts in homelessness policy will, if implemented, address the needs of homeless drug users and people in recovery who are experiencing difficulty in accessing accommodation.

There are approximately 47 dedicated drugs rehabilitation community employment (CE) schemes for recovering drug users, which include 1,000 ring-fenced places. The objective of these CE schemes is to provide vocational training and personal development to clients to assist them to access further

education and/or employment. The number of clients referred to the schemes increased during 2013, but just over one fifth of the 1,000 places were unfilled. Eleven participants in a recent study identified the main benefits of participating as the stability, structure and routine that the projects provided, the supports provided by key workers and peers which helped to increase coping skills and develop team-working abilities, and an improvement in their self-esteem and confidence. In addition, the transformative and empowering effect of education was noted both by participants and by referral and state agencies. Two recent reports have called for a reorientation of services for drug users towards a recovery-focused paradigm, prioritising the building and maintenance of recovery capital.

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

Data from the Irish Prison Service for 2013 shows that the number of persons in custody for controlled drug offences comprised 17% of the total prison population. The majority of drug offenders were serving sentences of 5 to 10 years. The Probation Service published the findings of the first large-scale, nationwide survey of drug and alcohol misuse among young offenders (aged 20 years or under) who were on probation supervision. With regard to the link between substance misuse and crime, in more than 80% of cases substance misuse was linked, in the opinion of the probation officer, to current offending. Alcohol was the substance most frequently linked to offending, with drug misuse on its own being linked to a relatively small amount of offending.

The issue of drug-related intimidation, much of it related to drug debt, has emerged as a major concern for many communities in Ireland. A recent report has investigated the causal factors underlying intimidation with a view to informing possible interventions and responses by partner agencies and the wider community. The CityWide Drugs Crisis Campaign, in association with the Health Research Board, is currently conducting a national audit of drug-related intimidation and community violence in drugs and alcohol task force areas throughout the state. A recent journal article provides an Irish perspective on drug-facilitated sexual assault (DFSA). It discusses the various ways in which DFSA is defined, the limitations associated with establishing its prevalence in Irish society, the various substances that have been found to be associated with it in other jurisdictions, and the complex evidential issues that can arise in trying to establish its basis in law.

A position paper by the Irish Penal Reform Trust has called for a non-custodial approach to be adopted for women offenders and, in the few cases where prison is necessary, for the negative impact of imprisonment on women, and those they care for, to be minimised. A report on the Dóchas Centre (a female prison) by the Inspector of Prisons has highlighted the serious problems associated with drugs in the Centre. The Dublin City Business Association has called for the establishment of a community court as a means of addressing low-level crimes such as vandalism, theft, anti-social behaviour, drug use and drug dealing in the capital. The National Advisory Committee on Drugs and Alcohol has published the findings of a study it commissioned 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 authors have made a series of recommendations for drug treatment services in prison.

10. Drug markets

Forced labour in the production of cannabis is the subject of a research report by the Migrant Rights Centre Ireland (MRCI). According to MRCI, this phenomenon involves human trafficking for the purpose of criminal exploitation. The study examined trafficking for cannabis production, specifically focusing on cases and reports where Vietnamese and Chinese nationals were involved.

The illegal street sale of prescription drugs has emerged as an important issue in the Irish drug scene in recent years. Data produced by the Forensic Science Laboratory shows trends for some of the main prescription drugs, primarily benzodiazepines and Z-hypnotics, seized by An Garda Síochána. There has been a significant increase in the seizures of alprazolam and diazepam since 2009, while seizures of zopiclone have trebled since 2009.

As part of a recent Flash Eurobarometer survey on young people and drugs, respondents were asked about the perceived availability of drugs. Around a quarter of respondents believed it would be easy to obtain cocaine, new substances that imitate the effects of illicit drugs, and ecstasy; over half believed

it would be easy to obtain cannabis. The proportion of Irish respondents who responded that it was 'very easy' to obtain certain substances was above the proportion across all EU member states for all substances, except tobacco.

An analysis of heroin and cocaine seizures submitted to the Forensic Science Laboratory (FSL) between April 2010 and March 2012 sought to assess the current status of these particular drug markets, in order to track changes in the markets, and for comparison to reported European data. The study revealed 'a general decline of diamorphine [heroin] purity over the time period, with the 2012 average being nearly half the average purity obtained for 2010' (p. 2). As part of the study, the Garda National Drugs Unit provided price data for 144 street-level heroin cases submitted to the FSL between 2010 and 2011. There was a correlation between pack sizes and prices, leading the authors to conclude that 'the driving factor for diamorphine prices may not be perceived quality, but perhaps the quantity of drug sold, or customer demand in times of limited diamorphine supply' (p. 3). Purity was determined for 217 cocaine cases over the 2010–2012 period, with the average purity remaining fairly stable, at 15% for 2010, 19% for 2011 and 17% for the first three months of 2012. Price data were obtained from the GNDU for 17 cocaine seizures for which purity was determined during the study period but no correlation was found between price and purity.

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 (NDS)** provides the implementation framework for illicit drugs policy in Ireland (Department of Community 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 and alcohol task forces (DATFs) to deliver the Strategy, with the statutory agencies critical in terms of core service provision. The Minister for Health has overall responsibility for the NDS, and an **Oversight Forum on Drugs (OFD)**, chaired by the Minister for Health, and comprising senior representatives of the various statutory agencies involved in delivering on the Strategy, and representatives from the community and voluntary sectors, meets every quarter to monitor progress and address any operational issues. The **National Co-ordinating Committee for Drug and Alcohol Task Forces (NCC)** drives implementation of the NDS at the local and regional level. It is responsible for making recommendations to the Minister in relation to the implementation of the Strategy. The committee is chaired by a senior official in the Department of Health with a membership comprising two representatives of each of the four networks – the LDTF Chairs, the LDTF Coordinators, the RDTF Chairs and the RDTF Coordinators; representatives of the key Departments and agencies involved in the implementation of the NDS; and two community sector representatives and two voluntary sector representatives.

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

- *Initial funding:* DATF projects are set up as pilot projects with funding provided through the Drugs Initiative, administered by the Department of Health. The relevant government department or agency 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 mainstreamed, responsibility for funding the project transfers to that department or agency and the Department of Health is no longer involved. DATFs continue to have a monitoring role in relation to mainstreamed projects.

1.2 Legal framework

This update covers drug-related Acts and Bills of the Oireachtas introduced or progressed during the reporting year. It also identifies new substances brought under control within the terms of the Misuse of Drugs legislation. Subject to the obligations of European Union (EU) membership as provided in the Constitution of Ireland, the sole and exclusive power of making laws for the State is vested in the Oireachtas. The Oireachtas consists of the President and two Houses, Dáil Éireann (House of

Representatives) and Seanad Éireann (Senate). Bills are proposals for new laws. They are usually approved by a Minister or another member of the government. Occasionally, a private member's bill is proposed by a member of the opposition. Such bills, because they have not originated in government, are less likely than government-sponsored bills to become law. To become law, a bill must first be approved by both the Dáil and the Seanad, although the Dáil can override a Seanad refusal to pass a bill. Joint committees are groups of members of Parliament, including both government members and members of the opposition, which discuss proposed legislation and make recommendations for amendments to the Minister. Bills can be introduced in either the Dáil or Seanad and there are five stages in considering a bill. The second and third stages are considered the most important as they offer the fullest opportunities to members to discuss and amend the contents of the bill. Once the bill has been passed by the Oireachtas, the Taoiseach (Prime Minister) presents it to the President to sign into law, and then it becomes an Act.

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

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

1.2.1 Laws, regulations, directives or guidelines in the field of drug issues

This update covers drug-related Acts and Bills of the Oireachtas introduced or progressed between August 2013 and July 2014. It also identifies any new substances brought under control within the terms of the Misuse of Drugs legislation.

The **Health Identifiers Act 2014** provides the legal basis for individual health identifiers for health service users and unique identifiers for health service providers. It provides, inter alia, for the assignment of a unique number to an individual to whom a health service is being, has been or may be provided and makes provision for the establishment and maintenance of registers in respect of such numbers and other particulars of the individuals to whom the numbers are assigned. It also makes provision for the basis on which such registers may be accessed and the personal data contained therein may be processed. This will progress action 52 of the NDS, which aims to put in place such a unique identifier to facilitate the development of reporting systems (Department of Community 2009). The absence of such an identifier has been regarded as a key constraint in implementing the NDS. It is anticipated that the new legal provisions will allow the reporting system to 'track individual histories and permit the calculation of numbers treated for specific drugs in the population' (p.70).

The **Fines (Payment and Recovery) Act 2014** provides for the introduction of attachment of earnings as a means of recovering unpaid fines with the intention of reducing substantially the numbers of people committed to prison for the non-payment of fines. Where a person fails to pay a fine by the due date for payment (including by instalments where the person has chosen to pay by instalments) the court will make either a recovery order or an attachment order. If neither of these is considered appropriate (for example, where the person is not in employment and has no realisable assets), the court will consider imposing a community service order. The court may commit a person to prison if it is not possible to make any of the three orders. Community service is also an option, as an alternative to imprisonment, where a recovery order or an attachment order has been imposed, but where the fine or a portion of the fine remains outstanding.

The **Road Traffic (No.2) Act 2014** provides, inter alia, new measures to test for driver intoxication. Members of An Garda Síochána will be empowered to require people driving or attempting to drive a

mechanically propelled vehicle in a public place, to undertake intoxication impairment testing. This involves non technology-based cognitive tests (e.g. walking a straight line, tipping one's nose, counting while standing on one leg). The results of these tests may be used in evidence in support of the Garda forming an opinion that the person is intoxicated. Under the new provisions, the Minister will be empowered to prescribe in regulations the nature of the tests and their manner of administration, as well as a form for recording the observations made during the tests. It will also be an offence to fail to comply with a requirement to undergo intoxication impairment testing. Section 12 amends the Road Traffic Act 2010 to allow for the taking, subject to medical approval, of a specimen of blood from an incapacitated (e.g. unconscious) person following a road traffic collision involving death or injury.

1.2.2 Laws implementation

Medicinal cannabis

Approved medicines containing the active ingredients of cannabis can now be prescribed in Ireland, after outgoing Minister of State at the Department of Health Alex White signed regulations legalising their use in mid-July 2014. The move means sufferers of multiple sclerosis (MS) will soon be able to legally use Sativex, an oral spray containing cannabis extracts, which has proven to help some MS patients with spasticity symptoms.

The Health Products Regulatory Authority (HPRA),² formerly the Irish Medicines Board, recommended the approval of the product for use here in 2012. However, its use remained against the law, because of the banning of all types of cannabis under misuse of drugs legislation. The changes enable such products to be prescribed, while at the same time maintaining tight controls on cannabis availability. Sativex will only be available on prescription from doctors, once it comes to market. The National Centre for Pharmacoeconomics (NCPE) will have to assess the likely costs of the product, before deciding whether it will be available to medical card holders.³

Legislation on new psychoactive substances

A journal article by Kavanagh and Power examines the impact of legislative and law enforcement responses to the emergence of new psychoactive substances (NPS) and so-called 'head shops' in recent years in Ireland (Kavanagh and Power 2014). In particular, the article considers how controls in this area have adversely impacted on academic research on NPS.

In relation to the 'legal highs' phenomenon, on 11 May 2010 the government made the Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order 2010 (S.I. 199 of 2010), declaring a range of 'legal highs' to be controlled drugs. To give effect to this decision, on the same day the Minister for Health and Children 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 'head shops' and which included the vast majority of products of public health concern, were declared to be controlled drugs. Following on from this, the Criminal Justice (Psychoactive Substances) Act 2010 (PSA) was implemented in response to the 'head shops' selling 'legal highs' (Irish Focal Point (Reitox) 2010) (Chapter 1.2.1).

Following the implementation of the various statutory instruments referred to above, the Forensic Science Laboratory (FSL), which analysed a number of head shop products obtained by means of test purchases, found that in the case of cathinone derivatives, 'following the initial control of a selected range of compounds, the contents of retail products were quickly changed to alternative compounds not yet controlled' (p.2). Consequently, the authors suggest that the head shops had managed to remain open, something that was contrary to the political intention behind these amendments to the misuse of drugs legislation. The PSA, however, did succeed in significantly reducing the number of head shops during its first year in operation (Irish Focal Point (Reitox) 2011). The authors provide an interesting perspective on why this may have occurred:

There was considerable societal concern about head shops and the owners, being 'business people' who saw the potential to make a quick profit, in general, complied with retail and

² <http://www.hpra.net>

³ <http://www.ncpe.ie/>

legitimate business rules, paid taxes and preferred to operate in a licit rather than an illicit marketplace. The introduction of the PSA and public protests at legal high retail units caused unease amongst these shop operators and, along with media pressure, many shops voluntarily closed and surrendered their products for destruction. (p. 2)

The authors also refer to a reduction between 2010 and 2012 in post-mortem blood samples testing positive for cathinone derivatives, based on toxicological analysis conducted by the State Laboratory for the Coroners Service. Furthermore, the Drug Treatment Centre Board (DTCB), which screens methadone programme patients, reported a 25% decrease in the presence of cathinone derivatives in urine samples between 2010 and 2011.

With regard to the impact on the research community, the authors suggest that in the midst of these various legal changes, academics involved in NPS research had to ensure that they had the appropriate licence for any substance they were investigating. As a consequence, they suggest, 'Some researchers preferred to avoid projects involving, or that might involve controlled substances' (p.1). A potentially negative consequence of the approach to NPS is, they suggest, that 'with little or nothing known about their actual harm potential, numerous compounds became controlled drugs, thus discouraging academia from pursuing research due to licensing requirements' (p. 4). In hindsight, they suggest that 'it may have been prudent...to allow researchers to study such compounds by allowing them to hold small amounts (i.e. quantities smaller than typical single doses as reported anecdotally) in their university based laboratories' (p. 4).

Future legislative approaches in this area should, according to the authors, recognise the potential for academics and forensic service providers to work together, something that would need to be facilitated through primary legislation. For example, with regard to the testing of suspected drug seizures, 'forensic drug chemists are primarily interested in uniquely identifying controlled substances in case samples rather than impurity or by-product profiling. However, the latter is an important intelligence-gathering tool, which can be used to link batches of drugs and provide a valuable insight into manufacturing and supply trends' (p. 6). Work of this type is more research oriented and, as the authors observe, 'academics have more freedom and time to think outside the box and are not shackled by accreditation protocols or the seemingly ever-increasing workloads that forensic service providers continually face' (p. 6).

In conclusion, they call for a review of the current legislative framework so that it can accommodate an academic input and allow for more targeted research. And although it is acknowledged that any relationship between academics and forensic science is rendered more challenging by virtue of the fact that some of the work might involve case samples that are *sub judice*, legislation should, they argue, 'provide better mechanism for academia and forensic service providers to work together and share data so that more informed policy decisions can be made' (p. 6).

Organised crime – use of emergency legislation

The Criminal Justice Act 2006 and the Criminal Justice (Amendment) Act 2009 created, for the first time, the offence of participation in a criminal organisation and made provision to enable all organised crime offences to be declared scheduled offences for the purpose of trial in the Special Criminal Court, which operates with three judges and without a jury (Alcohol and Drug Research Unit 2007). In a Seanad debate a resolution to provide for the continuation in operation of section 8 of the Criminal Justice (Amendment) Act 2009 for a 12-month period beginning on 30 June 2014 was supported (Conway 2014, 19 June). The Act provides for a limited number of specific organised crime offences to be prosecuted in the Special Criminal Court. The proposal to use the Special Criminal Court for such offences removes the possibility of jury-tampering or the intimidation of jurors. Addressing the debate, Minister of State John Perry TD stated:

The purpose of section 8 is to ensure organised criminal gangs cannot interfere with the criminal process to determine the outcome of cases. To this end the section declares that the ordinary courts are inadequate to secure the effective administration of justice and the preservation of public peace and order in regard to certain offences. The offences in question are the organised crime offences under Part 7 of the Criminal Justice Act 2006. In brief, they concern the following: directing the activities of a criminal organisation – section 71A of the Criminal Justice Act 2006; participating in or contributing to certain activities of a criminal

organisation – section 72; committing a serious offence for a criminal organisation – section 73; and liability for offences committed by a body corporate – section 76. Section 8 of the Criminal Justice (Amendment) Act 2009 makes these scheduled offences for the purposes of Part V of the Offences against the State Act 1939. While this means that the Special Criminal Court will hear prosecutions for the offences in question, the Director of Public Prosecutions may still exercise her power to direct that the offences should be tried in the ordinary courts.

Sentencing in drug cases

A recent study conducted by the Irish Sentencing Information System (ISIS)⁴ examined the sentencing practice of the courts in relation to the offences of possession or importation of controlled drugs for the purpose of sale or supply (Mackey 2014). There are four such offences which were covered by the study:

- possession of controlled drugs for unlawful sale or supply (s.15 of the Misuse of Drugs Act 1977, as amended);
- possession of controlled drugs (valued at €13,000 or more) for unlawful sale or supply (s.15A of the Misuse of Drugs Act 1977, as amended);
- importation of controlled drugs for unlawful sale or supply (several provisions found in the Customs Acts, Misuse of Drugs Acts 1979–1984, as amended, and the Misuse of Drugs Regulations 1988); and
- importation of controlled drugs (valued at €13,000 or more) for unlawful sale or supply (s.15B of the Misuse of Drugs Act 1977, as amended).

Convictions under s.15A or s.15B attract a ‘basic presumptive sentence’ of 10 years or more (for discussion of legislation, see (Irish Focal Point (Reitox) 2011), Chapter 1.2.2). A sentencing court may, however, impose a lower sentence where there are mitigating factors that amount to ‘exceptional and specific circumstances’, which would render the imposition of a sentence of 10 years or more ‘unjust in all the circumstances’. Part I of the report analysed the legislative basis for these drug trafficking offences and the reserved judgments of the superior courts. Part II examined the application of sentencing principles in relation to the ‘basic presumptive sentence’ provided for in sections 15A and 15B above. Part III examined 79 judicial decisions involving 81 offenders before the Court of Criminal Appeal from 2009 to 2012. Twenty of these judgements related to ordinary offences and 59 to offences carrying the presumptive sentence.

The case law analysed showed that ‘in the majority of s.15A and s.15B sentences (67% of those surveyed) the presumptive minimum sentence of 10 years imprisonment or more is not imposed by the courts despite the fact that this sentence is popularly described as a “mandatory minimum” ’ (p. 6). However, this did not mean that the courts were disregarding the presumptive minimum sentencing provisions. As the author explained, ‘the Court of Criminal Appeal has repeatedly emphasised that the upper parameters of these offences are properly defined by reference to the maximum penalty of life imprisonment and not, as is often the case, to the presumptive mandatory minimum of 10 years’ (p. 6).

This was the case with regard to possession for supply offences. Regarding importation offences, the analysis concluded that the statutory framework ‘is less coherent’. This was due to the fact that the ordinary offence existed under legislative provisions which provided different maximum penalties, ‘one of which carries a maximum penalty of 14 years imprisonment and the other carries a maximum sentence of life imprisonment’.

This anomaly existed primarily for historical reasons that could be traced back to the emergence of the heroin epidemic in Dublin in the mid-1980s. Prior to the introduction of the maximum sentence of life imprisonment in 1984, the upper limit of 14 years applied to importation and possession for sale and supply offences. Such a maximum sentence was imposed in *The People (Director of Public Prosecutions) v. L.D.*, i.e. Larry Dunne, a leading member of the family largely credited with introducing heroin to Dublin at this time ((Flynn and Yeats 1985)). In the period between the commission of the offence and the date of sentencing, the legislature had increased the maximum penalty. In passing sentence, McMahon J. stated that the major players involved in drug trafficking could in future expect life imprisonment. As the ISIS report showed, however, up to the time of the

⁴ <http://www.irishsentencing.ie/>

study no convicted person had received the maximum sentence of life imprisonment. As a consequence, as the author pointed out, 'It is sometimes therefore popularly espoused that custodial sentences imposed are too short or that disparity exists from one sentence to the next.' (p. 7). Such disparity was demonstrated in the following cases examined by the report:

... one offender found with €300,500 of cannabis and cocaine was sentenced to the presumptive minimum of 10 years while another found with €329,301 of cocaine received a wholly suspended sentence; a man found with €43,000 of cocaine received a 1.5 year custodial sentence while another man found with €287,050 of cannabis received 4 years. (p. 7)

The report found that in supply offences involving drugs valued at €13,000 or more, the value was the most important factor in the determination of the appropriate sentence. However, this was not the only factor considered as sentences differed relative to the circumstances of individual cases and individual offenders. This approach was regarded as consistent with general sentencing principles. The analysis of cases provided in this report led to the conclusion that there were four primary factors that featured most prominently in the construction of sentences for drug trafficking offences:

- the quantity or value of the controlled drug or drugs,
- the type of the controlled drug or drugs,
- the role of the offender, and
- the condition of the offender.

The Law Reform Commission (LRC)⁵ recently recommended that the presumptive sentencing regime for drug offences be repealed (Irish Focal Point (Reitox) 2011) (Chapter 1.2.2).

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

1.3.1 National action plan and/or strategy

Combining drugs and alcohol

Regarding progress on the incorporation of drug and alcohol policies in the one national substance misuse strategy, in October 2013 the government approved an extensive package of measures to deal with alcohol misuse, to be incorporated in a Public Health (Alcohol) Bill, the general Scheme of which was published in 2014 (Martin 2014). The main measures include:

- minimum unit pricing for retailing of alcohol products,
- regulation of marketing and advertising of alcohol,
- structural separation of alcohol from other products in mixed trading outlets,
- enforcement powers to be given to Environmental Health Officers, and
- health labelling to include warnings and advice.

A working group is due to report in 2015 on the issues surrounding the regulation of sports sponsorship.

National Drugs Strategy Conference

On 16 January 2014 the Department of Health hosted a half-day conference for those in the government, statutory, community and voluntary sectors working in the drugs and alcohol field. The objectives of the conference were to assess how the partnership approach to the delivery of the NDS could be maintained and strengthened, and to provide a forum for participants to give their views on how drug and alcohol task forces could integrate alcohol into their work. For details on the second objective regarding alcohol, see Section 1.3.2 below.

Reaffirming the primacy of the NDS and the five 'pillars', Tánaiste (Deputy Prime Minister) Eamon Gilmore TD stressed the importance of maintaining the partnership approach in face of emerging challenges, including prescription drugs and grow houses. Minister Alex White TD, then Minister of State at the Department of Health with responsibility for Primary Care and the NDS, outlined the extensive review of the drugs task forces and the series of bilateral meetings with other government

⁵ The LRC is an independent statutory body established to keep the law under review and to make proposals for reform. <http://www.lawreform.ie>

ministers, state agencies and the community and voluntary sectors on drugs and alcohol issues, which had just concluded (see Section 1.3.4 below for detail on the outcomes of the review and bilateral meetings). He highlighted the evidence that had emerged from these engagements of an absolute commitment to realising the core objectives across the five pillars of the NDS.

In her presentation, Susan Scally of the Drugs Policy Unit in the Department of Health, expanded on the bilateral meetings that Minister White had held with government departments, statutory agencies, and representatives of the community and voluntary sectors and the regional and local drugs task forces. The meetings indicated that a significant level of progress had been achieved across the five pillars. However, some key strategic issues, needing to be addressed, had emerged:

- the challenge of new psychoactive substances,
- the needs of children living with parental substance misuse,
- support for children and young people at risk in high-support settings, and
- the importance of rolling out the National Drugs Rehabilitation Framework.

Speaking on behalf of the community sector and reflecting on the last twenty or so years of drug policy implementation in Ireland, Fergus McCabe listed five things necessary to ensure effective policy implementation:

- political commitment with a special focus on disadvantage,
- effective cross-cutting and co-ordinating structures,
- equitable distribution of adequate resources,
- timely and relevant research and evaluation, and
- processes for real engagement involving all sectors.

Tony Duffin of the Ana Liffey Drug Project (ALDP) spoke on behalf of the National Voluntary Drug Sector (NVDS), a representative body of voluntary drug services across the state which engages with the drugs task force structures and processes. The NVDS had identified four key issues regarding the implementation of the NDS:

- *Lack of a national representative body to oversee implementation:* in principle, the newly established National Co-ordinating Committee will meet this need but to be effective it must be a real decision-making forum.
- *Role of drugs task forces needs to be refocused and reconstituted:* the recent review addresses this need and a timeframe for implementing the recommendations needs to be put in place. Speaking from his own experience in ALDP, Duffin stressed the need for task forces to take an evidence-based approach to selecting services.
- *Alcohol:* what existing budget is there for alcohol and what budget will be transferred for the implementation of the combined drug and alcohol strategy? Duffin pointed out that the health costs of alcohol use far exceed tax receipts from the drinks industry. Also, what role is envisaged for the voluntary sector with regard to alcohol? Duffin pointed out that merging drug and alcohol policies will mean treatment options, including residential services, will have to be enhanced to ensure polydrug users are not excluded.
- *Funding:* the cuts since 2008 have resulted in services being cut and this has had a real impact on service users. At ALDP much of the progress made over the last 15 years is being lost and the service is 'moving backwards'.

Cabinet reshuffle

On 11 July 2014, following a cabinet reshuffle, responsibility for the NDS and for alcohol policy passed to the Minister for Health, Leo Varadkar TD. Responsibility for drug and alcohol policy now rests with a senior government minister with a seat at the cabinet table. Prior to this reshuffle, responsibility for both policy domains was held by a junior minister without a seat a cabinet, Alex White TD, Minister of State in the Department of Health with responsibility for Primary Care.

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

Integrating drugs and alcohol at operational level

The National Drugs Strategy Conference held in January 2014 and described above in Section 1.3.1 provided a forum for participants to give their views on how drugs and alcohol task forces could integrate alcohol in their work. The conference heard four presentations on incorporating alcohol in prevention work.

Promoting community engagement in addressing alcohol issues

Community action seeks to change collective rather than individual behaviour. Because it impacts on the environment, it is a universal intervention. Mobilising a community to action on alcohol effectively anchors and maximises the work by actively involving local groups and exploiting existing networks. Anne Timoney of Community Action on Alcohol outlined the process, from introducing the concept to developing the action plan, implementing and evaluating. www.alcoholforum.org

Ballymun community alcohol strategy

A road to change: Ballymun Community Alcohol Strategy 2010–2016 (Ballymun Local Drugs Task Force and Safer Ballymun 2010) aims to use a public health approach to reduce alcohol-related risk to the Ballymun community's health, safety and well-being. Hugh Greaves, co-ordinator of the Ballymun LDATF, outlined the process whereby the strategy was developed, the principles underpinning the approach, and the contents – 41 actions across six pillars:

1. Supply reduction, availability and enforcement
2. Community awareness
3. Treatment and rehabilitation
4. Prevention and education
5. Harm reduction
6. Policy and research

Galway City alcohol strategy

The *Galway City strategy to prevent and reduce alcohol-related harm 2013–2017* (Galway alcohol strategy 2013) focuses on four key areas – prevention; supply, access and availability; screening, treatment and support services; and research, monitoring and evaluation – and includes 40 associated actions. An annual action plan is developed, including commitments from a range of partners, groups and organisations for each proposed action, and, at the end of the year, a progress report is compiled. Among the achievements to date, Evelyn Fanning of HSE West highlighted increased public awareness of the issues, improved information and understanding of alcohol availability and advertising, and patterns of alcohol-related harm, and responses that have begun to have an effect on the level of alcohol-related problems.

Hello Sunday Morning (HSM) initiative

HSM is a blogging website that encourages people to undertake a period of sobriety and reflect on the role alcohol plays in their life. Bloggers or 'HSMers' come from several countries but are predominantly Australians. They write blog posts, make videos and take pictures of their experiences as part of their participation. Ian Power of Spunout.ie described a study that aimed to conceptualise and evaluate the social impact of HSM. Analysis of the blog posts of 1,768 HSMers showed that over time they changed from being very self-focused, considering their own drinking and the views of peers, to reflecting on the role of alcohol in their lives, to finally taking a broader view of the role of alcohol in society and ways to help and support others in their personal HSM experiences. www.hellosundaymorning.org

Paul Barron, Assistant Secretary, Department of Health, then chaired a workshop session on how drug and alcohol task forces could have an impact on changing positively Ireland's relationship with alcohol. Conference participants identified 10 key points relating to three questions:

What are the key objectives that should guide our response to the misuse of alcohol in the community?

1. identify needs/gaps and specific local issues through assessing/measuring the extent of the problem, e.g. local prevalence surveys, public order offences, public health issues (pregnancy etc.), density of alcohol-related outlets, opening hours of pubs/off-licences, rural issues (isolation of individuals and home drinking), effects on family;
2. raise public awareness of alcohol-related harms (including long-term effects), laws, own drinking habits, cultural norms, pressures on young people to drink and treatment options;
3. tackle vested interests and challenging situations which can promote a drinking culture or facilitate harmful drinking, e.g. Halloween celebrations, sporting events, music festivals;
4. provide early interventions for children so they understand the health effects of alcohol misuse;
5. develop a detailed strategy which considers needs of under-18's and over 18's separately;

6. extend membership of task forces, e.g. by including homeless services (wet hostels) and representation from Vintners or linkages with those involved in the promotion of events which have association with alcohol;
7. develop a response to alcohol as part of poly-drug use that is different from that appropriate for people who have alcohol-only problems;
8. offer alternative activities to encourage positive healthy behaviours, in conjunction with youth sector;
9. target women, young people and poly-drug users using alcohol; and
10. provide brief intervention training (e.g. the SAOR model) to GPs, pharmacies, teachers etc.

What skills, insight and experience can the drugs task forces bring to this work?

1. extensive drugs task force infrastructure, networks and connections and understanding that drugs task forces cannot work alone;
2. experience of planning and developing multi-agency strategies and partnerships which promote collective action;
3. knowledge, experience and skills in relation to the issue of addiction;
4. local knowledge and intelligence;
5. understanding the issue of stigma which can be a barrier to engaging in addiction services;
6. capacity to champion and/or facilitate local initiatives and to evaluate them;
7. capacity to mobilise and build support in communities and to promote attitudinal/cultural changes, in particular, where there is ambivalence in relation to alcohol, which is still not considered a drug;
8. well-placed to identify gaps in services and developing initiatives or advocating for resources to bridge those gaps;
9. role in raising awareness and developing education programmes; and
10. experience in making referrals and linking clients to services.

What are the outcomes that you would like to see for your community from this work?

1. a cultural shift in attitudes towards alcohol in Ireland,
2. reduction of overall consumption of alcohol,
3. reduction in alcohol-related harm to individuals, families and communities,
4. reduction in alcohol-related public order problems,
5. reduction in alcohol outlets.,
6. healthier society, improved health and well-being, and improved mental health,
7. better quality of life, e.g. Hello Sunday Morning initiative (parents in playgrounds not in hangovers),
8. appropriate interventions for different people according to their needs,
9. better treatment facilities and proper funding for treatment for people with addiction problems, and
10. comprehensive response to alcohol without losing focus on disadvantage.

Concluding the session, Minister of State Alex White said it was his firm intention that the drugs task forces should become drug and alcohol taskforces, but did not wish to be overly prescriptive in relation to how this would be done. He acknowledged that a different approach was likely to be needed in relation to alcohol. He suggested that the approach should build on the experience people had had in relation to addressing the drug problem, but might involve working together with other agencies and groups on a broader canvas, along the lines of the Galway City Strategy, or it might feature an initiative-based approach, such as the 'Hello Sunday Morning' initiative. He looked forward to the drugs task forces elaborating their plans and ideas as to how they can integrate into their work the alcohol agenda.

Department of Health progress report on implementing the NDS, 2013

Early in 2014 the Department of Health published its annual report on progress in implementing the NDS in 2013 (Department of Health 2014). The new initiatives implemented in 2013 in line with 17 actions in the NDS are noted below in Table 1.3.2.1. Progress in implementing other initiatives in line with the other 46 actions in the NDS may be found in the Department of Health report or elsewhere this report in the relevant chapter.

Table 1.3.2.1 New initiatives implemented in line with actions in the NDS, 2013

Action	New initiatives
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Supply Reduction (Actions 2–18)

2. Establish Local Policing Fora (LPF) in all LDTF areas and other areas experiencing serious and concentrated problems of drug misuse.	Guidelines for the operation of LPF were circulated to the relevant Local Authorities/Joint Policing Committees, An Garda Síochána and LDTFs for implementation.
5. Develop a framework to provide an appropriate response to the issue of drug-related intimidation in the community .	A framework has been developed, and under it, a 'Drug-Related Intimidation Programme' has been established by the GNDU in conjunction with the community-based national FSN, with the support of the HSE's Social Inclusion Unit. The purpose of the programme is to respond to the needs of drug users, their family members and/or friends who experience drug-related intimidation to repay drug debts. As part of this framework, an Inspector has been nominated in every Garda Division nationwide. The GNDU in conjunction with the FSN has developed an on-line campaign, which was launched in July 2013. More information about the programme is available at www.garda.ie , www.fsn.ie and www.drugs.ie
7. Develop an initiative to target adults involved in the drugs trade who are using young children (some under the legal age of culpability) to engage in illegal activities associated with the drug trade.	A framework has been developed and is now in place on a national level, whereby an Inspector has been nominated in every Garda Division nationwide to ensure that there is an appropriate Garda response to target adults involved in the drugs trade who use children to engage in illegal activities associated with the drugs trade. All information will be dealt with at local level and will be acted upon in a way that does not put any child or their family at risk or further risk of harm from criminal adults who have used children to assist in the illicit trade.
10. Engage in appropriate enforcement strategies to ensure compliance with the prohibition of the sale of alcohol to persons under 18 years of age .	The Departments of Justice & Equality and Health have agreed a three-step approach to provide for the structural separation of alcohol from other products in mixed trading outlets. This involves replacing the current voluntary code with a statutory code under Section 17 of the Civil Law (Miscellaneous Provisions) Act 2011. After two years both Departments will review its effectiveness in achieving the policy objectives of Section 9 of the Intoxicating Liquor Act 2008.

Prevention (Actions 19–32)

20 & 21. Improve the delivery of Social and Personal Health Education (SPHE) in primary and post-primary schools through the implementation of the recommendations of the SPHE evaluation in post-primary schools.	The report on the SPHE evaluation in post-primary schools was published in September 2013. See detailed account of the evaluation in Chapter 3.3.1 later in this report.
23. Implement SPHE in Youthreach Centres of Education and in Youth Encounter Projects and ensure that substance misuse policies are in place in these recognised Centres for Education.	As part of a major reform programme, 16 Education and Training Boards (ETBs) have been established with effect from July 2013, replacing the existing 33 VECs. In October 2013, the legislation establishing SOLAS was enacted and FÁS was dissolved. SOLAS will be responsible for the coordination and funding of Further Education and Training and will play a complementary role to the new ETBs in the development of appropriate further education and training programmes and curricula.
24. Co-ordinate the activities and funding of youth interventions in out-of-school settings (including the non-formal youth sector) to optimise their impact through targeting risk factors, while developing protective factors for youth at risk.	Throughout 2013 the Department of Children and Youth Affairs developed a National Children's and Young People's Policy Framework. A Youth Strategy specific to those aged 12–25 years is now being developed to support implementation of the policy framework. See account of the policy framework in Chapter 3.2.3 later in this report.
28. Develop a sustained range of awareness campaigns .	Following the announcement of the government's measures to deal with alcohol misuse on 24 October 2013, a Steering Group was re-established to set out the strategic direction for the Awareness Campaign. During 2013 the HSE's National Social Inclusion Office actively supported the 'Let's Talk About Drugs' National Media Awards.

Action	New initiatives
29. Develop a series of prevention measures that focus on the family .	<p>For more detail, see Chapter 3.6 later in this report.</p> <p>The HSE established a National Hidden Harm Project Management Group in June 2013. The Hidden Harm project operates as an interagency response to 'hidden harm' led by the National Social Inclusion Office and the Child and Family Agency. The overarching aim of the project is to ingrain awareness of hidden harm into the overarching framework within substance misuse and childcare systems nationally; in order to bridge the gulf between substance misuse and childcare systems; and to ultimately improve outcomes for children.</p>
31. Maintain the focus of existing programmes targeting early-school-leaving and the retention of students in schools.	<p>For more detail, see Chapter 3.3.2 later in this report.</p> <p>The Educational Research Centre's most recent report, launched on 16 December 2013, <i>Changes in pupil achievement in urban primary schools between 2007 and 2013</i>, has found that test scores in DEIS primary schools at all grade levels have increased significantly. Levels of pupil absence have also fallen from 10.8% in 2007 to 7.1% in 2013. A Key Performance Indicator (KPI) in the NDS is to reduce the early-school-leaving figures for those within the age range 18 to 24, from 11.5% in 2007 to 10% by 2012. This KPI has been achieved: the figure for 2012 is 9.7%, below the EU average of 12.8%.</p>
32: Develop a comprehensive integrated national treatment and rehabilitation service for all substance users using a 4-tier model approach.	<p>The National Drugs Rehabilitation Framework (NDRF) was developed by the National Drugs Rehabilitation Implementation Committee (NDRIC) to improve the quality and quantity of interagency referrals between drugs services (community, voluntary and statutory) and the range of services that a person may need to access in their recovery. The framework was piloted in 10 sites across the country and in November 2013, a process evaluation was concluded. The evaluation found that within the pilot sites there was almost universal enthusiasm about the framework and what it is attempting to do, and quite a degree of optimism that the considerable shift in focus that is required will take place. NDRIC is developing an implementation plan for national rollout of the framework, building on key areas identified in the evaluation.</p> <p>See Chapter 8.3 later in this report for a full discussion of the evaluation.</p>

Treatment and Rehabilitation (Actions 33–48)

33. Maximise operational synergies between drug addiction services, alcohol treatment and rehabilitation services, general and emergency hospital services and mental health services . Within this context, there should be a focus on addressing the needs of dual diagnosis clients.	<p>The HSE's National Addiction Training Programme (NATP) undertook to provide an introduction to dual diagnosis (DD) as an awareness raising exercise. (1) An outline for an introduction to awareness of DD was developed for initial presentation to staff of addiction and allied health and social care services in Bridge House, Cherry Orchard Hospital, in May 2013. (2) A conference on DD was held in June 2013. Two members of NATP addressed the conference. The main theme of the day was the lack of access to mental health services by clients with substance misuse disorders and the lack of agreed protocols in the management of clients with coexisting disorders. (3) A conference on DD was organised by HSE South-East Substance Misuse Services in November 2013. This module was replicated and delivered in Waterford, and later in Donegal and Limerick (January 2014).</p>
39. Maintain and develop treatment services dealing with blood-borne viruses (BBVs) , with particular emphasis on hepatitis C treatment services.	<p>The HSE National Hepatitis C Strategy Implementation Committee was established in April 2013 and held three meetings during 2013. Three sub-groups have been established to progress the recommendations of the strategy: Treatment, Surveillance and Screening and Education, Prevention and Communication.</p>

Research and Information (Actions 49–56)

52. Seek to put in place a unique identifier to facilitate the development	<p>The Health Identifiers Act 2014 was enacted on 8 July 2014.</p>
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Action	New initiatives
of reporting systems in the health area while respecting the privacy rights of the individuals concerned.	See detailed account in Section 1.2.1 earlier in this chapter.
54. Consider the further development of systems monitoring changing drug trends in line with the EU Early Warning System .	The Early Warning and Emerging Trends Sub-Group of the National Advisory Committee on Drugs and Alcohol (NACDA) has recommenced with the re-constitution of the NACDA and its subcommittees and is supporting Ireland's full participation in the EU early warning system.

Co-ordination (Actions 57–63)

62. Review and renew the participation and commitment of members of the drugs task forces .	A series of measures arising from the review of the drugs task forces (Department of Health 2012) were announced on 18 December 2012. The reforms are intended to better equip the task forces to respond to the current pattern of drug and alcohol misuse. A National Coordinating Committee (NCC) to guide the work of the task forces and drive the implementation of the NDS. Its inaugural meeting was held on 23 January 2014.
	See Section 1.3.4 later in this chapter for more details.

Source: (Department of Health 2014)

1.3.3 Other drug policy developments

Parliamentary debate on cannabis

On 5–6 November 2013 Irish politicians held a full debate in Dáil Éireann (Irish Parliament) on the drugs issue, specifically on a private member's motion to regulate the cultivation, sale and possession of cannabis products (Flanagan 2013, 5–6 November). They voted 112 to 8 in favour of a government amendment that recognised the health risks associated with cannabis and its role as a 'gateway' drug, recognised that leniency in cannabis control could endanger overall international efforts against drugs, to which Ireland is signed up under the 1961 and 1971 UN drug conventions, and endorsed current government policy 'to maintain strict legal controls on cannabis and cannabis products in Ireland'. Individual deputies contributing to the debate raised three different options – prohibition, decriminalisation or regulation. The arguments made in favour of the various options were as follows:

Prohibition

- The current system of strict controls and regulation of cannabis should continue because of the health and social risks associated with cannabis use.
- Cannabis is a 'gateway' drug.
- The balance of the greater good for society lies in continuing prohibition.
- The current economic situation would preclude putting in place the measures to deal with the 'excesses' that would ensue if cannabis were legalised.
- The benefits of legalisation would not exceed the costs.
- Ireland would become an even bigger channel for the importation of illegal drugs to Europe.
- Why reduce controls on drugs when controls on tobacco and alcohol are being strengthened?

Decriminalisation

- Need to stop using prison as a means to tackle the drug issue. Most drug users do not commit crimes except the crime of possession.
- Users found with small amounts of cannabis should not be criminalised or jailed, should not have convictions.
- In Portugal decriminalisation has led to a reduction in drug-related deaths, with no increase in drug prevalence.
- Decriminalising cannabis is a minimum step and a first step along the road in this debate.
- If cannabis were to be legalised, there is as yet no assurance that the drug gangs will be tackled or that enough treatment centres, mental health services and other supports needed will be provided.

Regulation

- Given that cannabis is freely available in Ireland and its use is normalised (over 7% of the population regularly use cannabis), the situation should be regulated so that cannabis users are not criminalised and criminals do not profit from the market in cannabis.
- Public opinion supports regulation of the cannabis market.
- The health risks associated with cannabis have not been conclusively proven.
- Regulation of recreational and medicinal cannabis use is happening elsewhere in the world.

Decriminalisation of drug use

In November 2013 CityWide Drugs Crisis Campaign published *Decriminalisation: a new direction for drugs policy* (CityWide Drug Crisis Campaign 2013). The publication of the leaflet followed on from a conference organised by CityWide earlier in the year, when a number of speakers addressed the topic 'Criminalising addiction: is there another way?' For an account of this conference, see Chapter 1.3.3 in the 2013 National Report (Health Research Board 2013)). At the conference, according to the leaflet, 'the most frequent comment from attendees was that they had not fully understood the difference between decriminalisation and legalisation and that they were unaware of the way decriminalisation has worked in other countries'. The purpose of the leaflet was to provide basic information and sources of further information to inform the debate.

The leaflet begins by distinguishing between decriminalisation and legalisation. Legalisation is described as a process whereby the importation, sale, purchase and use of drugs are regulated by the state in the same way as alcohol and tobacco. With decriminalisation, drugs would remain illegal, but a person found in possession of drugs for personal use would not receive a criminal sanction. Instead, 'depending on the circumstances, they could be given a warning, a fine or be directed to drug awareness classes or to drug treatment'. The importation of drugs, drug trafficking and the commission of crimes to fund drug use would still be prosecuted under the criminal law.

The leaflet identified a number of reasons why Ireland should consider the decriminalisation of drugs for personal use. Criminalisation 'does not act as a deterrent when someone decides to use drugs but it does cause significant harm to an individual's future prospects as the requirement to disclose previous convictions never lapses'. Furthermore, decriminalisation, by directing problematic drug users into treatment programmes rather than the criminal justice system would reduce criminal costs and allow money to be redirected towards tackling organised crime. The leaflet highlighted the model introduced in Portugal in 2001, where 'addiction and drug use are treated as public health issues rather than criminal justice issues'. Noting the emphasis on evidence-based policy in the NDS, CityWide asserted that 'there is now a significant evidence base on the impact of criminalisation of drugs for personal use and on the experience of decriminalisation'. This information should, according to CityWide, inform Ireland's contribution to UNGASS 2016.

Children and young people and drugs

On 1 February 2014 the **Irish Bishops Drugs Initiative (IBDI)** held a national conference in Dublin with the theme 'Quenching the thirst: spirituality and addiction'. The IBDI addressed the pastoral response to substance abuse throughout Ireland, aiming to foster a community and pastoral response to the problem of addiction. Addressing the conference, Archbishop Martin said:

Many young people today are attracted into the world of drinking because they are told that it will help them to socialize. For some, alcohol and drug use sadly open for them a path which is the opposite of socializing: a path of isolation and marginalization from society and community. The Irish Bishops' Drugs initiative stresses that healing must come from community. Community must become the place where broken lives are welcomed back into a place of integration and healing....

The Church must become the place where broken lives encounter the restoring of love of God through the life and witness of the Christian community. I congratulate all those associated with the Irish Bishops' Drugs Initiative. I encourage especially those young people who are part of this initiative to witness through the way they live to that message of moderation and simple and healthy life style, and to be ready to sustain their friends who fail on the path and to help them refind the way of hope.' (Martin 2014)

On 24 June 2014 a **Flash Eurobarometer survey of young people and drugs** across the 28 EU member states was released (TNS Political and Social 2014). The last such survey was conducted in 2011 (The Gallup Organization 2011). Commissioned by the Directorate-General for Justice in the European Commission, the telephone poll was conducted between 3 and 23 June 2014. Thirteen thousand EU citizens aged between 15 and 24, including 500 in Ireland, were contacted by telephone and asked 12 questions.⁶ The responses of Irish young people to questions about their views on drugs and drug policy are noted here. See Chapter 10.4.1 for an account of their responses with regard to accessing illicit substances.

Questions 1, 2 and 6: Becoming better informed about illicit drugs and drug use?

Irish young people have the same order of preferences regarding how to obtain information on illicit drugs and drug use as their EU peers – the Internet, asking a friend, consulting a health professional, talking to parents, approaching someone at school or work, or using the media. However, they are half as likely as their EU peers to consult a specialised drug counsellor/centre (10% vs 21%), or the police (5% vs 13%). While the perceived role of media campaigns and school prevention programmes in informing young people about illicit drugs has declined sharply since 2011 (down 12% and 9% respectively), in Ireland these types of interventions are still perceived to play a role. Moreover, while 16% of young people across the EU volunteered that they ‘had not been informed at all’ about illicit drugs’, only 7% of Irish respondents made this assertion.

Question 7: Perceived health risks of using drugs?

Respondents were asked about the health risks associated with individual substances, using a 5-point scale (high, medium, low, no risk and don’t know). Irish young people were the least likely in the EU to regard regular cannabis use as high risk (46% vs 63% across the EU), and only young people in the Czech Republic and the Netherlands were less likely than Irish young people to regard occasional use (once or twice) as high risk (11% in Ireland vs 21% across the EU). Regarding alcohol, while broadly in line with their EU peers, Irish young people tended to play down the health risks. Regular alcohol use was regarded by 87% of young Irish people as a high or medium risk (92% across the EU), while 84% of young Irish people regarded drinking alcohol only once or twice as low or no risk (77% across the EU).

Question 8: How should society’s drug problems be tackled?

Young Irish people’s views on how society’s drug problems should be tackled are broadly in line with those of young people across the EU. However, there are differences in emphasis. A greater proportion of young people in Ireland than across the EU were in favour of:

- offering more sport, entertainment and cultural activities to young people (44% vs 36%),
- treatment and rehabilitation of drug users (34% vs 33%),
- reducing poverty and unemployment (28% vs 22%), and
- making drugs legal (21% vs 18%).

A smaller percentage of young people in Ireland than across the EU favour:

- tough measures against drug dealers and traffickers (49% vs 57%),
- information and prevention campaigns (37% vs 43%), and
- tough measures against drug users (22% vs 25%).

Questions 9 and 10: To ban or regulate illicit drugs and new substances that imitate the effects of illicit drugs?

Fifty-six per cent of Irish respondents believed the cannabis market should be regulated, while 43% believed it should remain illegal. Conversely, across the EU, 45% of young people believed the cannabis market should be regulated and 53% believed it should continue to be banned. Ireland and Italy have the joint second highest percentage in favour of regulation, behind the Czech Republic on 71%. Regarding new psychoactive substances, 53% of young Irish people thought they should be banned only if they pose a risk to health, 29% thought they should be banned under any circumstance, and 17% thought they should be regulated. Regarding alcohol and tobacco, 97% of Irish young people thought alcohol use should be regulated and 77% thought tobacco use should be regulated.

⁶ The basic sample design in all states was multi-stage random (probability). Substances investigated in the survey included cannabis, ecstasy, cocaine, heroin, new psychoactive substances (defined as ‘substances that imitate the effects of illicit drugs and that are sold as legal substances’), alcohol and tobacco.

1.3.4 Co-ordination arrangements

On 16 January 2014 the Department of Health hosted a half-day conference on the NDS for those in the government, statutory, community and voluntary sectors working in the drugs and alcohol field. The objective of the conference was to assess how the partnership approach to the delivery of the NDS could be maintained and strengthened, and to provide a forum for participants to give their views on how drug and alcohol task forces could integrate alcohol into their work.

In Sections 1.3.1 and 1.3.2 earlier in this chapter the contributions to the conference of government ministers and representatives from the voluntary and community sectors are given. Here the presentation of Susan Scally of the Drugs Policy Unit in the Department of Health is described. She focused on the local effort to tackle the drugs problem. She said that government recognised that there is a need for DTFs to foster interagency and community-based responses to the drugs problem at the local level. However, the challenge is to ensure that DTFs continue to remain relevant, effective and fit for purpose. Ms Scally stated that it was within this context that government carried out a review of DTFs in 2011 (Department of Health 2012). The review recommended the establishment of a new National Coordinating Committee (NCC) for drug and alcohol task forces, which would replace the Drugs Advisory Group; new terms of reference for task forces; and strengthened accountability and feedback mechanisms between local and national structures. Details of the revised co-ordinating structures presented here have been taken from the website of the Department of Health on 31 July 2014.⁷

At a national level, an **Oversight Forum on Drugs (OFD)**, chaired by the responsible Minister, meets quarterly to oversee progress in relation to the actions of the NDS and address any emerging issues. The Forum reports to the Cabinet Committee on Social Policy, as required. The terms of reference of the OFD are to:

- examine the progress of the NDS 2009-2016 across the five pillars of supply reduction, prevention, treatment, rehabilitation and research in the context of the aims, priorities, actions and key performance indicators set out therein;
- address operational difficulties and blockages in implementing the NDS and agree on appropriate ways forward to overcome these difficulties;
- monitor progress on associated mainline services with a view to influencing outcomes;
- provide any reports on existing actions and details/rationale of future plans sought by the Minister of State, as chairperson of the Forum;
- consider developments in drugs policies, and in dealing with problem drug use generally, at EU and international level; and
- discuss and agree, as far as possible, on the approach to drugs issues at the Cabinet Committee on Social Policy.

The OFD comprises representatives from the key statutory Departments and agencies involved in the implementation of the Strategy, the National Advisory Committee on Drugs and Alcohol, the community and voluntary sectors and representatives of the Chairs of the Local and Regional DTFs.

The **National Co-ordinating Committee for Drug and Alcohol Task Forces (NCC)** drives implementation of the NDS at the local and regional level. It is responsible for making recommendations to the Minister in relation to the implementation of the Strategy. The terms of reference of the NCC are to:

- drive implementation of the NDS at local and regional level,
- oversee, monitor and support the work of the task forces and to ensure that policy on drugs is informed by their work,
- monitor implementation of NDS actions specific to drug and alcohol task forces,
- monitor the expenditure and activities of the task forces and of drugs projects in their areas, and
- make recommendations to the minister in relation to the implementation of the NDS and effective co-ordination of service delivery at local and regional level.

The committee is chaired by a senior official in the Department of Health with a membership comprising two representatives of each of the four networks – the LDTF Chairs, the LDTF

⁷ <http://health.gov.ie/healthy-ireland/national-drugs-strategy/>

Coordinators, the RDTF Chairs and the RDTF Coordinators; representatives of the key Departments and agencies involved in the implementation of the NDS; and two community sector representatives and two voluntary sector representatives.

Local and Regional Drugs and Alcohol Task Forces (DATFs) play a key role in assessing the extent and nature of the drug problem in their areas and coordinating action at local level so that there is a targeted response to the drug problem in local communities. They implemented the NDS in the context of the needs of their region or local area through action plans which have identified existing and emerging gaps in the following areas – Supply reduction, Prevention, Treatment, Rehabilitation and Research.

DATFs comprise representatives from a range of relevant agencies, such as the HSE, the Gardaí, the Probation Service, education and raining boards, local authorities, the Youth Service, as well as elected public representatives and voluntary and community sector representatives. LDATFs were originally set up in areas with the highest levels of drug misuse. Following the establishment of RDTFs under the first NDS (2001–2008), all areas of the country are covered by a DTF. There are 14 LDATFs and 10 RDTFs. Funding from the Drugs Initiative supports local projects set up by DATFs in the areas of curbing local supply, prevention and awareness and research.

1.4 Economic analysis

1.4.1 Public expenditures

Direct public expenditure on the drugs issue in 2013 shows a 15% decrease (unadjusted) in public spending since 2009 (see Table 1.4.1.1).

Table 1.4.1.1 Public expenditure directly attributable to drugs programmes, 2009–2013

Department/Agency	Public Expenditure €m				
	2009	2010	2011	2012	2013
Department of Health	39.377	34.992	32.876	31.475	30.524
Department of Children and Youth Affairs	28.501	25.740	25.000	22.669	20.310
Department of Education and Skills	3.643	2.461	0.411	0.815	0.810
Health Service Executive	104.867	105.400	91.149	90.752	90.392
Department of Social Protection	18.800	18.000	14.934	11.859	13.434
Department of Environment, Community and Local Government	0.461	0.461	0.400	0.200	0.00
Department of Justice and Equality	14.801	14.478	18.681	18.580	18.553
Irish Prison Service	5.000	5.200	5.200	5.000	4.500
An Garda Síochána	45.004	44.500	45.014	45.850	44.000
Revenue's Customs Service	15.867	15.797	15.470	14.241	14.624
TOTAL	277.240	267.792	249.839	242.342	237.147

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

The classification of Ireland's direct drug-related public expenditure according to COFOG Levels 1 and 2 for 2013 is shown in Table 1.4.1.2 below. COFOG, a system for the 'classification of functions of government', was developed by the United Nations as a means of obtaining comparable figures on government expenditures across different jurisdictions – by focusing on 'functions' rather than accounting categories, which can vary across countries. This approach has been adopted by the

EMCDDA as a means of seeking comparable data on drug-related public expenditures across EU member states (European Monitoring Centre for Drugs and Drug Addiction 2008).

Table 1.4.1.2 Direct drug-related public expenditure, by COFOG functions (Level 1) and groups (Level 2), 2013

Agency/Service	Purpose of the Expenditure	COFOG – 1 st & 2 nd Levels	Expenditure €m
Department of Health – Total Expenditure €30.524m			
Health Research Board (HRB)	Research and reports in relation to drug services and drug-related deaths	gf07.05	0.294
Health Research Board (HRB)	National Documentation Centre	gf07.05	0.663
National Advisory Committee on Drugs and Alcohol (NACDA)	Research and advisory function of the NACDA	gf07.05	0.089
Local Drugs and Alcohol Task Forces	Treatment and rehabilitation services provided to drug users	gf07.02	19.110
Regional Drugs and Alcohol Task Forces	Treatment and rehabilitation services provided to drug users	gf07.02	8.935
Homeless projects	Homeless focused rehabilitation projects	gf07.04	0.394
Citywide Drug Crisis Campaign	National network of community activists and community organisations	gf07.04	0.211
Family Support Network	Supports the development of family support groups throughout the country	gf07.04	0.201
Dial to Stop Drug Dealing	Freephone service to report drug dealing and drug related crime	gf07.04	0.032
Education initiative	UCD co-funded education initiative	gf07.06	0.035
Community and voluntary	Community and voluntary representation on advisory groups	gf07.06	0.121
Other	Various salaries and other miscellaneous activities	gf07.06	0.294
Capital	Various capital grants	gf07.06	0.145
Department of Children and Youth Affairs – Total Expenditure €20.310m			
Young people's facilities and services fund (round 1)	Youth programmes with drug-specific initiatives	gf08.01	5.905
Young people's facilities and services fund (round 2)	Youth programmes with drug-specific initiatives	gf08.01	13.209
Local drugs task force projects	Mainstreamed drug projects	gf08.01	1.196
Department of Education and Skills – Total Expenditure €0.810m			
Local Drugs and Alcohol Task Force area projects	Drug education and prevention projects	gf09.05	0.398
Drug Court – education support	Drug Court - education support	gf09.05	0.412
Health Service Executive – Total Expenditure €90.392m			
Drug-related health services	Drug-related health services	gf07.04	63.662
National Drug Treatment Service	Drug-related health services	gf07.04	7.462
Primary Care Reimbursement Service	Drug-related health services	gf07.04	19.268
Department of Social Protection – Total Expenditure €13.434m			
Community Employment Programme	Training and rehabilitation places for drugs referred clients on Community Employment	gf10.05	12.772

Agency/Service	Purpose of the Expenditure	COFOG – 1 st & 2 nd Levels	Expenditure €m
LDATF mainstream projects	Support for community-based drugs projects	gf10.07	0.662
Department of Justice and Equality – Total Expenditure €18. 553			
Courts Service– Public Order and Safety	Drug Treatment Court	gf03.03	0.124
Health Research Board – Health	Research on drug-related deaths	gf07.05	0.100
Probation Service – Health	Community-based rehabilitation services	gf07.06	1.595
Irish Youth Justice Service – Education	Youth crime diversion programmes	gf09.06	16.734
Irish Prison Service	Drug treatment services in prisons	gf03.04	4.500
An Garda Síochána	Policing and investigation costs	gf03.01	44.000
Revenue’s Customs Service	Supply reduction – border policing and anti-smuggling	gf03.01	14.624

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

1.4.2 Budget

The budget for directly drug-related public expenditure in 2014 is set out in Table 1.4.2.1 below. It shows a small increase in total expenditure compared to 2013. An administrative change has been made, with ‘mainstreamed funding’ (€21.570m) in respect of 220 treatment and rehabilitation community drugs projects, being channelled via the Health Service Executive rather than the Department of Health as in previous years. The funding remaining in the Department of Health Vote (€7.381m) supports 100 community drugs prevention projects, the National Advisory Committee on Drugs and Alcohol, the National Family Support Network and the Citywide Drugs Crisis Campaign

Table 1.4.2.1 Allocations for directly drug-related public expenditure, 2014

Agency/Service	€m
Department of Health	8.425
Department of Children and Youth Affairs	19.548
Department of Education and Skills	0.810
Health Service Executive - addiction services	93.207
Health Service Executive - Drug Task Force projects	21.570
Department of Social Protection	15.178
Department of Environment, Community and Local Government	0.000
Department of Justice and Equality	18.573
Irish Prison Service	4.200
An Garda Síochána	44.000
Revenue's Customs Service	14.624
TOTAL	240.135

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

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

2.1 Introduction

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

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

The questionnaire and methodology for this drug prevalence survey are based on best-practice guidelines drawn up by the EMCDDA. The questionnaire is 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 this age range, 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 and 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. The most recent (third) survey was conducted in 2010/11 and to date, five bulletins on the findings have been published.

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

The **Survey of Lifestyles, Attitudes and Nutrition (SLÁN)** is a national survey of the lifestyles, attitudes and nutrition of people living in Ireland. To date, three surveys have been completed – in 1998 (Friel, *et al.* 1999), 2002 (Kelleher, Cecily, *et al.* 2003) and 2007 (Morgan, *et al.* 2008) – and have examined the health and social status, and related health service use, of adults aged 18 years and older living in private households. SLÁN 1998 and SLÁN 2002 were postal surveys, based on samples from the electoral register, and involved 6,539 respondents in 1998 (62% response rate) and 5,992 in 2002 (53% response rate). SLÁN 2007 interviewed 10,364 respondents face-to-face in their homes, based on samples from the GeoDirectory (62% response rate). The SLÁN data are not comparable with the results of the 2002/3, 2006/7 and 2010/11 all-Ireland general population drug prevalence survey as the SLÁN survey excludes those aged between 15 and 17 years and includes those aged over 65 years.

The **Health Behaviour in School-aged Children (HBSC)** is a cross-national research study conducted in collaboration with the WHO (World Health Organization) Regional Office for Europe. The study aims to gain insights into, and increase our understanding of, young people's health and

well-being, health behaviours and their social context. It collects information on the key indicators of health and health-related attitudes and behaviours (including alcohol and cannabis use) among young people aged 11, 13 and 15 years. HBSC was initiated in 1982 and is conducted every four years. It is a school-based survey with data collected through self-completion questionnaires administered by teachers in the classroom.

The Health Promotion Research Centre, National University of Ireland, Galway was invited to join the HBSC network in 1994 and conducted the first survey of Irish schoolchildren in 1998 (Friel, *et al.* 1999). The survey has been repeated in Ireland in 2002 (Kelleher, Cecily, *et al.* 2003), 2006 (Nic Gabhainn, *et al.* 2007) and 2010 (Kelly, C, *et al.* 2012).

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

The 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). Data were collected for the fifth iteration of ESPAD in 2010/2011 and the survey findings were published in 2012 (Hibell, *et al.* 2012).

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

Cocaine use in Ireland: 2010/11 survey results

The NACDA recently published Bulletin 4 in its series of reports on the 2010/11 survey on drug use in the general population (National Advisory Committee on Drugs and Alcohol 2014b). The bulletin focuses on cocaine use in the adult population (15–64 years) and provides a profile of cocaine use. The final achieved sample was 5,134 in the Republic of Ireland. This represented a response rate of 60%.

Table 2.2.1 below summarises the prevalence data for cocaine use (including crack) collected in the three iterations of the general population drug use survey. Lifetime cocaine use increased in 2010/11 when compared to 2006/7 (National Advisory Committee on Drugs and Public Health Information and Research Branch 2008). The proportion of adults who reported using cocaine (including crack) at some point in their lives increased from 5% in 2006/7 to 7% in 2010/11. The proportion of young adults who reported using cocaine in their lifetime also increased, from 8% in 2006/7 to 9% in 2010/11. As expected, more men reported using cocaine in their lifetime than women, 10% compared to 4%. However, the proportion of adults who reported using cocaine in the last year (recent use) remained stable between 2006/7 and 2010/11 at just under 2%. The proportion of young adults who reported using cocaine in the last year also remained stable at 3%. The proportion of adults who reported using cocaine in the last month (current use) also remained unchanged between 2006/7 and 2010/11, at less than 1%.

Table 2.2.1 Prevalence of cocaine use (including crack) in Ireland, 2002/3, 2006/7 and 2010/11

Cocaine use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010 /11	2002/3	2006/7	2010 /11	2002/3	2006/7	2010 /11	2002/3	2006/7	2010 /11
Lifetime	3.0	5.3	6.8	4.3	7.0	9.9	1.6	3.5	3.8	4.7	8.2	9.4
Last year	1.1	1.7	1.5	1.7	2.3	2.3	0.5	1.0	0.7	2.0	3.1	2.8

Cocaine use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010 /11	2002/3	2006/7	2010 /11	2002/3	2006/7	2010 /11	2002/3	2006/7	2010 /11
Last month	0.3	0.5	0.5	0.7	0.8	0.8	0.0	0.2	0.3	0.7	1.0	1.0

Sources: (National Advisory Committee on Drugs and Public Health Information and Research Branch 2008), (National Advisory Committee on Drugs and Alcohol 2014b)

Of the 5,134 survey respondents, 7% had used cocaine powder; crack cocaine use was rarely reported (0.6%). Half of all cocaine powder users commenced cocaine use before they were 21 years old, while half of all crack users commenced before they were 23 years old. Since 2006/7 there has been no change in the median age at which either cocaine powder or crack cocaine use commenced.

Of the 26 current cocaine powder users, 95.5% used cocaine less than once per week, while 4.5% used it at least once per week. The majority of the current cocaine powder users (95%) reported snorting the drug, while the remaining 5% reported smoking it. No other form of cocaine use was reported.

Of the 76 recent cocaine powder users, only 4% obtained their cocaine from a person who was not known to them. Cocaine powder was most commonly obtained at the home of a friend (39%) or at a disco, bar or club (37%). The majority (70%) of recent cocaine powder users said that it was easy to obtain within a 24-hour period.

Of the 75 self-defined 'regular' cocaine powder users, 83% had successfully stopped taking cocaine. The most common reasons for discontinuing were: did not want to continue using it (18%), could no longer afford it (17%), concerns about its health effects (15%), pros did not outweigh the cons (14%), and no longer part of social life (13%).

Trying cocaine once or twice was perceived as a 'great risk' by 74% of those surveyed. This perception of risk was particularly marked (at 78%) among those who had never tried cocaine, compared to lifetime users at (30%).

Variation in cocaine prevalence was analysed by a number of socio-economic indicators (social class, work status and age ceased education), none of which proved statistically significant. However, renting from a private landlord, having a third-level education and co-habiting were all associated with a significantly higher prevalence of lifetime cocaine use.

The findings of this survey should be interpreted with care in view of the small number of responses on which the patterns of cocaine use are based. The socially excluded population is unlikely to be represented in a general population survey of this kind; its members may not live at a fixed address or, if listed, may be difficult to locate for interview.

Polydrug use in Ireland: 2010/11 survey results

The NACDA also published Bulletin 5 in its series of reports on the 2010/11 survey on drug use in the general population (National Advisory Committee on Drugs and Alcohol 2014a). The bulletin focused on polydrug use in the adult population (15–64 years). Polydrug use was defined as concurrent substance use, where a person uses at least two substances within a one-month period. The final achieved sample was 5,134 in the Republic of Ireland. This represented a response rate of 60%.

Twenty per cent of all adults had not used any substance within the last month. Women were more likely than men not to have used any substance (23% vs 19%).

The most common combination of substances used was alcohol and tobacco (16%), followed by alcohol and other legal drugs (7%), alcohol, tobacco and other legal drugs (2%), and alcohol, tobacco and any illegal drug (2%).

Last-month prevalence rates for alcohol, tobacco plus any illegal drug were higher among men (3%) than women (0.4%) and among young adults aged 15 to 34 (3%) than among older adults aged 35 to 64 (1%). However, older adults were more likely than younger adults to have used a combination of

alcohol and anti-depressants. The last-month prevalence of polydrug use including any illegal substance was 3%.

Patterns of association between use of one substance and a range of other substances are outlined in Table 2.2.2. Association between use of alcohol and tobacco was high. Users of cannabis, amphetamine-type stimulants (ATS) and cocaine were highly likely to have used other legal and illegal substances. Of those who used cannabis within the last month, 85% used alcohol and 77% tobacco. Of those who used cocaine within the last month, all reported having used alcohol, 77% smoked tobacco, 41% used cannabis, 14% used ATS and 12% used anti-depressants.

Table 2.2.2 Total number of users of one substance by users of another substance and related percentages, all adults (aged 15 to 64), 2006/7 and 2010/11

	Last month prevalence		Users of Alcohol		Users of Tobacco		Users of Cannabis		Users of ATS		Users of Cocaine		Users of ST		Users of Anti-Depressants	
	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11
Total weighted N	4967	5126	365	362	161	145	128	143	19	5	25	26	1	14	154	209
Alcohol	73.4	70.6			81.2	78.3*	90.0	84.5	10.0	10.0	10.0	100	5.4	65.2	62.1	63.5
Tobacco	32.6	28.3	36.1	31.4			88.3	76.7*	84.2	88.3	80	77.2	5.6	46.1	50	43.5
Cannabis	2.6	2.8	3.2	3.3	7	7.6			78.9	62.4	60	40.9	4.7	9.0	5.8	6.1
ATS	0.4	0.1	0.5	0.1	1	0.3*	11.7	2.2*			25	14.1	0.7	4.0	0.6	1.2
Cocaine	0.5	0.5	0.7	0.7	1.2	1.4	11.7	7.4	33.5	74.1			7.0	2.1	0	1.5
ST	3	2.8	2.6	3.7	4.8	6.3	5.5	9	5.3	7	4	11.4			38.3	26.2*
Anti-Depressants	3.1	4.1	2.6	3.7*	4.8	6.3	7	8.9	5.3	52.9	0	12.4	4.0	38.1		

All figures are based on weighted data, are rounded to the nearest decimal place and based on valid responses.

* Denotes a statistically significant change between 2006/7 and 2010/11

ATS – Amphetamine-type stimulants (Ecstasy and Amphetamines)

ST – Sedatives or Tranquillisers

Sources: (National Advisory Committee on Drugs and Drug and Public Health Information and Research Branch 2009), (National Advisory Committee on Drugs and Alcohol 2014a)

Table 2.2.2 shows that since 2006/7 there has been a statistically significant reduction in the prevalence of tobacco and ATS use among cannabis users (National Advisory Committee on Drugs and Drug and Public Health Information and Research Branch 2009). There has also been a statistically significant reduction in the use of sedatives or tranquillisers among anti-depressant users. But there has been a statistically significant increase in the prevalence of anti-depressants among alcohol users and ATS users.

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

Health behaviour in school children: alcohol and cannabis use (trends over time report)

The Health Behaviour in School-aged Children (HBSC) survey 2010 was published in 2012 (Kelly, C, *et al.* 2012). Researchers at the National University of Ireland, Galway, conducted the survey of which previous iterations had been undertaken in 2006, 2002 and 1998. A further report on trends in Ireland between 1998 and 2010 was published in September 2013 (Gavin, *et al.* 2013).

A nationally representative sample of primary and post-primary schools in Ireland was randomly selected and subsequently, within schools, classes were randomly selected. The HBSC questionnaire was developed by the international HBSC research network, administered by teachers and completed by the selected students themselves. Younger children received a shorter questionnaire. Just over two-thirds (67%) of invited schools and 85% of students participated in the survey. There was a

higher representation from social classes 1 and 2 and lower representation from social classes 3, 4, 5 and 6 in the 2010 survey than in the 2006 survey.

Overall, there was a statistically significant decrease between 1998 and 2010 in the percentage of young people aged 15–17 who reported ever having been drunk, from 29.3% to 28.3%. The pattern over time was inconsistent: there was an increase between 1998 and 2002, from 29.3% to 31.2%, and again between 2002 and 2006, up to 32.4%, followed by a decrease between 2006 and 2010, down to 28.3%. Gender differences were evident: the number of girls reporting ever having been drunk increased from 24% in 1998 to 26.6% in 2010. However, the percentage reporting ever having been drunk remains consistently lower for girls and for boys.

There was a statistically significant decrease between 1998 and 2010 in the percentage of young people aged 15–17 who reported cannabis use in the past 12 months, from 10.3% to 8.3%. There was an increase between 1998 (10.3%) and 2002 (11.1%), and between 2002 and 2006 (12.4%), but these changes were not statistically significant. There was a statistically significant decrease between 2006 and 2010, from 12.4% to 8.3%. The decrease over time was evident among both boys and girls.

In 2002, 62.1% of young people aged 15–17 reported they had ever tried smoking; the percentages were 54.1% in 2006 and 45.7% in 2010. Data on lifetime prevalence were not available for 1998. There was a statistically significant decrease in the percentage of young people who reported that they currently smoked, from 21.1 % in 1998 to 11.9% in 2010, and also between each of the intervening years. There was also a statistically significant decrease between 2002 and 2010 in the percentage of young people who reported having their first cigarette at 13 or younger.

2.4 Drug use among targeted groups/settings at national and local level

For the most recent research, on substance use among third-level students in Limerick, see the 2011 National Report (Health Research Board 2011).

3. Prevention

3.1 Introduction

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

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

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

The NDS identifies as priorities for Prevention, improving the delivery of Social, Personal and Health Education (SPHE) in primary and post-primary schools and co-ordinating the activities and funding of youth interventions in out-of-school settings to optimise their impacts. Drug prevention interventions in schools are delivered through the **Walk Tall** (primary schools) and the **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 NDS calls for a continued focus on orienting educational and youth services towards early interventions for **people and communities most at risk**. Actions are to be developed to further support the families of drugs users, and community development is acknowledged as an important step in building the capacity of local communities to avoid, or respond to and cope with, drug problems. Early school leavers are targeted through measures such as the School Completion Programme and embedding the government’s DEIS (Delivering Equality of Opportunity in Schools) Action Plan, which tackles disadvantage among the school-going population, in schools in LDTF areas. The Department of Education and Skills (DES) has also developed a strategy to tackle educational disadvantage and early school leaving in the Traveller community.

Stand-alone **mass media awareness and information campaigns** are regarded as less effective than multi-component, multi-level interventions that reflect the complex nature of drug prevention and harm reduction. The NDS proposes that preference be given to the development of timely awareness campaigns targeted in a way that takes individual social and environmental conditions into account in key areas such as third-level institutions, workplaces, sports and other community and voluntary organisations.

3.2 Environmental prevention

3.2.1 Alcohol and tobacco policies

Alcohol

In October 2013 the government approved a number of measures to be included in a Public Health (Alcohol) Bill, including limiting advertising of alcohol, minimum pricing for the sale of alcohol and restricting outdoor advertising of alcohol. It is reported that the Bill will also increase the powers of Environmental Officers to tackle underage drinking. Work is ongoing on developing the legislative framework.

In July 2013 the Joint Committee on Transport and Communications published its report *Sponsorship of sports by the alcohol drinks industry (Joint Committee on Transport and Communications 2013)*. Based on evidence from the medical profession, sporting organisations, the drinks industry and advocacy groups, the committee stated in their foreword to the report that 'it does not believe that the link between sponsorship and alcohol consumption has been proved' and that 'before any prohibition could be contemplated other identifiable streams of funding, which could adequately replace that provided by the alcohol industry, would have to be identified' (p. 3).

Tobacco

Budget 2014 increased excise duty on cigarettes by 10 cents per packet of 20, with a *pro rata* increase for other tobacco products. Also announced was an increase in the one-off charge to retailers wishing to register to sell tobacco products. This increase is in line with the Tobacco Free Ireland policy approved by the government in July 2013 (Tobacco Policy Review Group 2013). The Tobacco Free Ireland policy sets a target of a tobacco-free Ireland by 2025, in other words a prevalence rate of smokers of less than 5%. There are two key themes in the report: protecting children and the de-normalisation of smoking.

In May 2012 a number of senators introduced a private member's Bill to provide a ban on the smoking of tobacco in vehicles when any child under 18 years is present. The Department of Health is now working with the Office of the Attorney-General to draft the necessary amendments to the Protection of Children's Health from Tobacco Smoke Bill 2012 to provide for the enactment of this legislation (Crown 2012, 9 May).

3.2.2 Other social and normative changes

See Chapter 3.2.1 in the 2012 National Report (Health Research Board 2012) for the most recent information.

3.3 Universal prevention

3.3.1 School

SPHE and substance use education

The Department of Education and Skills (DES) recently launched the report from the working group set up to examine how education on substance use is provided in post-primary schools in the context of Social, Personal and Health Education (SPHE) (Working Group on educational materials for use in SPHE in post-primary schools and centres for education 2014). This work arose from a commitment in the 2011 Programme for Government to 'update the out-dated drugs awareness programme in schools to reflect current attitudes and the reality of recreational drug use among teens' (Fine Gael and the Labour Party 2011).

The working group reviewed a selection of international and national literature and concluded that '...multi-element programmes which have whole-school, parent and community support strands, coupled with a harm reduction approach, appear to offer considerable advantages as regards effective substance use education programmes for young people...' (p. 40). In recognising the potential benefits of including harm reduction components in school-based substance use education, the working group cited evidence from an evaluation by McKay and colleagues of an adapted version

of the School Health and Alcohol Harm Reduction Project (SHAHRP), conducted in Belfast (McKay, *et al.* 2012).

McKay and colleagues undertook a controlled non-randomised trial with post-primary school students aged 13–16 years: eight schools received SHAHRP delivered by teachers, twelve schools received SHAHRP delivered by external alcohol and drug education workers, and nine schools, the control arm of the trial, received the standard curriculum on alcohol education. The researchers found that, in contrast to participants in the control group, participants receiving the SHAHRP intervention were significantly more likely to report increased levels of knowledge about alcohol and its effects, safer alcohol-related attitudes, fewer alcohol-related harms (both personal and from others) and lower alcohol consumption. These effects were maintained over the 11-month period in which none of the students received any intervention. The researchers concluded that ‘the adapted SHAHRP intervention is a promising means to address one of the major health and social challenges facing young people [alcohol consumption]’ (p. 118). They also acknowledged that harm reduction interventions targeting young people can be controversial; however, as in the case of students receiving SHAHRP in Belfast, such interventions do not necessarily promote or produce alcohol-friendly attitudes and/or behaviours among target groups.

The working group addressed the sometimes contentious nature of the term harm reduction, particularly when considered in the context of school-based substance use education. They acknowledged that the term may have negative connotations, but they went on to say that ‘taking care of oneself or looking after one’s own safety, topics already covered in *On My Own Two Feet* is effectively a harm reduction strategy...’ (p. 44). This interpretation is in line with the aims of the education provided in Belfast through the SHAHRP intervention. The key messages included in the SHAHRP intervention include advice on staying close to trusted friends when consuming alcohol, knowing basic first-aid, organising group transport home, having mobile phones available, not making decisions while drunk, being able to identify when friends are getting drunk, being on the alert for drink spiking and mixing alcohol with other drugs and avoiding arguments and aggressive behaviour by self and others.

After considering the evidence and the arguments for and against harm reduction, the working group recommended that ‘...teaching and learning resources used in schools and centres for education be aimed at reducing, postponing and/or eliminating substance use, as appropriate, in recognition of the reality that a proportion of students are using legal and illegal substances...’ (p. 8.)

The working group also undertook a wide-ranging consultation with academics, researchers, public health experts, school management and teacher unions. The group also visited eight schools and three Youthreach centres and consulted with staff and students in both settings. Arising from these consultations and consideration of relevant documents and literature, the working group concluded that ‘...quality substance use education is dependent on the quality of standard of delivery, which is supported through the use of relevant educational resources...’ (p. 7).

The working group reached the view that updating the current *On My Own Two Feet* resource (implicit in the 2011 Programme for Government commitment) was not an adequate response. The group set out recommendations to assist teaching staff, schools and centres for education to deliver SPHE. These included providing continuous personal development (CPD) for SPHE teachers, and adopting a whole-school approach to student well-being in which providing SPHE was the central strategy. These and a number of other recommendations primarily related to supporting teachers and schools and embedding SPHE in the school curriculum. These recommendations and principles underpinning them are in line with actions 20–21 in the current NDS, which relate to the implementation of SPHE in schools

Finally, the working group noted the large number of textbooks and resource materials for SPHE that had become available since the early 1990s. They cautioned that ‘...it is possible that teachers could become over-reliant on text-book material and so diminish the experiential, interactive approach, which is regarded as an essential part of SPHE delivery...’ (p. 55). There is consensus in the evidence base that non-interactive programmes are not effective; such programmes include information provision alone, emotional education alone, transmission of values and decision-making

alone and DARE-type programmes (delivered didactically by police officers in the United States) (Bühler and Kröger 2008).

SPHE in post-primary schools

The Department of Education and Skills compiled a composite report of the findings from SPHE subject inspections undertaken in 63 post-primary schools during the 2010/2011 academic year (Department of Education and Skills 2013a). Inspectors observed over 300 SPHE lessons in the classroom, with 47 (15%) of the lessons observed relating to the substance use module (see Table 3.3.1.1). The inspectors also used questionnaires and focus group interviews to gather the views of students regarding their experience of SPHE. Discussions with teachers, SPHE personnel and school management were also held to elicit views on the SPHE programme.

Table 3.3.1.1 Number of lessons observed in each module of Junior Cycle SPHE, 2010/2011

Modules in SPHE	Number of lessons observed from each module
Relationship and sexuality education (RSE)	58
Emotional health	48
<i>Substance use</i>	47
Physical health	37
Self-management	26
Influences and decisions	23
Friendship	21
Communication skills	19
Belonging and integrating	14
Personal safety	13

Source: (Department of Education and Skills 2013a)

All schools are required to timetable SPHE in the Junior Cycle as a discrete subject for at least one period per week. All schools visited complied with this requirement, with the vast majority considered to have 'fully appropriate' provision; in 13% of schools availability was deemed 'less appropriate'. The deployment of staff to deliver SPHE was considered 'good' or 'very good' in over 80% of schools visited. Schools are encouraged to promote a whole-school approach to the provision of SPHE, i.e. personal and social development of students is supported through an integrated and structured set of initiatives such as anti-bullying and positive mental health interventions. The inspectors reported that in 90% of the schools visited the quality of the whole-school approach was 'good' or 'very good'. Almost all the schools visited (98%) had a policy on substance use in place. External facilitators were used by 35% of schools to deliver the substance use module of SPHE.

Student and parent involvement in reflective practice and self-evaluation of SPHE was practised less in schools, with teachers being the main actors in this process. According to the report, '...the experimental or active learning cycle is recognised as a very appropriate strategy for use in SPHE lessons...[it]...allows students to actively participate in their own learning and consists of four stages: experiencing: processing: generalising and applying...' (pp 20–21).

When third-level students were surveyed regarding their experience of teaching methods and resources used to deliver SPHE, over 90% responded that discussion and group or pair work were widely used and the vast majority either 'agreed' or 'strongly agreed' that these methods were effective in supporting their learning in SPHE. Survey responses also showed that students reported high levels of satisfaction with their learning from the module on substance use, with the vast majority reporting that they learned about reasons for substance use/misuse, and the effects on individuals, families and society. According to the report, '...these findings suggest that SPHE lessons are very effective in enabling students to acquire knowledge but are less effective in supporting the development of some skills...' (p. 27).

The inspectors voiced concerns about the quality of assessment in SPHE. In 80% of schools visited, SPHE departments had not agreed or implemented a common assessment policy. This meant that measuring student participation and progress was generally overlooked. This relative lack of emphasis on assessment of student progress in SPHE had implications for how the subject was experienced and perceived, as the report stated: 'In most of the schools visited, students...did not demonstrate an awareness of how their progress in SPHE was assessed and were often unaware of the purpose, relevance or value of assessment in SPHE...' (p. 29). However, the report also noted that in over half the schools visited, students were encouraged to engage in self-assessment and self-reflection during SPHE lessons. The inspectors endorsed this strategy, citing an extract from a school

report ‘...this technique [self-assessment] illustrates the great value of assessment at the time of learning and provides good evidence of students’ learning and should be further developed by all teachers...’ (p. 31).

SPHE in primary schools

The most recent data available on SPHE in primary schools derives from a report documenting findings from the Chief Inspector’s Report (Department of Education and Skills 2013b). The report included a summary of the key findings on the quality of teaching and learning of SPHE in primary schools during 2010–2012. The findings were based on an analysis of data from 117 whole-school evaluations (WSEs), which included an inspection of SPHE, and the incidental inspection of 164 SPHE lessons in primary schools during 2010–2012. The findings regarding SPHE in primary schools were generally positive. However, aspects of SPHE provision needing more focused attention by a considerable number of teachers included preparation for the lessons, the provision of opportunities for pupils to work collaboratively, and assessment practices.

Preparation by teachers for 24% of the lessons evaluated through incidental inspection was found to be less than satisfactory. For 16% of the lessons, the teachers did not have written plans for SPHE.

The overall quality of teaching and learning in SPHE was found to be ‘good’ or ‘very good’ in 93% of the primary schools inspected. Incidental inspections of SPHE lessons found that learning outcomes were ‘satisfactory’ in 86% of lessons; appropriate teaching approaches, effective use of resources and consolidation of learning were evident in 88% of lessons; pupils were engaged appropriately in their learning in 90% of lessons; and talk and discussion were well used in 91% of lessons. Teachers displayed satisfactory classroom management skills in almost all (97%) lessons, while pupils engaged in collaborative learning in just 65% of lessons. WSE reports frequently commented on the positive atmosphere evident in classrooms (the school climate and atmosphere being one of the key ways in which the SPHE curriculum is delivered in primary schools). The majority of parents (96%) agreed that the school helped their child’s social and personal development although a sizeable proportion (24%) did not know how the school dealt with bullying.

As in the findings reported in relation to SPHE in post-primary schools, in over a third of the SPHE lessons evaluated through incidental inspection in primary schools, assessment practices were found to be less than satisfactory.

Drug prevention policies and programmes in schools

A report on the results of a life-skills survey, undertaken in 2012 in both primary and post-primary schools, included data on the implementation of drug prevention policies and programmes (Department of Education and Skills 2014). The report stated that 88% of primary schools that responded to the survey (n=2,089) reported having a substance use policy in place, an increase of 1% since the first life-skills survey in 2009. Approximately 94% of respondent primary schools (n=2,035) reported using the Walk Tall programme, an increase of 2% since 2009.

Respondent primary schools reported providing information, through the curriculum, on the health risks associated with smoking (94%, n=2,041), promoting awareness of and combating alcohol abuse (90%, n=2,030), and promoting awareness of and how to combat drug abuse (90%, n=2,019). Primary schools reported that they provided this information to students to enable them to make sound decisions in relation to these substances and to resist inappropriate peer pressure. Some primary schools (n=771) provided information on their use of external agencies to provide information to students on substance use, 54% using the services of An Garda Síochána.

In relation to post-primary schools, 93% of respondent schools (n=313) reported having a substance use policy in place, a drop of 3% since 2009. Use of the On My Own Two Feet resource, which was developed specifically to facilitate drug prevention in post-primary schools, was reported by 83% (n=271) of respondent post-primary schools, an increase of 11% since 2009. The vast majority of respondent post-primary schools reported providing information to students on harmful substances (n=292), on the dangers of smoking (n=292), on alcohol abuse (n=292), and on how to combat substance abuse (n=293). The vast majority of respondent schools also reported providing training in life skills to enable students to identify influences on their decision-making (n=291), and to withstand inappropriate peer pressure (n=291).

3.3.2 Family

Action 29 of the NDS aims to develop a series of prevention measures that focus on the family under three programme headings – supports for families experiencing difficulties owing 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. The progress report on implementing the NDS in 2013 (Department of Health 2014) reported that a broad mix of measures are being provided to support families, including individual counselling, family therapy and, in some regions, the Strengthening Families programme and the Community Reinforcement Approach. However, no data are presented profiling the families using these services or indicating the outcomes for families and their children. According to the progress report, the HSE established a National Hidden Harm Project Management Group in June 2013. The Hidden Harm project operates as an interagency response to hidden harm and is led by the National Social Inclusion Office and the Child and Family Agency. The aim of the project is to ensure a response to possible hidden harms is included in the overarching national substance misuse and childcare systems, thereby bridging the gulf between substance misuse and childcare systems, and ultimately improving outcomes for children.

3.2.3 Community

In 2014 the Department of Children and Youth Affairs (DCYA) published the long-awaited national policy framework for children and young people (Department of Children and Youth Affairs 2014). The framework sets out an ambitious plan to achieve five outcomes for children and young people up to the age of 24 by 2020:

1. Be active and healthy and have physical and mental wellbeing
2. Achieving full potential in all areas of learning and development
3. To feel safe and protected from harm
4. To have economic security and opportunity
5. To feel connected, respected and contributing to their world

To support children and young people to achieve these outcomes, the framework includes a commitment to transform existing policies, services and resources to be more effective, and sets out six aims to realise this transformation:

1. Support parents in the important task of parenting
2. Provide earlier interventions and prevention efforts
3. Build a culture that listens and involve children and young people in key decisions affecting their lives
4. Ensure quality services that are outcome-driven, effective, efficient and trusted
5. Enable effective transitions at key developmental stages and between child and adult services
6. Improve cross-government and interagency collaboration and coordination

The framework includes a small number of key indicators, which will be used to measure progress in several areas; a more extensive set of indicators will be developed in the course of 2014. Table 3.2.3.1 lists the indicators relating to substance use among young people and closely related correlates of substance use that will be used to assess progress towards achieving outcome 1, which relates to the health and wellbeing of children and young people.

Table 3.2.3.1 Indicators relating to substance use, to be used to measure progress towards health and well-being of children and young people, National Policy Framework for Children and Young People, 2014–2020

Key indicator	Current baseline in Ireland	Current international average	Data source
% of 15–16 year olds who have ever used cannabis	18%	17%	European School Survey Project on Alcohol and Other Drugs (ESPAD)
Cigarette use in past 30 days	21%	28%	ESPAD
Alcohol (cl of pure alcohol) consumed last drinking day among alcohol consumers aged 15–16	6.7cl	5.1cl	ESPAD
% of 15-year-olds who report being drunk once in	26.4%	24.1%	Health Behaviour in School-Aged Children study

Key indicator	Current baseline in Ireland	Current international average	Data source
last 30 days			(HBSC)
Early school leaving rate	9.7%	12.7%	Eurostat
% of 15–24-year-olds not in education, employment or training	18.7%	13.2%	Eurostat

Source: (Department of Children and Youth Affairs 2014)

The framework adopts both a universal (general population of children and young people) and a targeted (children and young people with elevated risk factors) approach. Given that children and young people make up 34% of the overall population of Ireland, it is important that policy makers both respond to the specific needs of over a third of the national population with investment in evidence-based policies, and also recognise that a significant minority of young people are at an elevated risk of poorer outcomes compared to the general population of young people and respond with approaches targeting this minority.

3.4 Selective prevention in at-risk groups and settings

3.4.1 At-risk groups

Kelleher and colleagues undertook a review of national and international literature on the participation of ‘seldom heard young people’ (Kelleher, Cathy, *et al.* 2014). The purpose of the review was to identify best practice around participation, i.e. overcoming barriers, and to identify approaches to improve the inclusion and experience of seldom heard young people.

There is general consensus in the literature that ‘seldom heard young people’ are groups of people who do not have a collective voice and are often under-represented in consultation or participation activities; they are, as the reviewers suggested, ‘...young people whose voices are not heard in decisions that affect them...’ (p. 1). These groups rarely form a homogeneous collective and, according to the reviewers, ‘...the heterogeneity of the seldom heard population requires diverse responses to meet their needs within the participative process...’ (p. 28). The key for practitioners is to understand why the voices of certain groups are not heard in the decision-making that affects them and to make available and accessible ways of including their voice.

The reviewers defined participation as ‘...the process by which young people have active involvement and real influence in decision-making on matters affecting their lives, both directly and indirectly...’ (p. 29). They also acknowledged that formal participation structures, e.g. Dáil na nÓg (youth parliament) and school/student councils, may not be accessible to disadvantaged and/or socially excluded young people. The review signalled that there appears to be a reinforcing loop of exclusion between the adults who operate these formal participative structures and the groups of seldom heard young people: the adults assume that the seldom heard young people such as homeless youth are so chaotic as to be incapable of articulating a rational and strategic view; the young people internalise this adult view, and their exclusion is reinforced. Another barrier identified in the literature is that the issues that concern seldom heard young people are particularly challenging for formal participatory structures. Thus, issues such as poverty, social exclusion and stigma are primarily driven by systemic and structural forces and forums such as youth parliaments and school councils may be unable or unwilling to accommodate such issues on their agenda.

Meaningful participation must extend beyond ‘having a voice’ to ‘making a difference’. This is the message given by the reviewers. They summarised the views of marginalised young people who want the focus of participation to be relevant to their everyday lives and for participation to be an opportunity where they can make a difference by giving something back to their communities. According to the reviewers, ‘...for participation to be meaningful, it should reflect the most salient issues for young people at that time, and not the agendas of the organisations and services involved’ (p. 43). This observation led to consideration of different levels of participation and the type of influence seldom heard young people can bring to the decision-making process. The reviewers highlighted one model with three levels of participation, distinguishing between consultative and active participation:

1. *Consultative participation*: An adult-led activity where information is exchanged, and/or the views of youth are sought on specific issues but are not necessarily incorporated into decisions and subsequent actions.
2. *Collaborative participation*: Youth share responsibility to varying degrees with adults at any or all stages of decision-making and can influence both process and outcome.
3. *Children/youth led participation*: Youth are supported to pursue their own agendas and make decisions autonomously. Adults may provide information and support.

The reviewers distinguished between the ‘youth development’ and ‘youth involvement’ approaches documented in the literature. The first approach helps young people to effect personal change, whereas the second empowers young people to be active in social change: ‘...the emphasis in a youth involvement approach extends beyond individual change in young people themselves and argues that through participation young people are able to change policy-making, organisations and society...’ (p. 44). The reviewers pointed out that youth involvement approaches offer the best opportunity to provide effective opportunities for seldom heard young people to participate meaningfully in formal decision-making structures that affect their lives. Reflecting the heterogeneity of seldom heard young people, the reviewers suggested that methods to engage these youth must be related to their needs and preferences and, in parallel, practitioners need to reflect on current methods of engagement which may exclude rather than include young people.

Reflecting the view expressed in the literature, the authors contended that ‘...overall, it is important to highlight that young people are seldom heard, not as a consequence of an inherent characteristic that precludes them from participating, but rather due to the absence of appropriate participation structures and supports to facilitate their voices being heard...’ (pp. 53–54). They recommended that organisations wishing to include seldom heard young people in the decision-making process could begin by examining four key components of their work:

1. *Structure*: Does the organisation have an adequate level of planning, development and resourcing for participation?
2. *Culture*: Is the organisational ethos committed to participation?
3. *Practice*: Does the organisation have the skills and knowledge to engage young people?
4. *Review*: Does the organisation have a system to monitor and evaluate participation activity?

These four components, when combined, comprise what is termed in the literature a whole-systems approach. It is essential that they are implemented together to enable organisations to provide meaningful opportunities for participation. According to the reviewers, in organisations that do not implement these components ‘...the likelihood of creating opportunities for effective and meaningful participation [for seldom heard young people] are greatly reduced...’ (p. 65).

3.4.2 At-risk families

Barnardos is a registered children’s charity that works with vulnerable children and their families through 40 services across the country. It recently compiled a report examining different ways to support parents experiencing difficulties and to improve outcomes for their children (Barnardos 2014). The report was based on desk research and discussion with parents, carers, mental health experts and professionals. The report and the recommendations were grounded in the day-to-day work that Barnardos staff do with at-risk families. For example, since the onset of austerity measures, some families have been finding it difficult to make their declining incomes and support cover their needs. According to the report, ‘...the combination of cutbacks to services and reductions in social welfare support compound the sense of hopelessness among families...’ (p. 10).

In tandem with the impact of austerity, the report noted that parents using Barnardos’ services have been reporting a decline in their mental health and well-being. Barnardos have also observed that large numbers of parents using their services are using prescribed medication, various types of benzodiazepines, to alleviate their anxiety and stress. Once prescribed, parents often secure repeat prescriptions and their use of and reliance on benzodiazepines endures. According to the report, ‘...they are frequently taken in tandem with other drugs such as non-prescription painkillers, methadone or alcohol’ (p. 11).

The report made five recommendations to improve the response to parents with mental health problems and improve outcomes for children affected by their parents' poor mental health (see Table 3.4.2.1).

Table 3.4.2.1 Recommendations to improve mental health outcomes for parents experiencing difficulties and outcomes for their children

Recommendation	Rationale
Challenge mental health prejudice and discrimination	Parents often are reluctant to access appropriate support due to the entrenched prejudice in society towards people with mental health difficulties.
Adopt a family model approach	Due to the dominance of the current medical model on treatment and recovery in mental health, rarely is the individual parent seen in their family context but too often seen only as a patient in isolation.
Talk with children	Children living with a parent experiencing mental health issues need to be informed and reassured about their parent's mental health, in an age appropriate manner.
Expedite the roll out of community based services	Implement the multi-disciplinary team model to provide holistic support in the community setting.
Consult with parents affected by poor mental health	Build a support response for parents with mental difficulties around what services and supports they identify as necessary for them and their children.

Source (Barnardos 2014)

See Chapter 7.4 later in this report for more detail from this Barnardos study regarding the effects on children living in families experiencing mental health difficulties.

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

See Chapter 3.4.3 of 2008 National Report (Alcohol and Drug Research Unit 2008) for most recent information.

3.5 Indicated prevention

3.5.1 Children at risk with individually attributable risk factors

Child and Adolescent Mental Health Service (CAMHS) teams are the first line of specialist mental health services for children and young people. The multi-disciplinary teams include psychiatrists, psychologists, nurses, social workers, speech and language therapists and occupational therapists. The latest CAMHS annual report states that 66 such teams are currently in place, an increase of three since 2012 (Health Service Executive 2014c).

The report shows that from October 2012 to September 2013 a total of 12,022 referrals were accepted by the service, a 21% increase on the previous 12 months. A total of 9,616 new cases were seen by Community teams in the same period, compared with 8,671 for the previous 12 months, an increase of 11%.

The report describes the findings of the fifth annual clinical audit carried out by the 60 Community CAMHS teams, in November 2012. This audit recorded information on a total of 8,577 cases seen in the course of the month. For the purpose of the audit, only one disorder / problem was entered for each case. The audit found that:

- ADHD / hyperkinetic category was the most frequently recorded primary presentation (31.6%), followed by the anxiety category (18.3%).
- Psychotic disorders/problems (including schizophrenia, manic depressive disorder, or drug-induced psychosis) accounted for 1.5% (n=125) of primary presentations.
 - Deliberate self-harm (including lacerations, drug/medication and alcohol overdose) accounted for 5.1% (n=440) of primary presentations.
- Street drugs were involved in 12% of male and just 1% of female intentional drug overdose acts.
 - Substance abuse referred to drug and alcohol misuse accounted for 0.5% (n=40) of primary presentations.

3.5 National and local media campaigns

Action 27 of the NDS seeks to further develop a national website on substance-use-related issues to provide fully integrated information, and access to a national helpline; action 28 seeks to develop a sustained range of awareness campaigns on substance-use-related items. The progress report on implementing the NDS in 2013 (Department of Health 2014) reported that drugs.ie, the national website on substance-use-related materials contains information on relevant drug/alcohol campaigns, over 50 on-line videos relating to drugs and alcohol in Ireland and an interactive support/chat services for people looking for support with drug/alcohol issues. Two specific developments planned are (1) an update of the national directory of drug and alcohol services and (2) an online self-assessment tool and brief intervention video for people with alcohol problems. It is estimated that the drugs.ie website received 114,000 unique visits in 2011, the year in which the site began building its social media presence through Facebook and Twitter, which is now used to disseminate information and video content on substance-use-related issues.

4. High Risk Drug Use (HRDU)

4.1 Introduction

This chapter provides an overview of developments and trends in the prevalence and characteristics of high-risk drug users (HRDUs) in Ireland. HRDU is defined as 'recurrent drug use that is causing actual harms (negative consequences) to the person (including dependence, but also other health, psychological or social problems), or is placing the person at a high probability/risk of suffering such harms'.

A **national 3-source capture-recapture (CRC) study**, to provide statistically valid estimates of the prevalence of opiate drug use in the national population, was commissioned by the National Advisory Committee on Drugs (NACD) and undertaken in 2001 and 2006 (Kelly, Alan, *et al.* 2003), (Kelly, Alan, *et al.* 2009). The second study indicated that use had 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 some doubt over the estimate produced of a possible further 8,983 opiate users who had not come into contact with any of the drug treatment services, hospital in-patient services or the Gardaí. The following 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 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.

Other sources of data regarding HRDU cited in this chapter are as follows.

Merchants Quay Ireland (MQI) is a national voluntary agency providing services for homeless people and for drug users. Its needle exchange health promotion unit provides drug users with information about risks associated with drug use and the means to minimise such risks. It also provides drug users a pathway into treatment and the possibility of living life without drugs.

The **National Drug Treatment Reporting System (NDTRS)** is an epidemiological database on treated problem drug and alcohol use collected at treatment centres throughout Ireland. Episodes of treatment, rather than the number of persons treated each year are recorded which means that individuals may appear more than once if they attended more than one treatment service in a year and may reappear in the subsequent years.

4.2 Prevalence of and trends in HRDU

4.2.1 Estimates of high risk drug use prevalence

Findings on cocaine use (Bulletin 4) and polydrug use (Bulletin 5) from the 2010/11 survey on drug use in the general population were recently published by the NACDA and are outlined in Chapter 2.2.

4.2.2 Other sources of information on prevalence of high risk drug use

Treated problem alcohol use in Ireland, 2008–2012

In April 2014 the HRB published figures from the NDTRS on treated problem alcohol use in Ireland, for the period 2008 to 2012 (Health Research Board 2014b).

The total number of cases treated for problem alcohol use increased from 7,940 in 2008 to a peak of 8,604 in 2011, decreasing to 8,336 in 2012. The number of new cases treated rose by 17.9%, from 3,833 in 2008 to 4,520 in 2011, but dropped to 4,028 in 2012. The number of previously treated cases increased by 16.8%, from 3,606 cases in 2008 to 4,212 in 2012. The treatment status of 96 cases in 2012 was recorded as 'unknown'.

Incidence and prevalence

The incidence of treated problem alcohol use among the adult population (age 15 to 64 years) living in Ireland, expressed per 100,000 of the population, increased from 119.7 in 2008 to 141.2 in 2011 and subsequently decreased to 125.1 in 2012. The prevalence of treated problem alcohol use among 15–64-year-olds living in Ireland, expressed per 100,000 of the population, increased from 248.2 in 2008 to 269.8 in 2011 and subsequently decreased to 261.5 in 2012. Fluctuations in prevalence and incidence may be attributed to changes in patterns of problem alcohol use in the population, levels of participation and reporting to the NDTRS, or a combination of both.

Poly-drug use

Of those treated for problem alcohol use in 2012, a total of 1429 (17.5%) reported using at least one other drug, a similar proportion to that observed in previous years. Cannabis (12%), cocaine (5%), benzodiazepines (4%) and ecstasy (3%) were the four most common additional problem drugs reported (see Figure 4.2.2.1). This reflects a minor change since 2008, when opiates were the fourth most common additional drug. In 82.5% of cases where additional problem drug use was reported, only one substance other than alcohol was reported and in 10% of cases two additional substances were reported. These figures are similar to previous years.

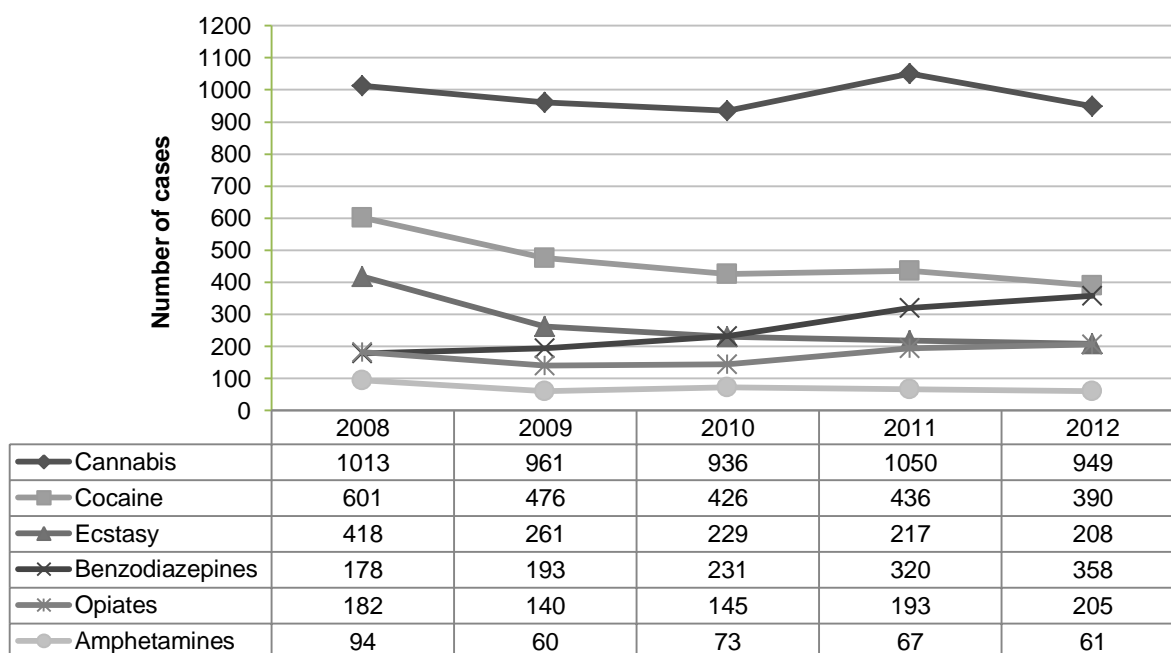


Figure 4.2.2.1 Number of cases, additional problem substances associated with alcohol as a main problem substance, 2008–2012

Source: (Health Research Board 2014b)

Socio-demographic characteristics

Of the problem alcohol use cases treated for the first time in 2012, 63% were men 5% were under 18 years old and 3% were homeless. The median age was 38, similar to previous years. The proportion of new cases (aged 16 to 65) in employment decreased from 37% in 2008 to 24% in 2012. For those cases of problem alcohol use combined with one or more other problem drug, the median age at which any drug (excluding alcohol) was started was 16 years.

Problem alcohol use combined with other substances over the period 2008–2012

Of those new cases of problem alcohol use combined with other substances over the period 2008 to 2012, 75% were male, 21% in employment, 13% aged 17 years or under and 4.5% in unstable accommodation (Figure 4.2.2.2).

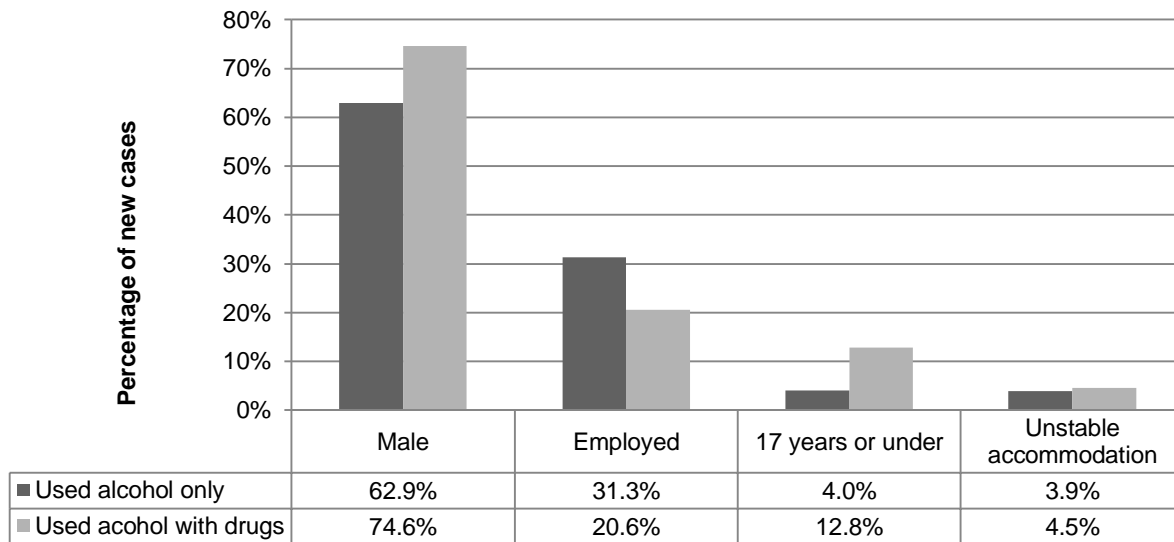


Figure: 4.2.2.2: Characteristics of new cases, by alcohol only used only and alcohol used with other drugs, 2008–2012

Source: Published data NDTRS (Health Research Board 2014b).

Treatment

Of all problem alcohol use cases treated in 2012, 54% (4,508) were outpatient treatments, 40% (3,309) inpatient and 6% (519) provided with low threshold services only. These figures are consistent with previous years. Over half (51%) received one initial treatment intervention only. A further 23% received two interventions, 11% three interventions, 4% received four and 6% received five interventions. The NDTRS records the treatment intervention(s) provided when the client is first admitted to a treatment service. Counselling was the most common initial treatment intervention, being recorded in 52% of cases, followed by brief intervention (42%), group counselling (27%), education (25%), alcohol detoxification (24%) and medication-free therapy (19%).

Non-medical use of psychotropic prescription drugs among adolescents in substance use treatment

A recent paper outlined a study conducted with adolescents (aged 13 to 18 years) attending for treatment of substance-use disorders at the largest, outpatient treatment programme in Ireland between April and June 2011 (Apantaku-Olajide and Smyth 2013). The aim of the study was to examine the prevalence of non-medical use of seven classes of psychoactive prescription drugs (opioid analgesic, ADHD stimulant, sedative/anxiolytic, sleeping, antipsychotic, antidepressant, and anabolic steroid medication) and the sourcing activities among substance-abusing adolescents. A self-reported anonymous questionnaire was administered to participants.

All 85 adolescents attending the programme were invited to participate. Of these, 63 (74%) agreed, seven refused and in 15 cases the clinician failed to ask the young person to participate. The majority of the participants were male (76%) and the mean age was 16.3 (SD=1.3, range 13 to 18). Cannabis was the main substance of abuse for the majority (75%) of respondents, followed by alcohol (14%), cocaine (10%) and heroin (1%).

Overall, 43 (68%) of the sample reported life-time non-medical use of any of the seven classes of prescription drugs. The mean number of prescription drugs used non-medically was 2.3 (SD=1.1, range 1 to 5). The frequency of non-medical use of prescription drugs among the sample population is outlined in Table 4.2.2.1. Of those on prescribed medication, the most commonly used for non-prescribed purposes were hypnotics (100%) and sedatives/ anxiolytics (73%). The most common medication used without a prescription (i.e. diverted use) was sedative/ anxiolytics (62%) followed by sleeping (hypnotic) medication (43%). The study did not have sufficient power to analyse differences by gender.

Table 4.2.2.1 Frequency of lifetime use of prescription drugs among adolescents with substance use disorder (n=63), April–June 2011

Prescription drug	Non-use n (%)	Medical use <i>Of which non-prescribed use*</i>		Diverted use** n (%)
		n (%)	n (%)	
Opioid analgesics	31 (49)	27 (43)	7 (26)	12 (19)
Hypnotics	36 (57)	11 (17)	11 (100)	27 (43)
Sedatives/ anxiolytics	21 (33)	11 (17)	8 (73)	39 (62)
Stimulants	41 (65)	17 (27)	0 (0)	5 (8)
Antipsychotics	51 (81)	6 (9)	2 (33)	8 (13)
Antidepressants	46 (73)	15 (24)	5 (33)	7 (11)
Anabolic steroids	61 (96)	1 (2)	0 (0)	1 (2)

*Non-prescribed use: those prescribed the prescription medication and reported use of the same class medication for non-prescribed reasons.

**Diverted use: used without a healthcare professional prescription.

Source: (Apantaku-Olajide and Smyth 2013)

The most common reasons given for non-medical use were ‘getting a high or buzz’ (79%); ‘having a good time’ (63%); ‘relief of boredom’ (56%); ‘help sleep better’ (49%); and ‘fit into group’ (9%). All of the lifetime non-medical users gave more than one readily available source. Of the 43 non-medical users, 33 (76%) reported friends as sources, 17 (40%) street-level drug markets, seven (17%) thefts, and seven (17%) family members.

The paper concluded that non-medical use of prescription drugs is commonplace among adolescents who abuse illicit drugs and that they typically use these prescription drugs for hedonic reasons. The author suggested that prescribers should be aware of the potential abuse of antidepressant and anti-psychotic class drugs and that assessment of adolescents with substance use disorder should include exploration of abuse of prescribed medication.

4.2.3 Trends in this area

Data on trends in cocaine and polydrug use among the general population in Ireland (aged 15–64 years) between 2006/7 and 2010/11 were published in 2014 and are summarised here. (For a full account of the two bulletins reporting the results of the 2010/11 general population drug prevalence survey in relation to cocaine use (National Advisory Committee on Drugs and Alcohol 2014b) and polydrug use (National Advisory Committee on Drugs and Alcohol 2014a), see Chapter 2.2 earlier in this report.)

Lifetime cocaine use increased in 2010/11 when compared to 2006/7 (National Advisory Committee on Drugs and Public Health Information and Research Branch 2008). The proportion of adults who reported using cocaine (including crack) at some point in their lives increased from 5% in 2006/7 to 7% in 2010/11. The proportion of young adults who reported using cocaine in their lifetime also increased, from 8% in 2006/7 to 9% in 2010/11. However, the proportion of adults who reported using cocaine in the last year (recent use) remained stable between 2006/7 and 2010/11 at just under 2%. The proportion of young adults who reported using cocaine in the last year also remained stable at 3%. The proportion of adults who reported using cocaine in the last month (current use) also remained unchanged between 2006/7 and 2010/11, at less than 1%.

Since 2006/7 there has been a statistically significant reduction in the prevalence of tobacco and ATS use among cannabis users and (National Advisory Committee on Drugs and Drug and Public Health Information and Research Branch 2009). There has also been a statistically significant reduction in the use of sedatives or tranquillisers among anti-depressant users. But there has been a statistically significant increase in the prevalence of anti-depressants among alcohol users and ATS users.

For trends in treated problem alcohol use in Ireland between 2008 and 2012, see Section 4.2.2 above.

4.3 Characteristics of high risk drug users

4.3.1 Main patterns of polydrug use among the main groups of high risk drug users

No information available.

4.3.2 Data and studies of characteristics of high risk drug users

Merchants Quay Ireland (MQI) Review 2012

In September 2013 MQI published its annual review for 2012 (Merchants Quay Ireland 2013). It reported that there were 22,475 visits to Drug Services and 20,847 needle exchanges, a 10% increase from 2011. In total, 3,639 individuals used the service, of whom 558 were new clients. A total of 1,332 safer injecting workshops were undertaken with injecting drug users.

MQI, in association with the Midland Regional Drugs and Alcohol Task Force and the HSE, administers the Midlands Family Support and Community Harm Reduction Service, providing outreach and working with families of those actively using drugs in that task force region. The harm reduction service worked with on average 130 clients per month, with 1,079 interventions in the busiest month. An average of 289 needle exchanges were provided each month during the year.

Drug use in Irish prisons, 2011

The NACDA has published the results of a survey estimating the extent of drug use and the prevalence of blood-borne viruses among the prison population in Ireland (Drummond, *et al.* 2014). The survey questionnaire was completed by a random sample of prisoners between February and April 2011. Oral fluid samples were obtained to assess use of specific drugs (cannabinoids, opiates, methadone, cocaine and benzodiazepines) in the 24 to 72 hours preceding the survey and to detect the presence of hepatitis B, hepatitis C and HIV infections. Flexibility was required in different prisons to accommodate prison schedules, security arrangements and prisoner availability.

Invitations to participate in the study were issued to 1,666 randomly selected prisoners. Of the invited prisoners, 886 (53%) attended an information session, and of these 62 (7%) declined to participate in the study, leaving 824 (49.5%) to take part in the study. This response rate is much lower than that achieved in previous Irish prison studies (Allwright, *et al.* 2000) (Long, *et al.* 2000) (Hannon, *et al.* 2000) and lower than that required for a robust prevalence estimate. Oral fluid analysis were available for 46% (771/1,666) of the invited participants. Field workers reported that the reasons given by the 780 (47%) invited prisoners who did not attend the information session included unavailability, attendance at the gym, school or workshop, mistrust, suspicion, cynicism, apathy, and concerns regarding mandatory drug testing and DNA sample collecting.

Most respondents were male (95%) and Irish (92%). The average age was 31 years, and 50% were aged 28 years or younger. Almost one-in-four respondents (23%, 186) had received no schooling or primary education only compared to one-in-five of the general population in Ireland and only 13% (105) reported having had some, or completed, third-level education compared to 31% in the general population. Fifty nine per cent (483) had been in custody for more than one year, and 51% (419) had spent more than three of the past ten years in prison. More than one in ten had been homeless for more than seven days in the year before the survey. More women (46%) than men (22%) reported that they had been homeless in the 12 months prior to the survey.

Lifetime prevalence (ever used)

The drugs most commonly used among the prison population were cannabis (87%), cocaine powder (74%) and benzodiazepines (68%) (Table 4.3.2.1). There was no difference between men's and women's lifetime use of cannabis, cocaine or benzodiazepines (Tables 4.3.2.2–5). Lifetime heroin use was high at 43% (Table 4.3.2.4). Women were significantly more likely than men to have used heroin (64%), methadone (60%) and crack cocaine (59%) at some point in their life (Tables 4.3.2.2–5). It is important to note that some of the methadone and benzodiazepine use was prescribed, and most of the illicit drug use occurred outside the prison environment.

Last-year prevalence (recent use)

Cannabis, at 69%, was the drug most commonly used in the year prior to the survey, followed by benzodiazepines, at 55% (Table 4.3.2.1). The 25–34-year-olds were significantly more likely to have

used heroin (36%), compared to the older (20%) or younger (30%) age groups (Table 4.3.2.4). Of those who had used a drug in the last year, a majority in each case had used the drug while in prison: 88% had used cannabis; 85% benzodiazepines; 87% other sedatives or tranquillisers; 87% methadone; 84% heroin; 66% other opiates; and 52% crack cocaine.

Last-month prevalence (current use)

Cannabis (43%) was the drug most commonly used in the past month, followed by benzodiazepines (29%) (Table 4.3.2.1). One-hundred-and-three prisoners (13%) tested positive for methadone in the 24 to 72 hours prior to the survey and 106 reported being prescribed methadone daily in the last month. Eighteen per cent of those who tested positive for methadone were in the 25–34-year age group. Women were significantly more likely to test positive for methadone than men (33% vs 12%).

Use in previous 24–72 hours

Oral fluid sample testing for drug use in the previous 24–72 hours showed that proportionally more women than men were on daily methadone maintenance (Table 4.3.2.1). Four per cent (31), all men, had used cannabis in the 24–72 hours before the survey, and 10% (83) had used benzodiazepines. Women (20%) were two times more likely to test positive for benzodiazepine use than men (10%).

Table 4.3.2.1 Prevalence of drug use among Irish prisoners, inside or outside prison, 2011

	Cannabis	Cocaine powder	Crack cocaine	Heroin	Methadone	Benzo-diazepines	Other sedatives or tranquillisers
Lifetime use	708 (86.9%)	600 (74.2%)	284 (35.6%)	348 (43.3%)	262 (32.6%)	547 (67.8%)	466 (58.2%)
Last-year use	554 (68.6%)	226 (28.6%)	92 (11.7%)	233 (29.5%)	167 (20.9%)	434 (54.6%)	367 (46.3%)
Last-month use	349 (43.4%)	41 (5.3%)	15 (1.9%)	87 (11.1%)	106 (13.3%)	229 (29.0%)	367 (46.3%)
Past 24–72 hour use	31 (4.0%)	Not available	Not available	2* (0.3%)	103 (13.3%)	83 (10.7%)	Not available

*Opiates

Source: (Drummond, *et al.* 2014)

Table 4.3.2.2 Prevalence of cannabis use among Irish prisoners, inside or outside prison, by age and gender, 2011

Cannabis use	All	Male	Female	18–24 years	25–34 years	35–64 years
Lifetime use	708 (86.9%)	670 (87.0%)	38 (84.4%)	241 (94.9%)	297 (92.5%)	162 (70.4%)
Last-year use	554 (68.6%)	523 (68.6%)	31 (68.9%)	210 (84%)	231 (72.6%)	105 (45.7%)
Last-month use	349 (43.4%)	332 (43.7%)	17 (38.6%)	128 (51.2%)	148 (46.8%)	67 (29.4%)
Past 24–72 hour use	31 (4.0%)	31 (4.2%)	0	9 (3.8%)	14 (4.5%)	8 (3.8%)

Source: (Drummond, *et al.* 2014)

Table 4.3.2.3 Prevalence of cocaine use among Irish prisoners, inside or outside prison, by age and gender, 2011

Cocaine use	All	Male	Female	18–24 years	25–34 years	35–64 years
Lifetime use	600 (74.2%)	571 (74.6%)	29 (65.9%)	210 (83.7%)	262 (81.9%)	121 (53.1%)
Last-year use	226 (28.6%)	208 (27.8%)	18 (41.9%)	96 (38.9%)	101 (32.3%)	26 (11.8%)
Last-month use	41 (5.3%)	40 (5.4%)	1 (2.4%)	11 (4.6%)	19 (6.1%)	10 (4.6%)
Past 24–72 hour use	1	1	Not available	Not available	1	Not available

Table 4.3.2.4 Prevalence of heroin use among Irish prisoners, inside or outside prison, by age and gender, 2011

Heroin use	All	Male	Female	18–24 years	25–34 years	35–64 years
Lifetime use	348 (43.3%)	319 (42.1%)	29 (64.4%)	94 (37.8%)	159 (50.2%)	90 (39.7%)
Last-year use	233 (29.5%)	212 (28.4%)	21 (46.7%)	74 (29.7%)	112 (36.0%)	45 (20.4%)
Last-month use	87 (11.1%)	81 (11.0%)	6 (13.3%)	27 (10.9%)	40 (12.9%)	19 (8.8%)
Past 24–72 hour use	2* (0.3%)	2* (0.3%)	0	0	1* (0.3%)	0

*Opiates

Source: (Drummond, *et al.* 2014)

Table 4.3.2.5 Prevalence of benzodiazepine use among Irish prisoners, inside or outside prison, by age and gender, 2011

Benzodiazepine use	All	Male	Female	18–24 years	25–34 years	35–64 years
Lifetime use	547 (67.8%)	516 (67.7%)	31 (68.9%)	203 (80.2%)	229 (71.8%)	109 (48.4%)
Last-year use	434 (54.6%)	406 (54.1%)	28 (62.2%)	174 (69.3%)	188 (59.9%)	68 (30.9%)
Last-month use	229 (29.0%)	211 (28.3%)	18 (40.0%)	79 (31.5%)	106 (34.0%)	43 (19.7%)

Benzodiazepine use	All	Male	Female	18–24 years	25–34 years	35–64 years
Past 24–72 hour use	83 (10.7%)	74 (10.1%)	9 (20.0%)	25 (10.4%)	40 (12.9%)	18 (8.5%)

Source: (Drummond, *et al.* 2014)

Methods of heroin use

Two-hundred-and-twenty-six prisoners said they were 'doing heroin now'. Among these current heroin users, 75% reported smoking (or chasing the dragon) as their only method of choice, with 13% reporting injecting and 1% snorting as their only method. Only a very small proportion (1.3%) currently used all three methods of administration. The proportion of those who smoked and snorted was 1.3%, whereas 9% both smoked and injected.

Prescription drug use in prison

High usage of benzodiazepines, other sedatives or tranquillisers, methadone and other opiates was reported by participants. The vast majority (85%) of prisoners who reported taking methadone in prison in the month prior to the survey had taken it on prescription. A minority had taken benzodiazepines (14%) or other sedatives (22%) under medical supervision (or on prescription). A large proportion reported having taken unprescribed benzodiazepines in prison in the previous month.

Lifetime prevalence of injecting drug use – ever injected

Over 26% reported having ever injected drugs, with women (44%) more likely to have a lifetime history of injecting drug use than men (24%). Thirty-four per cent of the 25–34-year age group were more likely to have injected than their older (35–64 years, 22%) or younger (18–24 years, 18%) counterparts. The most commonly injected drug was heroin (19%), followed by cocaine powder (13%). Women were more likely than men to have ever injected heroin (43% vs 18%), cocaine powder (32% vs 12%), mephedrone (16% vs 4%), methylone (11% vs 2%) and any other drug (14% vs 4%).

Last-year prevalence of injecting drug use – recent injectors

The most commonly injected drug in the last year was heroin (7%), followed by cocaine powder (3%), benzodiazepines (3%) and steroids (2%). More women than men had recently injected heroin (21% vs 6%), cocaine powder (14% vs 3%), mephedrone (13% vs 2%), methylone (7% vs 1%), amphetamines (7% vs 1%) and benzodiazepines (11% vs 2%), with no significant differences across age groups.

Last-month prevalence of injecting drug use – current injectors

The numbers reporting injecting in the last month were low (1 to 8 people injecting each drug). Cocaine powder was injected by eight respondents (1%), heroin by seven (0.9%), benzodiazepines by four (0.5%) and steroids by four (0.5%).

Age at first use of drugs

Fifty per cent of cannabis users had used it by their 14th birthday. Half of all benzodiazepines users had used it by their 17th birthday. The median age for first use of cocaine powder was 18 years, and of heroin, 19 years. Among heroin injectors, the average length of time between moving from smoking to injecting was 2.8 years. The median age for commencing injecting head shop drugs such as methylone and mephedrone was 24 years, and for injecting steroid 22 years.

First use and first injection

Of those who reported having ever used heroin (smoking or injecting), 146 (43%) said they had taken it for the first time in prison and these were more likely to be men (46%) than women (17%). Twenty-one per cent of women and 6% of men (8% overall) who had ever injected heroin reported having injected it for the first time in prison. Of the 69 who had started injecting in prison, 16 (24%) injected steroids while 12 injected heroin.

Of injectors who had injected in the past year, 13 of the 19 recent steroid injectors had injected in prison, 9 of 56 recent heroin injectors had done likewise, as had 7 of 23 recent benzodiazepine injectors and 7 of 25 recent cocaine injectors.

Overdose history

While over a quarter (27%) of all prisoners reported ever overdosing, the proportion among injecting drug users was much higher (58%). There were significant differences between genders, as women

were more likely than men to report a history of overdose (44% vs 26%). This difference was even more apparent for injecting drug users (80% vs 55%). There were no significant differences between age groups.

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

5.1 Introduction

Two broad philosophies underlie the approach 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.

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

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 **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.

Other entities mentioned in this chapter are as follows:

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:

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

The **National Drug Rehabilitation Implementation Committee (NDRIC)** is responsible for overseeing and monitoring the implementation of the recommendations contained in the report of the Working Group on Drugs Rehabilitation, the development of protocols, service level agreements and

a quality standards framework, and ensuring appropriate training is instigated. Chaired by the HSE, the NDRIC comprises representatives of the HSE, government departments, agencies and community and voluntary sector organisations, the National Advisory Committee on Drugs, service professionals, problem drug users and families of problem drug users.

QuADS (Quality in Alcohol and Drug Services) is a quality standards framework developed in the UK by Alcohol Concern and SCODA in 1999. QuADS has been contextualised for Irish drug and alcohol services and has been adopted as the national quality standards for addiction services in Ireland.

The **Youth Drug and Alcohol Service (YoDA)** is a specialised adolescent outpatient drug treatment service in Dublin and is the largest service of its kind in Ireland.

5.2 General description, availability and quality assurance

5.2.1 Strategy/policy

HSE National Service Plan 2014

Approved by the Minister for Health on 17 December 2013, the HSE's *National Service Plan 2014* set out the type and volume of services the HSE would provide in 2014 (Health Service Executive 2013). With the health services budget for the year reflecting cost reductions of €619 million, and against a backdrop of a reduction in overall health service funding of almost €4 billion since 2008 and staff reductions of over 10,000 in that time, the HSE's top priority in 2014 was to protect the volume, quality and safety of frontline services.

'Addiction issues' were addressed by Social Inclusion Services in the Primary Care Division of the HSE. Social Inclusion Services support equity of access to services and provide targeted interventions to improve the health outcomes of minority groups, including Irish Travellers, Roma, and other members of diverse ethnic and cultural groups, such as asylum seekers, refugees and migrants, lesbian, gay, bisexual and transgender service users. Specific interventions are provided to address addiction issues, homelessness and medical complexities.

The key priorities for 2014 expected to have an impact on addiction services were set out on p.37 of the plan:

- achieve improved health outcomes for persons with addiction issues;
- deliver on the national policy objectives of the national drugs strategy 2009–2016 (Department of Community 2009), with specific reference to progressing implementation of relevant actions on early intervention, treatment and rehabilitation;
- implement recommendations from HSE Opioid Treatment Protocol (see Section 5.2.2.1 later in this chapter);
- implement recommendations with regard to Tier 4 in the residential addiction services report (Corrigan and O'Gorman 2007) within the context of available resources;
- finalise the implementation plan for the National Overdose Prevention Strategy (see Chapter 7.4 later in this report); and
- prioritise and implement HSE actions in the report on a national substance misuse strategy (Steering Group on a national substance misuse strategy 2012).

Table 5.2.1.1 Key performance indicators for HSE's Addiction Services, 2014

Key Performance Indicators	Expected Activity / Target 2014
<i>Opioid Substitute Treatment</i> No. of clients in opioid substitute treatment (outside prisons)	9,100
<i>Substance Misuse</i> No. and % of substance misusers (over 18 years) for whom treatment has commenced within one calendar month following assessment	1,260 (100%)
No. and % of substance misusers (under 18 years) for whom treatment has commenced within one week following assessment	105 (100%)

Source: (Health Service Executive 2013), p. 38

HSE National Performance Assurance Report, December 2013

The HSE National Performance Assurance Report published data on key performance areas for 2013 (Health Service Executive 2014b) (Health Service Executive 2014a). It gave a snapshot of how Addiction Services, located within Social Inclusion Services, were performing in December 2013. A summary of the report is given below:

- 9,100 clients (excluding clients in prisons) were on methadone maintenance treatment, of whom 42% were being treated by GPs in the community. The report states that this was 5% above the expected level of activity.
- 327 GPs, 73 HSE clinics and 10 prison-based clinics were providing treatment.
- 60 new patients started methadone treatment, mostly in HSE clinics.
- 93% (977) of all clients over the age of 18 who were assessed and required treatment, commenced treatment within one calendar month.
- This varied by HSE region: lowest (Dublin Mid Leinster – 81%); highest (Dublin North East – 100%).
- All 51 clients aged 17 years or younger started treatment within one week following assessment.

Evaluation of the National Drug Rehabilitation Framework

An external evaluation of the National Drug Rehabilitation Framework has been published (Barry and Ivers 2014). The framework, developed out of the work of NDRIC, comprises an integrated model of rehabilitation, care planning, case management, standardised assessments, protocols and quality standards (Doyle and Ivanovic 2010). According to the authors, of the ten pilot sites chosen to implement the framework, only six had commenced. While many challenges were encountered in the pilot, the authors felt that there was 'near universal' support for the project and the evaluation provided valuable lessons for improving the project. For a detailed analysis of the evaluation, see Chapter 8.3 later in this report.

5.2.2 Treatment systems

5.2.2.1 Organisation and quality assurance

Review of Dublin North City and County addiction service

A recent high-level review of addiction treatment services in the Dublin North City and County area concluded that a substantial reconfiguration of services was needed to effectively respond to population needs and to emerging national policy (Pilling, *et al.* 2013). The report contained 14 recommendations, eight calling for a reconfiguration of services and six for a reconfiguration of operational elements (Table 5.2.2.1.1).

Table 5.2.2.1.1 Dublin North City and County addiction service, recommendations for changes

Service recommendations	Operational recommendations
Deliver addiction services around clinical care pathways for drugs <i>and</i> alcohol, with a focus on recovery.	All service users should have agreed care plans which should be reviewed and updated regularly.
Organise addiction services to treat all addictions (including alcohol and stimulants) in multi-disciplinary teams which are locality based.	Locality teams should provide support to individuals with drug and alcohol problems who are treated by primary care services.
Develop specialist resources and services around dual diagnosis, pregnancy, hepatitis C, assisted withdrawal for individuals with complex needs, and children, young people and families.	All interventions should be evidence based and service providers should have appropriate training and supervision to ensure effective delivery.
Appoint a clinical director who should jointly chair the senior management team, and a designated clinical lead for each locality team and specialist services.	Assisted withdrawal (detoxification) services and rehabilitation services should be developed as a part of all care pathways.
Appoint a service manager who should jointly chair the senior management team; all staff should have clear lines of accountability.	Provide formal structures to enable service users to contribute to the design and evaluation of care.
Have in place a routine outcome monitoring programme; outcomes should link to agreed clinical and service performance measures.	Appoint a designated implementation manager and establish a steering group to implement the recommendations in this report.
Develop a clinical governance structure to support the work of all clinicians in the addiction service.	

Service recommendations	Operational recommendations
Assessment of need and regular reviews of identified need should be central to the delivery of addiction services.	

Source: (Pilling, *et al.* 2013), pp. 6–7

The review team drew heavily on consultations with representatives from a range of staff groups, including psychiatrists, pharmacists, voluntary sector representatives, service users and outreach workers. In summarising the main issues to emerge from these consultations, the authors acknowledged that while many elements of the service worked well:

The current service configuration is sub-optimal, meaning that it is not always possible for staff to deliver care in line with an evidence-tiered approach.... The service currently consists of a number of professional/staff groups, some of whom appear to have limited formal interaction with one another.... There are also a number of ad-hoc arrangements in place, with staff providing good services but again these are often not properly integrated within the wider service system.... Services have typically evolved, often without an overall strategic direction, responding to specific issues or opportunities. (p. 20)

The authors identified a lack of integration between the different elements of service provision. They also pointed out that, in the main, the primary functions of addiction treatment services across the area were to assess opioid dependence and dispense methadone. They saw the scope of service provision as needing expansion to prioritise responses to alcohol misuse, co-morbid mental health disorders, non-opiate drug misuse and the physical healthcare of service users. They also stated that a detailed and comprehensive needs assessment was required to document the nature and level of services required by people across the area with addiction-related needs.

Finally, the authors recommended that ‘in line with international opinion, the principle of recovery should underpin all treatment from the point of first contact’ (p. 20). They gave the following definition of recovery: ‘an individual, ‘person-centred journey, enabling people to gain a sense of control over their own problems, the services they receive, and their lives and providing opportunities to participate in wider society’ (p. 22).

Quality Standards Support Project

With the support of the HSE and the North Inner City Local Drugs and Alcohol Task Force at a local level, the Quality Standards Support Project continues to work to support projects to develop their services in line with good practice and QuADS. It provides training for ‘champions’, i.e. a key person in an organisation, a policy template library and links to useful resources (drugs.ie).

Development of clinical guidelines for opiate treatment

In April 2014 a draft of the clinical guidelines for opiate treatment was distributed to a wider group for consultation; the results of this consultation are still awaited (personal communication Suzi Lyons, Health Research Board). See Chapter 5.2.2.1 of the 2013 National Report (Health Research Board 2013) for a brief outline of the expected contents of the guidelines.

5..2.2.2 Availability and diversification of treatment

Pharmacist–patient structured methadone detoxification in prison

Drug treatment pharmacists were introduced in Mountjoy Prison in 2008, primarily to ensure the safe, accurate and efficient dispensing of methadone (Cronin, *et al.* 2014). The pharmacists currently dispense in 13 different locations in the Mountjoy complex. While the safe dispensing of methadone remains the priority, since 2010 pharmacists have also been supervising and managing pharmacist–patient structured methadone detoxification, otherwise known as self-directed detoxification (SDD).

Unlike other detoxification regimes, which are prescribed and have a fixed regime, SDD allows prisoners to opt to detoxify at times when they feel they are ready for and capable of change. The pharmacists offer SDD in 12 locations within the Mountjoy Prison Complex (excluding Dochas Women’s Prison). All SDDs must be requested 24 hours in advance by the prisoner in order to eliminate impulsive decisions. SDD may be undertaken if it is deemed clinically appropriate and if it is

provided within certain parameters, i.e. up to a maximum amount, which reduces each week, and is communicated to the addiction specialist doctor. The addiction specialist writes up the prescription weekly. If, at a later date, the prisoner chooses to return to their previous dose (i.e. increase their consumption), they must see the addiction specialist. The prisoner is supervised on a daily basis by the pharmacist so that any changes in demeanour and behaviour can be easily observed by a professional familiar with them and interventions can be made where appropriate.

Anecdotally this system has proved successful. However, it was decided to conduct a review in order to determine the exact number of prisoners involved in SDD and assess the outcomes. The outcomes of all pharmacist–patient structured methadone detoxifications in Mountjoy Prison in Dublin between June 2010 and May 2014 were reviewed. The results of the review are reported here for the first time.

Methods

Three different cohorts of prisoners were chosen for the purposes of the review:

1. Those on methadone maintenance therapy (MMT) who reduced their maintenance dose by over 20mls (or 50% of their dose) between their committal to Mountjoy and their final movement out of Mountjoy. This cohort included those who returned to the community or were transferred to another prison.
2. Those on MMT who detoxified completely and came off methadone while in custody in Mountjoy. For the purposes of the review, a prisoner on MMT was considered detoxified when sequentially reduced to a prescribed dose of 7mls or less. At this dosage, a prisoner will often stop their methadone completely but get prescribed lofexidine or another drug to aid with any symptoms of withdrawal.
3. Those on lofexidine therapy as an adjunct to SDD.

The review excluded two cohorts of prisoners:

1. Prisoners who were in receipt of MMT but who were in custody in Mountjoy for only a short period of time (less than 60 days consecutive days).
2. Prisoners who were prescribed a '21-day standard detoxification'. This group were not in receipt of any MMT prescription but tested positive for opiates and/or methadone and did not have an MMT clinic place externally. The prison can only offer a '21-day standard detoxification' until a clinic place is confirmed for when they are released to continue their care. This regime consists of 20mls methadone for two days, 30mls for four days, and then a 5mls dose reduction every three days to zero. As such their dose reductions cannot be considered SDD.

Data pertaining to all methadone and lofexidine prescriptions in Mountjoy Prison during the period June 2010 to May 2014 were examined. The number of prisoners eligible for inclusion in the study were as follows:

Methadone – 13,698 prescriptions, of which:

- 572 prescriptions were for '21-day standard detoxifications'. This equated to 390 prisoners who were excluded from the review.
- 13,126 prescriptions were for 1,207 prisoners on MMT. Of these, 405 were excluded as they had not been in custody in Mountjoy for 60 or more consecutive days.
- In total, 805 prisoners were included in the review.

Lofexidine – 138 prescriptions.

Results

Of the 805 prisoners on MMT included in the review, 416 (52%) chose to undertake SDD. Of these, 202 (49%) reduced their MMT dose by a significant amount of 20mls or more, and 214 (51%) detoxified off MMT completely while in Mountjoy. Of the 214 who detoxified off methadone completely:

- 134 (63%) used lofexidine to complete their SDD. Four prisoners had two courses of lofexidine but also completed SDD successfully.
- 80 (37%) did not use lofexidine to complete their detoxification but completed the programme with the support of the pharmacists.
- 27 (13%) either relapsed temporarily or went back on MMT.

Conclusions

1. The practice of SDD through the pharmacists is routine in Mountjoy Prison.
2. Over half of all prisoners prescribed methadone (for 60 or more consecutive days) in Mountjoy were able to reduce their methadone dose significantly using SDD.
3. Half the prisoners who undertook SDD were able to detoxify completely off methadone while in Mountjoy.
4. Lofexidine as an adjunct to MMT, to treat withdrawal symptoms, was used by 63% of those who chose to undertake SDD to complete their detoxification.
5. Over a third of those who undertook SDD chose to complete their detoxification without lofexidine and completed it in the main prison with the support of the drug treatment pharmacists.
6. At least 13% of prisoners who underwent SDD and detoxified completely relapsed, some only temporarily.
7. Information on what happened to the prisoners on release from Mountjoy is not known, e.g. did they relapse or return to treatment? It would be important to investigate this in order to gauge the overall success of the programme. This would require a further study using the HSE's Central Treatment List (CTL).

Treating problem alcohol use among drug users in primary care

Problem alcohol use among drug users can negatively affect outcomes of drug treatment and hinder recovery. A body of work has been undertaken to address the issue in the primary care setting. Drug users accessing primary health care highlighted the importance of the patient–GP relationship and also felt that GPs should be more proactive in managing their problem alcohol use (Field, *et al.* 2013). Two further publications have outlined the development of clinical guidelines (Klimas, *et al.* 2014a), and an education programme for GPs to identify and manage problem alcohol use in this group (Klimas, *et al.* 2014b).

The clinical guidelines were developed in three stages (Klimas, *et al.* 2014a): (1) identification of a wide range key stakeholders in the addiction, public health and primary care fields; (2) development of evidence-based draft guidelines; and (3) consensus on document reached through a modified Delphi-facilitated technique. Some of the key differences in the clinical guidelines for treating problem alcohol use among drug users, compared to problem alcohol use among those who do not have problem drug use, are:

- screening and treatment need to be more systematic and proactive;
- lower thresholds required for identification of problem use, treatment and referral; and
- need for GPs to have specialist skills to manage relapse/dependence.

5.3 Access to treatment

For a report on access to treatment in 2013, see 'HSE National Performance Assurance Report, December 2013' in Section 5.2.1 above.

Need for drug treatment in prison

As part of the NACDA's survey estimating the extent of drug use and the prevalence of blood-borne viruses among the prison population in Ireland, participants were asked about their need for drug treatment (Drummond, *et al.* 2014). Participants were asked if they ever needed different types of drug treatment while in prison. They were also asked whether those services were available to them (within a reasonable time frame) and, if available, whether they used those services. The different types of service were analysed by overall prison population, then by prison drug use category and by injecting drug use. To establish appropriate prison drug use categories, the authors used a *post-hoc* hierarchical clustering model to categorise prisons based on prisoners' self-reported use in the previous 12 months of the six drugs included in the EMCDDA 'problem drug use' definition. By this method they identified four prison clusters based on levels of drug use, which they categorised as

'low', 'medium', 'high' and 'very high'.⁸ Some of the main results in relation to need for treatment are summarised below.

Overall need

The greatest proportion of respondents expressed a need for addiction counselling (44%), followed by drug-free wing or landing (41%) and drug-free treatment programme (33%), while the smallest proportion expressed a need for alcohol detoxification (14%). Nineteen per cent expressed a need for benzodiazepine detox, and the same proportion expressed a need for opiate detox.

The availability of specific drug treatments in relation to the number of participants expressing a need for them varied widely, from a low of benzodiazepine detoxification availability for only 22% of those expressing a need for it, to a high of methadone maintenance treatment (MMT) availability for 73% of those expressing a need. Overall, a high proportion of participants who needed a drug treatment service, and for whom it was available in prison, used the service, ranging from 95% for MMT to 78% for alcohol detoxification. The authors noted that availability also varied across prisons (see below).

Need by prison drug use category

The need for services varied by prison drug-use category. As might be expected, the expressed need was highest in the 'very high' drug-use category prisons. The highest need in all prison categories was for addiction counselling, ranging from 56% in the 'very high' drug-use category prisons to 38% in the 'low' drug-use category prisons. The need for a more specific intervention, MMT, ranged from 6% in the 'low' drug-use category prisons to 46% in the 'very high' drug-use category prisons.

An analysis of the reported availability of services (among those who needed them) by prison drug-use category was also done. This showed a wide range of availability across categories. For example, in 'very high' drug-use category prisons, 88% reported that MMT was available, compared to 49% in 'medium' drug-use category prisons. In the 'very high' drug-use category prisons, availability of drug-free wings or landings (28%) or drug-free programmes (32%) was reported as low. Where these services were available there was high uptake, particularly in the 'high' and 'very high' drug-use category prisons.

A sub-group of participants comprising those who had ever injected was analysed by prison drug-use category. The expressed need for services was higher across all categories of prison drug-use. The need was particularly high for addiction counselling (ranging from 62% to 82%) and for drug-free treatment programmes (ranging from 53% to 74%). The authors stated that the results with regard to the availability of services and the high uptake of services for this group were similar to those in the general prison population as reported above.

Recommendations for drug treatment in prison include:

- Prisoners on MMT should be placed on an HSE clinic list or GP list to ensure that there is continuity of treatment on release from prison. This would reduce the risk of overdose or early relapse.
- If a prisoner is engaging with counselling, where possible there should be continuity of this treatment on release in order to support transition out of prison and into the community.
- A full range of drug treatment options, encompassing an integrated clinical and psychological approach, should be available in all closed prisons.
- There is a need for drug-free wings and drug-free areas not only for prisoners who do not use drugs but for those who wish to avoid relapse.
- As the women's prison was included in the 'very high' drug-use prison category, it is recommended that there be a specific strategy for the needs of women in order to improve their outcomes.

See Chapter 4.3.2 earlier in this report for an account of the findings of this NACDA prison study with regard to prevalence and patterns of drug use among prisoners, and Chapter 6.2.1 for an account of the findings with regard to the prevalence of blood-borne viruses among the prison population.

⁸ For a detailed description of the method used, see Drummond, A., Codd, M., Donnelly, N., McCausland, D., Mehegan, J., Daly, L. *et al.* (2014). Study on the prevalence of drug use, including intravenous drug use, and blood-borne viruses among the Irish prisoner population. National Advisory Committee on Drugs and Alcohol, Dublin. Available at <http://www.drugsandalcohol.ie/21750/> pp. 38–41

5.3.1 Characteristics of treated clients (TDI data included)

TDI data

A summary of the Treatment Demand Indicator (TDI) (see also TDI data), as provided by the NDTRS, shows that 8,684 cases entered treatment in 2013, an increase of 981 cases since 2012.⁹ In 2013, 3,470 (40.0%) cases were new entrants, an increase of 200 cases compared to 2012. In 2013, as in previous years, the majority of cases attended outpatient services (5,745, 66.1%). The majority were male (6,328, 72.9%) and the mean age was 29 years, similar trends to 2012.

As in previous years, opiates (mainly heroin) were the most common main problem drug reported by cases entering treatment in 2013 (4,451, 51.3%). This represents a decrease compared to 2012, when 4,971 cases entered treatment for problem opiate use. This decrease is not seen in the CTL data (see next section on 'Clients registered for MMT' and Standard Table 24). The reduction in the proportion of cases treated for cocaine as a main problem substance continued in 2013, decreasing from 8.5% in 2012 to 7.8% in 2013.

The number of cases entering treatment for cannabis as their main problem substance has continued to increase. In 2013, 2,511 (28.9%) cases entered treatment for problem cannabis use compared to 2,216 in 2012 and 2,086 cases in 2011. This is not surprising as the most recent general population survey showed a significant increase in the proportion of adults in Ireland who have ever used cannabis (National Advisory Committee on Drugs and Alcohol 2013). However, it may also reflect participation of services in the NDTRS or availability of treatment in the country.

Clients registered for methadone maintenance treatment (MMT)

The number of clients registered for MMT on 31 December each year is reported by the CTL (see Standard Table 24). On 31 December 2013, 9,640 clients were registered for MMT (including those receiving methadone in prison) (personal communication, Caroline Comar, CTL). This is a slight increase on the previous year (2%). While the number of clients registered has increased from 3,689 in 1998 to 9,640 in 2013, since 2008 the rate of increase has been less than 4% annually. This may reflect a change in patterns of drug use, but analysis of other sources, including treatment data and numbers of problem drug users, is necessary to explore this further. Of the 9,640 clients in 2013, the majority were male (69%) and the largest proportion (29%) were aged between 35 and 39 years, the same as in 2012.

MMT is provided by specialised clinics, specialist GPs and in prison. In 2013, 55% of patients were receiving treatment in specialist outpatient clinics, 40% from GPs and 5% in prison. The proportion of clients receiving treatment from GPs has increased slightly, from 35% in 2009 to 40% in 2013. The proportion of clients receiving treatment in specialist outpatient clinics has decreased slightly, from 58% in 2009 to 55% in 2013.

Travellers accessing addiction services in Ireland

Since 2007 the NDTRS has recorded ethnic identifiers comparable with those used by the Central Statistics Office in the national population census. The inclusion of an ethnic identifier question in routine data collection allows the recording of useful information on ethnicity for planning health services. These data formed the basis of a peer-reviewed paper which described individuals from the Traveller community who were assessed or treated for problem drug or alcohol use between 2007 and 2010 (Carew, *et al.* 2013). The study provided an insight into the needs of Travellers with problem substance use and will be useful in informing and developing policies and strategies to tackle barriers and issues faced by the Traveller community.

Numbers seeking treatment

In the period 2007–2010, 68,748 cases sought treatment for problem substance use and were reported to the NDTRS. Ethnicity was recorded for 68,329 cases (99.4%), of whom 1,098 (1.6%) identified themselves as Irish Travellers. The number of such cases increased by 163% in the four-year period, from 162 in 2007 to 427 in 2010. However, the authors noted that the number of Traveller cases recorded in the routine national drug treatment data is likely to be under-estimated.

⁹ It should be noted that the selection of NDTRS data for national analysis differs slightly to the selection of data for TDI. Therefore there are some differences between what is reported in TDI and what is published in HRB Trend papers and web updates.

The incidence of treated problem substance use among the Traveller community was three times that among the general population in 2010 (523 per 100,000 vs 173 per 100,000).

Main problem substance

- Alcohol was the most common problem substance for which cases from both the Traveller community (42.3%) and the general population (52.7%) sought treatment.
- The number of Travellers seeking treatment for opiates (heroin, methadone and other opiates) increased by 291% (from 43 cases in 2007 to 168 in 2010), comprising 36.0% of Traveller cases in the four-year period, compared to 28.7% of cases from the general population.
- Although the numbers were small, there was a 240% increase in the number of cases of Travellers reporting benzodiazepines as their main problem substance (from 5 in 2007 to 17 in 2010), and a 200% increase in cases of Travellers reporting cannabis as their main problem substance, from 16 in 2007 to 48 in 2010. A similar upward trend, if less pronounced, was observed in cases from the general population: benzodiazepines (a 147% increase, from 177 to 435 cases) and cannabis (a 118% increase, from 1,065 to 2,326 cases).
- Opiates (heroin and other types) were the most commonly reported problem substance among Traveller women, while alcohol was the most commonly reported problem substance among women from the general population.
- Albeit small in number, the proportion of Traveller women treated for benzodiazepines as a main problem substance (9, 4.0%) was higher than that in women from the general population (328, 1.9%).

Additional problem substances

- The proportion reporting problem use of more than one substance (poly-substance use) was higher among Traveller cases (523, 53.2%) than among cases from the general population (24,826, 42.1%). The proportion reporting problem use of more than one substance was higher among Traveller men (425, 56.1%) than Traveller women (98, 43.4%).
- Cannabis was the most commonly reported additional problem substance among both Traveller cases and cases from the general population. Alcohol, cocaine, and benzodiazepines were the next most frequently reported additional problem substances for both groups.

Age first used drugs

- Traveller men who had used drugs commenced their drug use at a younger age (median, 14 years) than either Traveller women (median, 16 years) or their male counterparts from the general population (median, 16 years).
- Traveller women who had used drugs commenced their drug use at an older age than women from the general population (median, 15 years). The median period of time between commencing alcohol or drug use and seeking treatment was shorter for Traveller women compared with women in the general population.

Injecting risk

A slightly lower proportion of Travellers reported ever injecting drugs compared to the general population (15.3% vs 18.1%), and injecting status differed for men and women.

The proportions of Traveller men who reported ever injecting or ever having shared injecting equipment were lower than those in the general population. Traveller men reported starting to inject at an older median age than men in the general population (22 vs 19 years).

A higher proportion of Traveller women reported ever having injected compared with women from the general population (24.3% vs 16.3%), and also started injecting at a younger median age than women from the general population (19 vs 20 years). The proportions of Traveller women who were injecting at the time of entry to treatment and who reported having shared injecting equipment were greater than those among women from the general population.

Gender differences

Traveller women reported high rates of problem opiate use and injecting behaviours, contrary to the perception that problem substance use in the Traveller community is a predominantly male issue. The findings present a major cultural issue and challenge to Traveller health services and, given the high level of sharing, this has implications for the delivery of needle exchange services.

The paper highlighted the fact that problem drug and alcohol use was a serious issue, presenting 'complex and multiple challenges for health services providing treatment', and the specific needs and vulnerabilities of Travellers must be considered in order to provide targeted, appropriate and effective addiction services.

Characteristics of adolescents in drug treatment

Three studies of adolescents attending the Youth Drug and Alcohol Service (YoDA) have been published recently (Apantaku-Olajide, *et al.* 2014) (Apantaku-Olajide and Smyth 2013) (Keane, Lisa, *et al.* 2014).

While the aims and methodologies of the three studies varied, there are many commonalities about the characteristics of the different study groups which can be ascertained from the different papers. The majority of clients were male. The main problem drugs reported were cannabis, alcohol, cocaine, heroin and benzodiazepines. It was common among this group to report mental health problems. Where there was a pre-existing comorbid diagnosis, it was most commonly attention deficit hyperactive disorder (ADHD). Polydrug use was very prevalent, including problem use of both illicit and prescription drugs. Overall, this group had complex needs requiring multi-disciplinary teams with appropriate training and good interagency collaboration in order to improve outcomes. The individual studies are described below.

Psychological characteristics (Keane, Lisa, *et al.* 2014)

The aims of this study were to (1) examine the psychological characteristics of adolescents, and (2) compare two different groups – those who were heroin dependent and those who were non-opioid-substance dependent. The study focused on the period 2005–2010. Cases during this period for whom the Beck Youth Inventories second edition (BYI-11) had been completed were eligible to be included in the study. The BYI-11 measures self-reported levels of depression, anxiety, anger, disruptive behaviour and self-concept (how someone thinks about or perceives themselves).

Fifty-three heroin-dependent adolescents were recruited for the study. Of these, 21 (40%) were girls. The mean age was 17.1 years. Most reported polydrug use: cannabis (54%), benzodiazepines (52%), and cocaine (24%). The majority of this group received opiate substitution treatment: methadone (37, 70%) and buprenorphine (10, 19%). Six (11%) received psychological interventions only.

Almost a quarter (17, 24%) of the 71 adolescents in the non-opioid-substance dependent group were girls. The mean age of this group was 16.1 years. Seventy-six per cent of this group used more than one drug. The main problem drugs reported were alcohol (96%), cannabis (72%), cocaine (15%), ecstasy (13%) and benzodiazepines (6%).

Many of the adolescents attending the specialised service regardless of type of problem drug use reported mental health problems (as per the BYI-11 scores). However, comparison of the scores showed significant differences between the heroin-dependent group and the non-opioid-dependent group for the domains of self-concept, anxiety, disruptive behaviour and depression, but not for anger. Girls in the heroin-dependent group had significantly different scores for self-concept and disruptive behaviour compared to boys in this group. The authors stressed the need for appropriately trained staff and care for mental health issues when working with adolescent problem drug users, particularly those who use heroin.

Educational attainment and drug use (Apantaku-Olajide, *et al.* 2014)

This study looked at the effect of three different issues on educational attainment: (1) severity of drug use and psychological problems, (2) a disruptive family environment, and (3) pre-existing psychiatric comorbidity. Data were collected between October 2005 and March 2009. In total, 193 of the 215 cases eligible were included in the study.

Of those included, 76% (147) were boys. The mean age was 16.1 years (SD 1.5, range 9 to 19 years). The majority were living with their families (163, 85%) but 7% were living in residential care, 6% were living in foster care and 2% in homeless accommodation. Polydrug use was common but the main problem drugs reported were cannabis (40%), alcohol (35%), heroin (11%) and cocaine (5%). Age first used drugs ranged from 12 to 15 years. Age first used alcohol ranged from 11.5 to 15

years. The majority (113, 65%) of cases had had some contact with the criminal justice system. Just over a third of cases (67, 35%) had a pre-existing psychiatric disorder. Of those 67, 40% (27) had ADHD, followed by conduct disorder (17, 25%) and depression (10, 15%).

Educational attainment was categorised into three groups: still in main stream education (84, 44%), engaged in alternative education (46, 24%) and school dropouts¹⁰ (63, 33%).

The study found significant differences between the three educational groups, with the school dropout group showing the greatest problems. They had higher levels of drug use, notably heroin and polydrug use, commenced alcohol use earlier, and reported higher levels of psychiatric comorbidity and higher levels of parental drug use. The authors concluded that the study demonstrated the complex needs of this vulnerable group and especially those adolescents who drop out of school early. There was the need for good interagency work involving not only the treatment services but also justice, mental health and education to improve the outcomes for these children.

Non-medical use of psychotropic prescription drugs (Apantaku-Olajide and Smyth 2013)

This final study looked at the non-medical use of seven different psychotropic medications (opiate analgesia, ADHD stimulant, sedatives/anxiolytic, hypnotics (sleeping), antipsychotics, antidepressant and anabolic steroids) among adolescents attending YoDA. The data were collected between April and June 2011, and 63 out of the 85 cases eligible participated in the study. The cases were categorised into three groups: (1) medical use (prescribed any of the medication), (2) non-prescribed use (i.e. prescribed any of the medication but also had non-medical use), and (3) diverted use (i.e. use of any of the medication without a prescription).

The majority were boys (76%). Cannabis (75%) was reported as the main problem drug, followed by alcohol (14%), cocaine (10%) and heroin (1%). Over two thirds (43, 68%) reported non-medical use of prescription drugs and many took more than one (mean number of drugs 2.3, SD = 1.1, range 1 to 5). The most common category of prescription drugs misused were sedative/anxiolytics followed by hypnotics (sleeping). The most frequent reasons cited for misusing these drugs were 'seek high or buzz' (34, 79%); 'to have a good time' (27, 63%); and 'relief from boredom' (24, 56%). The most common sources for the drugs were friends. The authors concluded that prescribers must be more aware of the potential for abuse and diversion of prescription medication and that interventions are required to reduce availability and diversion of these medications.

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

For most recent information, see Chapter 5.3.2 in the 2013 National Report (Health Research Board 2013).

¹⁰ School dropout was defined as 'case whose highest level of education attained is lower secondary or below and who have not received education (either formal or informal) in the four weeks prior to the assessment'.

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 (HSE), and originally known as the National Disease Surveillance Centre, the HPSC endeavours to protect and improve the health of the Irish population by collating, interpreting and disseminating data to provide the best possible information on infectious disease. The HPSC has recorded new cases among injecting drug users of HIV since 1982, hepatitis B (HBV) since 2004, and hepatitis C (HCV) since 2006.

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

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

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

The **National Suicide Research Foundation (NSRF)** is an independent, multi-disciplinary research unit which investigates the causes of suicide and deliberate self-harm in Ireland.

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 poisoning deaths, deaths among those who are alcohol dependent, extending back to 2004.

The **Central Statistics Office (CSO)**, acting on behalf of the Department of Health, 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.

6.2 Drug-related infectious diseases

6.2.1 HIV/AIDS and viral hepatitis

HIV surveillance, 2013

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1982. Figure 6.2.1.1 presents the number of new cases of HIV among injecting drug users (IDUs) reported in Ireland, by year of diagnosis; data from 1982 to 1985 are excluded as these four years were combined in the source records. According to the most recent report of the HPSC, at the end of 2013, 344 people were newly diagnosed with HIV in Ireland (crude notification rate of 7.5 per 100,000 population). Since 2010, the annual rate of new HIV diagnoses has been relatively stable, ranging from 7.0 to 7.5 per 100,000 population (Health Service Executive and Health Protection Surveillance Centre 2014).

In 2013, 5% (18) of newly-diagnosed HIV cases were IDUs. This is similar to the number diagnosed in the last four years (ranging between 13 and 23 cases since 2010). Of the 18 newly-diagnosed cases who were IDUs, 12 were men and six were women and the median age was 33.5 years (range 23 to 56 years). Ten cases were born in Ireland, three in Central and Eastern Europe and one in Western Europe. Country of birth was unknown for four. Where CD4 count was reported, 56% of IDUs in 2013 were diagnosed late, including 19% who were severely immuno-compromised. The proportion diagnosed late in 2013 was lower than in 2012 (63%) and 2011 (85%). One of the 18 IDUs was also diagnosed with an AIDS-defining illness at the time of their HIV diagnosis. Among the IDUs newly diagnosed with HIV infection, 83% were co-infected with HCV.

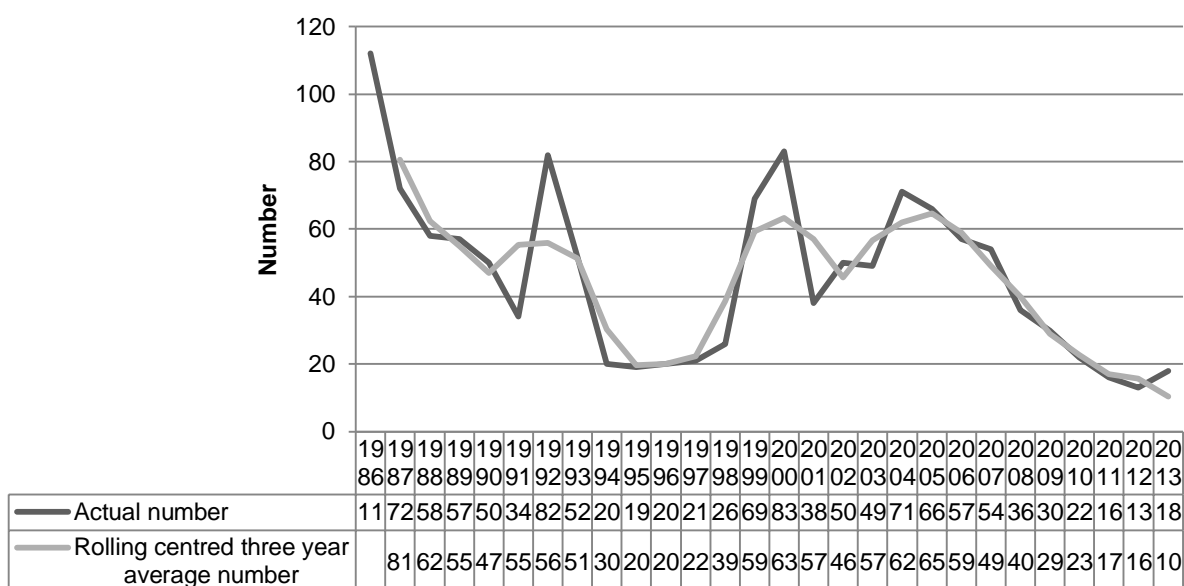


Figure 6.2.1.1 Number and rolling average number of new cases of HIV among IDUs, by year of diagnosis, reported in Ireland, 1986–2013

Hepatitis B (HBV) notifications, 2013

There were 431 notifications of HBV in 2013 compared to 581 in 2012, an 18% decrease (Table 6.2.1.1). Of the cases notified, 58% (248) were male, 41% (178) were female and in a further five cases the gender was unknown. The majority, 71% (306), were aged between 25 and 44 years. The number of acute cases remained low at 31, showing a small decrease since 2012 when there were 37 acute cases. Among acute cases of HBV in 2013, one was an IDU.

Table 6.2.1.1 Acute and chronic hepatitis B cases reported to the HPSC, by risk factor status, 2012-13

Hepatitis B status	2012			2013		
	Acute N (%)	Chronic N (%)	Unknown N (%)	Acute N (%)	Chronic N (%)	Unknown N (%)
Total number of cases	37	521	23	31	386	14
% of cases by status	(6.4)	(89.6)	(4)	(7.2)	(89.6)	(3.2)
Cases with reported risk factor data	36	243	5	30	230	6
% of cases with risk factor data	(97)	(47)	(22)	(97)	(59.6)	(42.9)
of which						
Injecting drug users	0 (0%)	5 (1%)	0 (0%)	1 (3.3%)	6 (2.6%)	0 (0%)
Cases without reported risk factor data	1	278	18	1	156	8
% of cases without risk factor data	(3)	(53)	(78)	(3)	(40.4)	(57.1)
Total		581			431	

Source: Unpublished data reported to Department of Health by National Disease Surveillance Centre and HPSC, 2014

Hepatitis C (HCV) notifications, 2013

There were 847 HCV notifications in 2013 (Table 6.2.1.2), a decrease of 18% on 2012 when there were 1,036 notifications. The notification rate for 2013 was 18.5 per 100,000 population. The notification rate has continued to decrease from a peak of 36.5 per 100,000 population in 2007. The median age at notification has increased steadily over the 10 years since notification began in 2004, from 32 to 38 years in males and from 29 to 36 years in females. Decreasing HCV notifications and increasing median age are indicative of a reduced incidence of HCV in the population. Demographic data in 2013 remained similar to previous years, with 68% (576) of cases being male and 87% (739) aged between 25 and 54 years.

Table 6.2.1.2 Hepatitis C cases and notification rates per 100,000 population, 2004–2013

Year	n	Notification rate
2004	1119	26.4
2005	1403	33.1
2006	1210	28.6
2007	1541	36.5
2008	1511	35.8
2009	1240	29.3
2010	1236	29.2
2011	1257	29.6
2012	1036	24.4
2013	847	18.5

Source: Unpublished data from HPSC, 2014

Risk factor data were available for 540 (64%) of the 2013 cases (Table 6.2.1.3). For 372 (69%) of these cases, injecting was the predominant risk factor. Among the cases for whom injecting was the predominant risk factor, 272 (73%) were men, the mean age was 37.6 years, and 297 (80%) lived in Dublin or the adjoining counties of Kildare and Wicklow (Table 6.2.1.4).

Table 6.2.1.3: Hepatitis C cases reported to the HPSC, by risk factor status, 2010–2013

Risk factor status	2010	2011	2012	2013
	n (%)	n (%)	n (%)	n (%)
Total number of cases	1236	1257	1036	847
Cases <i>with</i> reported risk factor data	728 (58.8%)	753 (59.9%)	651 (62.8%)	540 (63.8%)
Of which:				
Injecting drug users	550 (75.5%)	616 (81.8%)	484 (74.3%)	372 (68.9%)
Recipient blood/blood products	19 (2.6%)	19 (2.5%)	26 (4%)	16 (3%)
Other risk factors	143 (19.6%)	106 (14.1%)	127 (19.5%)	135 (25%)
No known risk factor identified	16 (2.2%)	12 (1.1%)	12 (1.8%)	17 (3%)
Cases <i>without</i> reported risk factor data	511 (41.3%)	504 (40.1%)	385 (37.1%)	307 (36.2%)

Source: Unpublished data from HPSC, 2014

Table 6.2.1.4: Hepatitis C cases who reported injecting drug use as a risk factor, by age, gender and place of residence, 2010–2013

	2010	2011	2012	2013
	n (%)	n (%)	n (%)	n (%)
Total number of known injector cases	550	616	484	372
Gender				
Male	409 (74%)	419 (68%)	348 (72%)	272 (73%)
Female	140 (25.5%)	196 (31.8%)	136 (28%)	99 (26.6%)
Gender not known	1	1	0	1
Age				
Mean age	35.8	35.4	36.9	37.6
Median age	34	34	36	37
Under 25 years	32 (5.8%)	45 (7.3%)	23 (4.8%)	10 (2.7%)
25–34 years	247 (44.9%)	269 (43.7%)	178 (36.8%)	137 (36.8%)
Over 34 years	271 (49.3%)	300 (48.7%)	282 (58.2%)	225 (60.5%)
Age not known	0 (0%)	2 (0.3%)	1 (0.2%)	0 (0%)
Place of residence				
Dublin, Kildare or Wicklow	466 (84.7%)	538 (87.3%)	399 (82.4%)	297 (79.8%)
Elsewhere in Ireland	84 (15.3%)	78 (12.7%)	85 (17.6%)	75 (20.2%)

Source: Unpublished data from HPSC, 2014

Pregnant women with blood-borne infections, 2012

The DOVE clinic in the Rotunda Maternity Hospital, Dublin, was established to meet the specific needs of pregnant women who have or are at risk of blood-borne or sexually-transmitted bacterial or viral infections. Figures from the clinic for 2012 were published in the hospital's annual report (The Rotunda Hospital 2013).

In 2012, a total of 227 women were booked into the DOVE clinic for ante-natal care. Of these:

- 31% (70) were positive for HBV surface antigen (down from 85 in 2011),
- 27% (61) were positive for HCV antibody (down from 74 in 2011),
- 16% (36) were positive for HIV (up from 27 in 2011),
- 7% (15) were positive for Treponemal serology (down from 16 in 2011), and
- 33% (73) were known to be on prescribed methadone programmes.

Deliveries to mothers attending the Dove Clinic are outlined in Table 6.2.1.5. A total of 89 deliveries were to mothers attending the drug liaison midwife (DLM), 76 were HBV positive, 70 were HCV positive, 31 HIV positive and 18 tested positive for syphilis. Fourteen babies were admitted to the neonatal unit with neonatal abstinence syndrome.

Table 6.2.1.5 Deliveries to mothers attending the DOVE Clinic who were positive for HIV, HCV, HBV or syphilis or who were attending the DLM, 2012

Mothers status	HIV(+ve)	HCV(+ve)	HBV(+ve)	Syphilis(+ve)	DLM
Total mothers delivered	31	70	76	18	89
Total mothers delivered <500g (inc miscarriage)	1	2	3	1	8
Total mothers delivered >500g	30	68	73	17	81
Live infants	30	71 (3 sets twins)	73	17	82 (2 sets twins)
Miscarriage	3 (triplets)	2	3	3 (triplets)	8
Stillbirth	0	0	0	0	1
Infants <37 weeks gestation	2	14 (3 sets twins)	5	0	18
Caesarean section	18	22	19	6	25
NICU admission for NAS	-	-	-	-	14
Maternal median age	32	30	28	30.5	-
Newly diagnosed at ANS	7	12	15	11	-

NICU = Neonatal intensive care unit
 NAS = Neonatal abstinence syndrome
 ANS = Ante-natal screening
 DLM = Drug liaison midwife
 Source: (The Rotunda Hospital 2013)

Prevalence of blood-borne viruses in Irish prisons, 2011

The National Advisory Committee on Drugs and Alcohol (NACDA) has published the results of a survey estimating the extent of drug use and the prevalence of blood-borne viruses among the prison population in Ireland (Drummond, *et al.* 2014). The survey methodology, and the demographic characteristics and prevalence of drug use in the sample population, are outlined in Chapter 4.3.2 earlier in this report.

Prevalence of blood-borne viral infection among the prison population

Risk factors for viral infection reported by prisoners were:

- *Sharing injecting paraphernalia*: Of those who reported having ever injected drugs and answered the questions on sharing equipment, 48.8% (84/172) shared needles, 49% (81/165) syringes and 52% (84/162) other injecting equipment. A greater proportion of females (78%) reported sharing needles and syringes compared to males (46%).
- *Sexual behaviour*: Self-reported rates of unprotected sex (having sex without a condom) were high both while in prison (62%) and outside prison (51%). Less than 2% of men reported that they had ever had sex with other men (1.5% outside prison and 0.9% in prison).
- *Tattooing*: More than two-thirds (68%) of participants had borstal or tattoo markings, and 35% had had a tattoo done in prison.

Hepatitis C prevalence: oral fluid test

The overall prevalence of HCV was 12.9% among the prisoners tested, and 41.5% (83/200) among those who were IDUs (Figure 6.2.1.2). Prevalence of HCV varied with the type of drug injected: the rates of positive test results were 54% (80/149) of heroin injectors, 66% (66/100) of cocaine injectors, 62% (42/68) of benzodiazepine injectors, and 27% (14/66) of steroid injectors (Figure 6.2.1.3). The prevalence rate in the Irish population has been estimated at 0.5-1.2% (Thornton, *et al.* 2011), much lower than the rate experienced by either prisoners or IDUs. A previous study reported a prevalence rate for HCV of 37% among prisoners and 81% among IDUs; however, these were mainly heroin injectors (Allwright, *et al.* 2000).

The concordance analysis revealed that 21 (9%) of those who thought they were negative had a positive test result and three (1%) of those who reported being positive had a negative test result. Multivariate analysis indicated that five factors were associated with HCV infection: being female, being over 25 years old, having a history of injecting drug use, sharing injecting equipment and having had tattoos done in prison.

HIV prevalence: oral fluid test

Fifteen participants tested positive for HIV, resulting in a prevalence of 1.9% among prisoners and 6.0% among IDUs in prison (Figure 6.2.1.2). Figure 6.2.1.3 presents the prevalence of HIV among IDUs by type of drug injected and demonstrates that the prevalence of HIV is between 7% and 10% among 'hard' drug users.

The concordance analysis revealed that three (1.4%) people who thought they were negative were positive and one (0.4%) prisoner who thought he was positive was negative. While the numbers who tested positive for HIV were small (15/657), four factors were found to be associated with HIV infection: being female, having a history of injecting drug use, sharing injecting equipment, and male-to-male sexual contact.

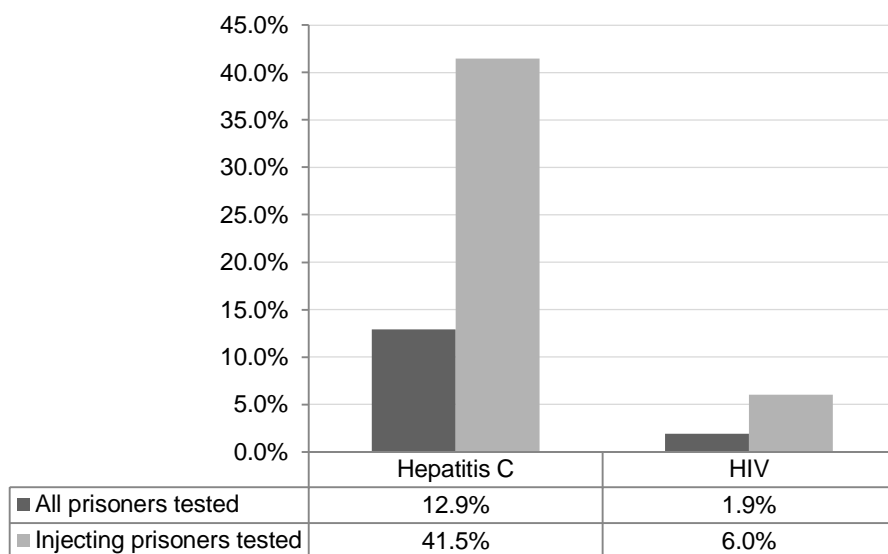


Figure 6.2.1.2: Prevalence of HCV and HIV among prisoners tested, 2011

Source: (Drummond, *et al.* 2014)

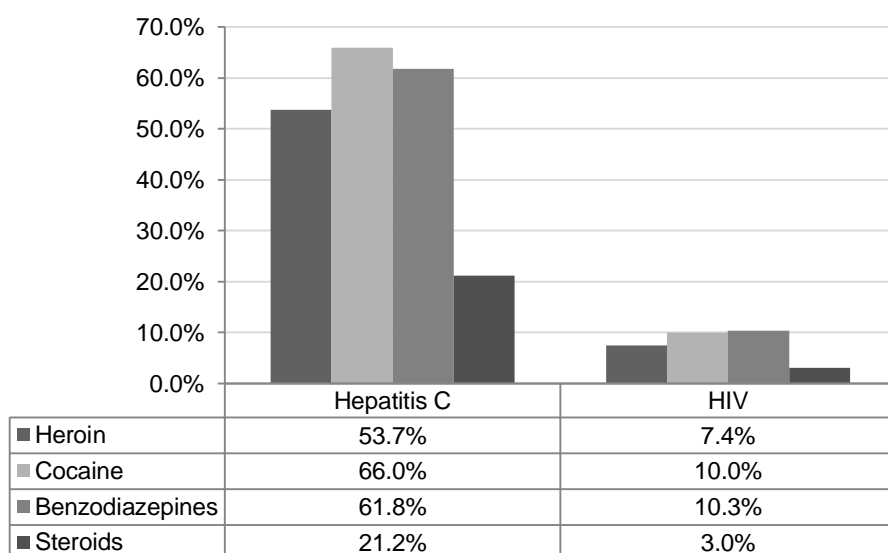


Figure 6.2.1.3 Prevalence of HCV and HIV in IDU prisoners tested, by type of drug injected, 2011

Source: (Drummond, *et al.* 2014)

Hepatitis B prevalence: oral fluid test

The prevalence of HBV was 0.3% among the prisoners tested. A previous prison study found prevalence rates for HBV of 9% among prisoners and 18.5% among injectors in prison (Allwright, *et al.* 2000). The introduction of blood-borne viral testing and hepatitis B vaccination by the Irish Prison Service in 1995 accounts for the reduction of HBV infection among drug users in prison.

The concordance analysis indicated that eight people (3%) thought they had a disease that they did not have and one person (0.4%) had a disease that he did not know he had and may not have been taking the necessary precautions to prevent spread of infection to others.

Steroid injectors

Of note, there were 69 self-reported steroid injectors, of whom 16 had started to inject in prison and 13 had injected in prison in the last year. Fourteen steroid injectors tested positive for HCV and two for HIV. This study identified a new cohort of injecting drug users and HCV infection.

Co-infection: oral fluid test

Fourteen per cent (106/777) of prisoners had serological evidence of blood-borne virus infection. No prisoner tested positive for all three viruses, and there was no co-infection with HBV and HIV. However, 10 participants (1.3%) were found to be co-infected with HCV and HIV. One (0.1%) was co-infected with HBV and HCV. The one factor identified as being significantly associated with co-infection was ever having shared injecting drug equipment.

6.2.2 STI's and tuberculosis

The 2013 HPSC HIV report found none of the newly diagnosed HIV cases were co-infected with either STIs or tuberculosis (Health Service Executive and Health Protection Surveillance Centre 2014). See Chapter 6.2.2 in 2013 National Report for the most recent information regarding STIs and tuberculosis (Health Research Board 2013).

6.2.3 Other infectious morbidity

A case of a 19-year-old male patient who presented at Accident and Emergency with uvulitis six hours after inhalation of mephedrone was documented in the journal *Anaesthesia* (Murphy and Haughey 2014). The patient mistook the mephedrone for ecstasy. Other than tachycardia, his vital signs were normal. He was dysphonic, and unable to complete full sentences or swallow his own saliva. On examination, the uvula was grossly swollen. Mephedrone ingestion was confirmed by urinary point-of-care testing.

He was treated with high-flow oxygen via facemask, hydrocortisone and chlorpheniramine intravenously, adrenaline intramuscularly and nebulised adrenaline. Over the following hour, his symptoms improved. He was admitted to a high-dependency unit for observation, but discharged after 12 hours symptom-free and with a normal-looking uvula. The authors concluded that in addition to tachycardia, hypertension, palpitations and respiratory difficulties, which are commonly described as side-effects of mephedrone, the patient suffered a hypersensitive reaction which responded rapidly to anti-allergy medications.

6.3 Other drug-related health correlates and consequences

6.3.1 Non-fatal overdoses and drug related emergencies

Data extracted from the Hospital In-Patient Enquiry (HIPE) scheme were analysed to determine trends in non-fatal overdoses discharged from Irish hospitals between 2005 and 2012. There were 4,462 overdose cases in 2012, of which 40 died in hospital. Only the 4,422 discharged cases are included in this analysis. The number of overdose cases increased by 5% between 2011 and 2012. However, trends over time indicate a decrease in overdose cases admitted to Irish hospitals, falling from 5,012 in 2005 to 4,422 in 2012, a reduction of 590 cases (Figure 6.3.1.1).

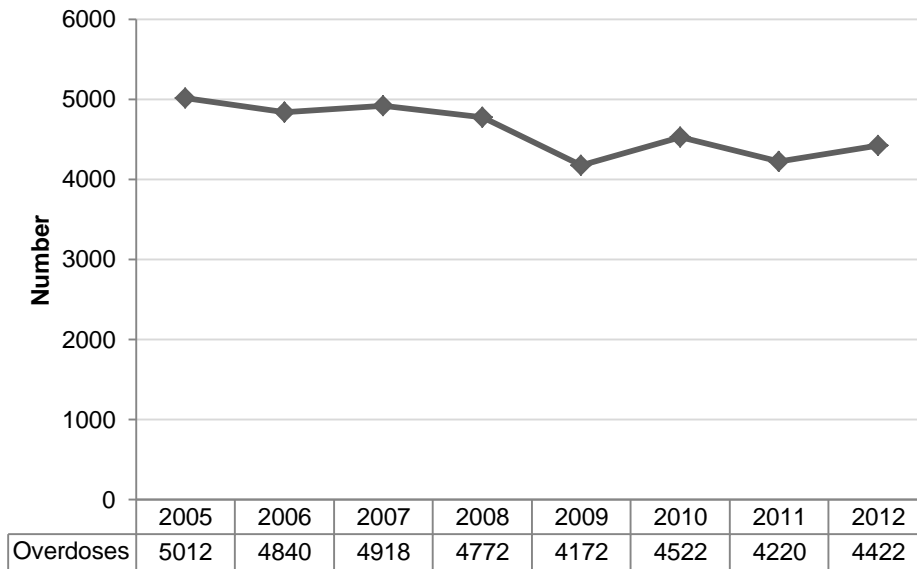


Figure 6.3.1 Non-fatal overdose cases admitted to Irish hospitals, 2005–2012 (N=36,878)

Source: Unpublished HIPE data, 2014

Gender

Between 2005 and 2012 there were more overdose cases among women than among men, with women accounting for 2,436 (55%) of all non-fatal overdose cases in 2012 (Figure 6.3.1.2).

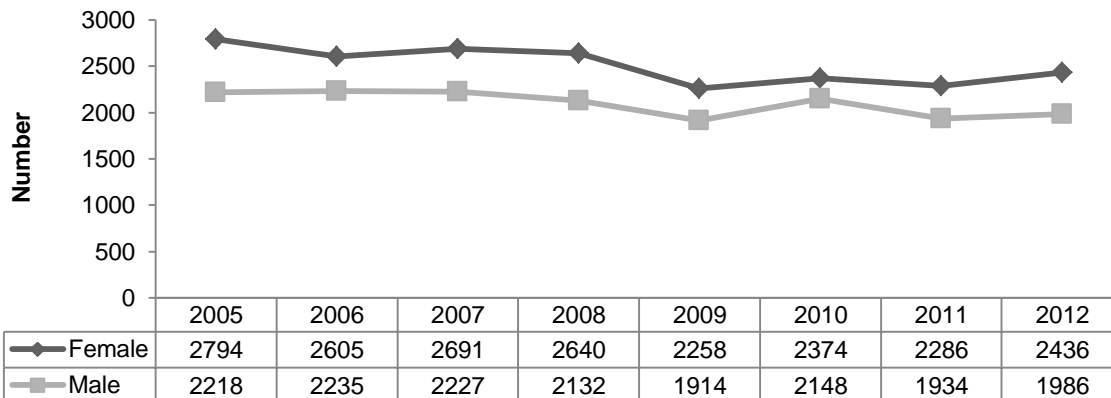


Figure 6.3.1.2 Non-fatal overdose cases admitted to Irish hospitals, by gender, 2005–2012 (N=36,878)

Source: Unpublished HIPE data, 2014

Age group

There was an increase in the number of non-fatal overdose cases in all age groups between 2011 and 2012, with the exception of those aged 15 to 24 years. There were 44 fewer overdose cases in this age group. The incidence of overdose peaked in the 15 to 24 age category and thereafter decreased with age (Figure 6.3.1.3). Trends over time showed that in 2005, 40% of cases were aged less than 25 years compared to 31% in 2012.

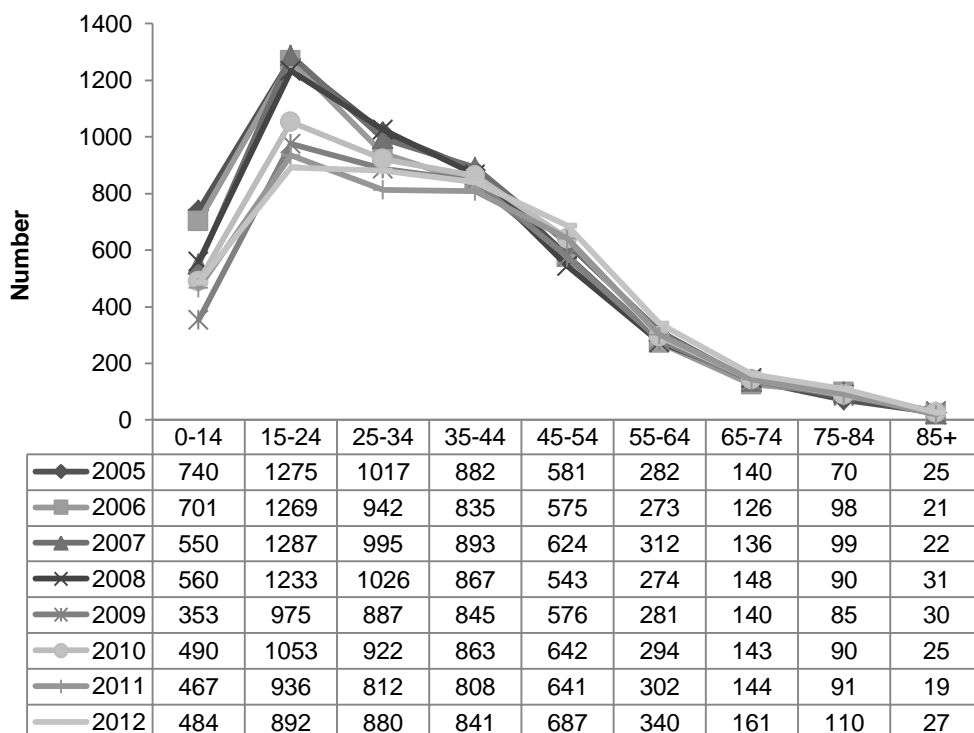


Figure 6.3.1.3 Non-fatal overdose cases admitted to Irish hospitals, by age group, 2005–2012 (N=36,878)

Source: Unpublished HIPE data, 2014

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 2012. Non-opioid analgesics were present in 34% (1,499) of cases. Paracetamol is included in this drug category and was present in 1,148 (26%) of cases. Psychotropic agents were taken in 1,028 (23%) and benzodiazepines in 924 (20%) of cases. There was evidence of alcohol consumption in 540 (12%) of cases. Cases involving alcohol are included in this analysis only when the alcohol was used in conjunction with another substance.

Table 6.3.1.1 Categories of drugs involved in overdose cases admitted to Irish hospitals, 2012 (N=4,422)*

Drug category	Number	%
Non-opioid analgesics	1499	33.9
Benzodiazepines	924	20.9
Psychotropic agents	1028	23.2
Narcotics and hallucinogens	563	12.7
Alcohol	540	12.2
Systemic and haematological agents	183	4.1
Cardiovascular agents	153	3.5
Autonomic nervous system	140	3.2
Anaesthetics	117	2.6
Hormones	117	2.6
Systemic antibiotics	74	1.7
Gastrointestinal agents	82	1.9
Other chemicals and noxious substance	276	6.2
Diuretics	59	1.3
Muscle and respiratory agents	35	.8
Topical agents	40	.9
Anti-infectives / Anti-parasitics	19	.4
Other gases and vapours	49	1.1
Other and unspecified drugs	908	20.5

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

Source: Unpublished HIPE data, 2014

Narcotic or hallucinogenic drugs were involved in 563 (13%) of overdose cases in 2012. Figure 6.3.1.4 shows the number of positive findings of narcotics or hallucinogens drugs among the 563 cases. Opiates were used in 478 (85%) of the cases, cocaine in 71 (13%) and cannabis in 38 (7%) of the cases. The sum of positive findings is greater than the total number of cases because some cases involved more than one drug from this category.

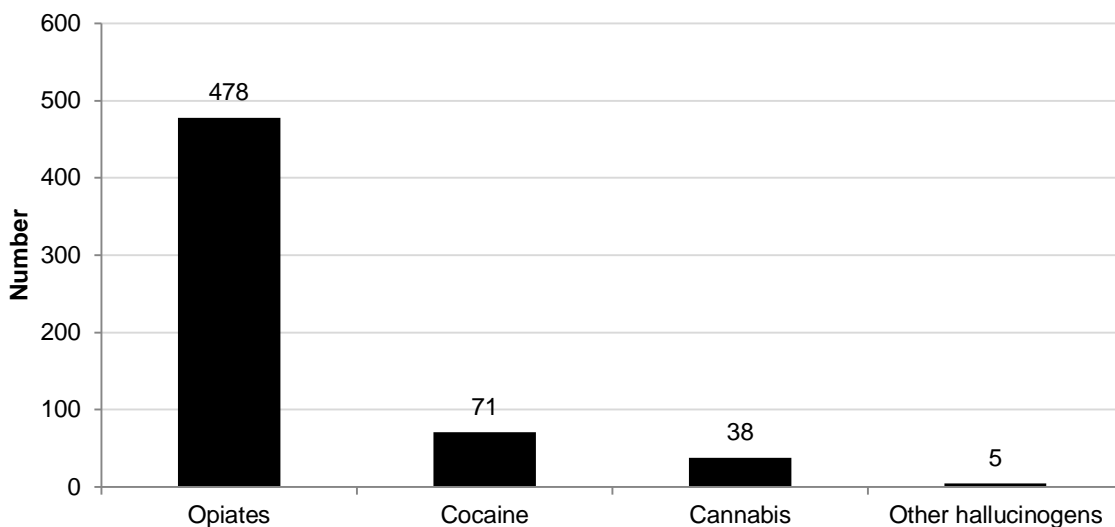


Figure 6.3.1.4 Narcotics and hallucinogens involved in non-fatal overdose cases admitted to Irish hospitals, 2012 (N=563)

Source: Unpublished HIPE data, 2014

In 2,921 cases (66%), the overdose was classified as intentional (Figure 6.3.1.5). For 81 cases, there was no classification of intent recorded. These cases were not included in the analysis.

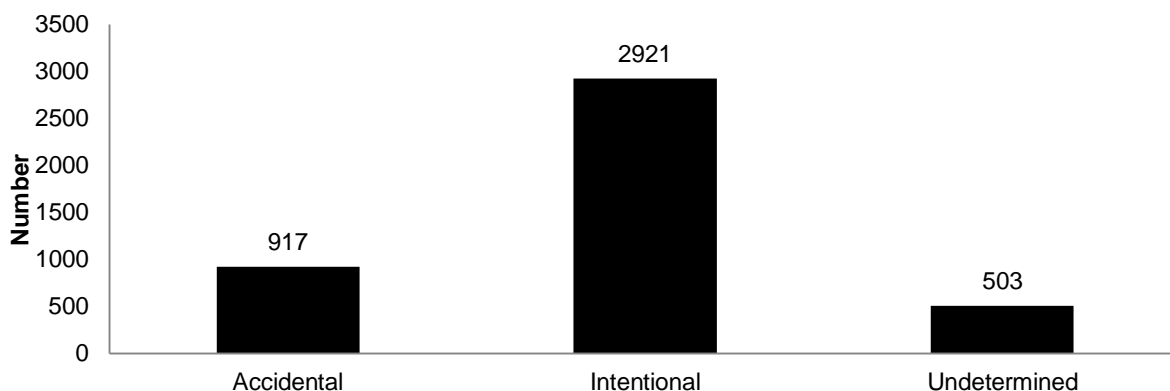


Figure 6.3.1.5 Overdose cases admitted to Irish hospitals, by classification, 2012 (N=4,341)

Source: Unpublished HIPE data, 2014

Table 6.3.1.2 presents the positive findings per category of drugs and other substances involved in cases of intentional overdose (n=2,921) in 2012. Non-opioid analgesics were involved in 1,205 (41%) of cases, benzodiazepines in 706 (24%) and psychotropic agents in 801 (27%).

Table 6.3.1.2 Categories of drugs involved in intentional overdose cases admitted to Irish hospitals, 2012 (N=2,921)*

Drug category	Number	%
Non-opioid analgesics	1205	41.3
Benzodiazepines	706	24.2
Psychotropic	801	27.4
Alcohol	380	13.0
Narcotics and hallucinogens	315	10.8
Cardiovascular	91	3.1
Systemic and haematological	92	3.1

Autonomic nervous system	90	3.1
Systemic antibiotics	55	1.9
Hormones	75	2.6
Gastrointestinal	64	2.2
Anaesthetics	36	1.2
Other chemicals and noxious substances	91	3.1
Anti-infectives/anti-parasitics	9	.3
Other gases and vapours	4	.1
Muscle and respiratory	18	.6
Topical agents	8	.3
Diuretics	44	1.5
Other and unspecified drugs	546	18.7

*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.
Source: Unpublished HIPE data, 2014

Incidence of opiate-induced neonatal abstinence syndrome

Neonatal abstinence syndrome (NAS) is a clinical condition which occurs among infants withdrawing from *in-utero* substance exposure. A recent study published in the *Irish Medical Journal* retrospectively identified cases of NAS in Cork city, Ireland, between 2000 and 2011 (Healy, *et al.* 2014). The aim of the review was to establish whether there had been an increase in the number of cases in line with evidence of increasing opiate abuse in the city.

In total, 16 cases of NAS were identified. Two of these occurred prior to 2007; two to three cases per year occurred between 2008 and 2010; and seven cases were identified in 2011. All mothers were self-declared multi-drug abusers. Opiates used included heroin (n=5), tramadol (n=3) and methadone (n=10). The mothers' age range was from 22 to 34 years (median age 27). The mean birth weight of the babies was 2,802 +/- 576g and the mean gestational age at delivery was 275 +/- 7 days. All infants received supportive care. Five required pharmacotherapy and prolonged hospital stays.

Only neonates who became symptomatic prior to discharge from the maternity hospital were included in the study. Therefore it is possible that other infants were admitted to other paediatric facilities with later onset of withdrawal symptoms. The article concluded that the incidence of NAS in Cork is increasing with implications for primary, secondary and tertiary care.

Methaemoglobinaemia secondary to amyl nitrate use

Two cases of methaemoglobinaemia secondary to amyl nitrate use were outlined recently in the *Irish Medical Journal* (Nees and Fitzgerald 2014). Methaemoglobinaemia occurs when red blood cells contain more than 1% methaemoglobin. This results in an inability to bind oxygen. Cyanosis results even if oxygen is given. Methaemoglobinaemia may be congenital or acquired. Acquisition causes include drug abuse with nitrates including the street drug 'poppers', and local anaesthetic toxicity.

The first case reported involved a 55-year-old male who had collapsed and was brought to a hospital emergency department (ED); the cause of the collapse was unknown. He had a history of abuse of amyl nitrate 'poppers' and alcohol. He was markedly cyanosed and his oxygen saturation was low. He was immediately intubated and ventilated with 100% oxygen. His blood was noted to be chocolate brown in colour. Tests showed a very elevated Met-Hb level of 76% (normal range 0-3%). Following treatment with methylene blue his condition improved rapidly.

The second case was a 22-year-old female brought into ED with fluctuating GCS¹¹ and slate-grey cyanosis. She had a known background history of heroin and methadone use, an empty bottle of amyl nitrate had been found beside her and she smelt strongly of alcohol. She was maintaining her own airway but intermittently apnoeic. Oxygen saturations were 87%. Met-Hb was 67% on ABG analysis. The urinary toxin screen was positive for benzodiazepine and tetrahydrocannabinol. She was treated with methylene blue, naloxone infusion, vasopressors and high-flow O₂ via face mask, and recovered quickly. She was kept overnight in the ED but self-discharged the next day.

¹¹ The 'Glasgow coma scale' is a neurological scale for assessing the level of consciousness of a person.

The authors concluded that these cases highlight a need for vigilance regarding methaemoglobinaemia secondary to amyl nitrate abuse. If methaemoglobinaemia is suspected, it can be diagnosed rapidly and it responds immediately to treatment.

6.3.2 Other topics of interest e.g. psychiatric and somatic co-morbidity

Trends in drug admissions to psychiatric facilities

The annual report based on the data collected in the National Psychiatric In-Patient Reporting System (NPIRS) in 2012 shows that the total number of admissions to inpatient care has continued to fall (Daly and Walsh 2013). There was a 21% decline in overall psychiatric admissions in the 10 years between 2003 and 2012

In 2012, 831 cases were admitted to psychiatric facilities with a drug disorder (ICD-10 code F11-19, F55), which is a rate of 7.8 per 100,000 total population. Of these, 358 (43%) were treated for the first time. This is similar to the number of admissions in 2011 when there were 839 cases, of which 352 were 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 psychiatric first admission between 1993 and 2012 of cases with a diagnosis of drug disorder.

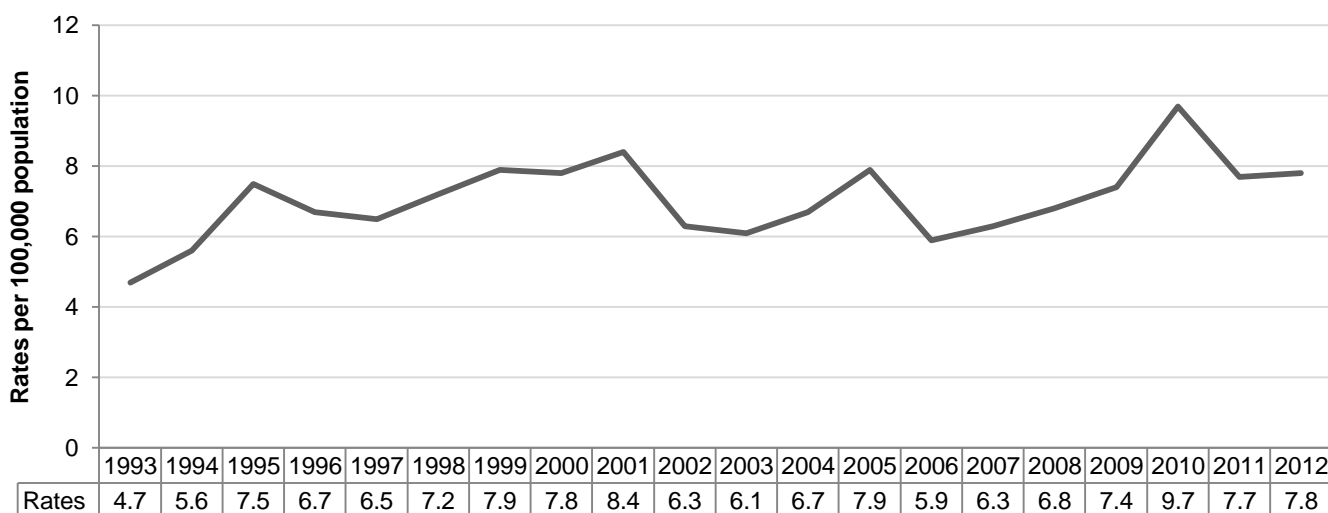


Figure 6.3.2.1: Rates of psychiatric first admission of cases with a diagnosis of drug disorder per 100,000 population in Ireland, 1993–2012

Source: (Daly and Walsh 2013)

Other notable statistics on first admissions for a drug disorder in 2012 included:

- The majority were to psychiatric units in general hospitals (246, 69%), followed by admissions to psychiatric hospitals (63, 20%) and to private hospitals (39, 11%).
- 14% were involuntary admissions.
- The rate was higher for men (11.8 per 100,000) than for women (3.9 per 100,000).

The majority of cases hospitalised for a drug disorder stayed just under one week (53%), and most were discharged within three months. It should be borne in mind that admissions and discharges represent episodes or events, not persons.

Suicide, hospital-treated self-harm and self-harm in the community among Irish adolescents

Suicide is a major cause of death among adolescents and those who self-harm are at increased risk of suicide. In a recently published study of suicide, hospital-treated self-harm and self-harm in the community among Irish adolescents, the 'iceberg' analogy was used to illustrate the relative incidences of adolescent suicide (highly visible), hospital-treated self-harm (less visible) and self-harm in the community (largely hidden) (McMahon, *et al.* 2014).

The study population consisted of adolescents (aged 15 to 17 years) in counties Cork and Kerry. Annual suicide rates were calculated using data from the Central Statistics Office (based on figures from 1997 to 2011). Data on hospital-treated self-harm (between 2003 and 2011) were obtained from the National Registry of Deliberate Self-Harm. Data on self-harm in the community were collected as part of the Child and Adolescent Self-Harm in Europe (CASE) study through a cross-sectional survey of 3,881 adolescents in Cork and Kerry (conducted between 2003 and 2004).

- The annual suicide rate among adolescents aged 15, 16 or 17 in the selected area was 10/100,000. The rate among boys was 16.5/100,000, among girls 2.7/100,000. The incidence ratio of male to female was 6:1.
- The incidence of hospital-treated self-harm cases was 344.4/100,000. For boys the rate was 256.2/100,000, for girls 438.1/100,000, giving an incidence ratio of male to female of 1:1.7.
- Of the respondents to the CASE survey, 8.9% of girls and 2.4% of boys reported self-harm within the past year. The rate of self-harm was 5,551/100,000. The rate among boys was 2,400/100,000, among girls 8,900/100,000. The incidence ratio of male to female was 1:3.7.

Based on these incidence rates, the frequency of suicide and self-harm were calculated. For every adolescent suicide there were 34 hospital presentations with self-harm and 555 adolescents reported having self-harmed. Among boys, for every suicide there were 16 cases of hospital-treated self-harm and 146 self-reports of self-harm. Among girls, for every suicide there were 162 cases of hospital-treated self-harm and 3,296 self-reports of self-harm.

Of the 37 suicides among adolescents aged between 15 and 17 years between 1997 and 2011, four were by overdose, 31 by hanging, one by drowning and one by other methods. Of the 775 cases of hospital-treated self-harm in the same age group between 2003 and 2011, 509 (66%) were by overdose, 146 (18.8%) by self-cutting, 66 (8.5%) by other methods and 27 (3.5%) by overdose combined with self-cutting. Of the 207 cases of adolescents reporting self-harm in the community in 2003/04, 55 (27%) were by overdose, 121 (58.5%) by self-cutting and 20 (7%) by overdose combined with self-cutting.

The study concluded that there are large gender differences in the incidence of self-harm and suicide among adolescents, with boys who have a history of self-harm being at particular risk of suicide. However, the majority of self-harm is unreported. The need for interventions to promote awareness of mental health issues and enhance help-seeking behaviours among adolescents is highlighted.

Factors associated with self-cutting and intentional overdose as methods of deliberate self-harm

A recent study published in the *European Journal of Public Health* used data from the Irish National Registry of Deliberate Self-Harm to compare hospital-treated self-cutting patients and those presenting with intentional overdose, looking in particular at gender differences, patients' characteristics and the outcomes associated with each method of deliberate self-harm (Arensman, *et al.* 2014). The definition of self-harm used was that of the WHO/EURO Multicentre Study, which includes all intentionally-initiated drug overdoses, poisoning or self-injurious behaviour regardless of suicidal intent.

The study examined data on 42,585 persons who presented to emergency departments in Ireland between 1 January 2003 and 31 December 2009 with a first self-harm episode resulting from self-cutting, intentional overdose or a combination of both. Of these, 24,775 (58.2%) were women. The highest number of presentations were as a result of overdose only (34,445), followed by self-cutting only (6,398) and finally a combination of overdose and self-cutting (1,742).

Gender was significantly associated with method of self-harm: 21% of male presentations were for self-cutting compared to 10% of female presentations. Place of residence was significant for both males and females, with those living in cities being over-represented among presentations involving self-cutting. Living circumstances were also significant, with those of no fixed abode being over-represented among self-cutting presentations.

Among those presenting with combined self-cutting and overdose, males and females were evenly represented (4.5% vs 3.8%). People living in cities were also over-represented among presentations

involving both self-cutting and overdose. Use of alcohol was significantly associated with overdose by both males and females. Presentations for self-cutting combined with overdose were less likely between 9am and 5pm, and more likely at weekends than cases of overdose only. Repetition was also significantly more likely among those presenting with self-cutting.

Multinomial logistic regression was used to identify factors independently associated with method of self-harm. When compared with overdose only, factors independently associated with self-cutting among both males and females were living in a city, being of no fixed abode or living in an inpatient or custodial setting, presenting outside the hours of 9am to 5pm or at weekends, no alcohol involvement and repetition within 12 months. In addition, being aged over 45 years for men and 55 years for women was significant. Factors independently associated with combined overdose and self-cutting for men were being over 35 year of age, living in a city, presenting at the weekend and repeating within 30 days. For women, significant factors were being over 45 years of age, residing in a city, alcohol involvement and repeating within 12 months.

The article concluded that the demographic and clinical differences between those presenting with different methods of self-harm has implications for choice of intervention. In particular, the association between self-cutting and repetition means that adequate follow-up and support needs to be put in place. Moreover, services need to be available outside regular working hours.

6.4 Drug-related deaths and mortality of drug users

6.4.1 Drug-induced deaths (overdoses/poisonings)

Drug-induced deaths – Selection D

In 2012, there were 181 deaths owing to poisoning recorded in Ireland by the National Drug-Related Deaths Index (NDRDI) as per Selection D. This represents a decrease to 2011, when 232 such deaths were recorded (Table 6.4.1.1; see also Standard Tables 5 and 6). It should be noted that annual data previously reported have been changed as the database has been updated as new information has become available.

Table 6.4.1.1 Poisonings (Selection D) by year, NDRDI, 2002–2011

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Selection D	105	127	165	189	208	215	216	175	232	181

Source: Unpublished data, NDRDI

Overall, the mean age of those who died owing to poisoning remained stable compared to previous years at 35.5 years (see Standard Table 6).

Opiates continue to be associated with most poisoning deaths (90.0%) in Filter D. Methadone (alone or with another drug) continues to be the opiate most commonly implicated. In 2012 there were 86 deaths compared to 119 in 2011. The reason for the trend in the number of deaths where methadone was implicated (alone or in conjunction with another drug) is still not clear. However, the same trend has been observed in Scotland in the same time period (General Register Office for Scotland 2013, National Records of Scotland 2013).

The number of deaths where heroin was implicated continues to drop from a peak in 2009 to 61 deaths in 2012. There were 24 deaths where cocaine was implicated (alone or with another drug), the same as 2011.

The majority of poisoning deaths (71.8%) involved more than one drug. As in previous years, benzodiazepines, alcohol, antidepressants, and other over-the-counter medications were among the main drugs implicated in poly-substance poisonings.

Drug-induced deaths – national data

The National Drug-Related Death Index (NDRDI) publishes national figures on drug-related deaths. This comprises all deaths owing to poisonings, including both illicit drugs covered by Selection D, and also other drugs such as alcohol and prescription medication not reported in Standard Table 6.

In the eight-year period 2004 to 2011, a total of 4,606 deaths by drug poisoning and deaths among drug users met the criteria for inclusion in the NDRDI database (Table 6.4.1.2) (Health Research Board 2014a). Of these deaths, 2,745 were due to poisoning and 1,861 were deaths among drug users (non-poisoning) (see section 6.4.3 below).

Table 6.4.1.2 Number of deaths, by year, NDRDI 2004 to 2011 (N=4,606)

	2004	2005	2006	2007	2008	2009	2010	2011
All deaths	431	503	561	630	624	653	597	607
Poisoning (n=2,745)	267	300	326	389	386	374	338	365
Non-poisoning (n=1,861)	164	203	235	241	238	279	259	242

Source (Health Research Board 2014a)

The annual number of poisoning deaths increased from 338 in 2010 to 365 in 2011. As in all previous years, males accounted for the majority of deaths (72%). The majority were aged between 20 and 44 years; the median age was 39 years.

Over half (215, 59%) of all poisoning deaths involved more than one drug (polydrug use). This represents a 28% increase from the previous year (168) (Table 6.4.1.3).

Table 6.4.1.3 Combinations of drugs involved in poisoning deaths, NDRDI 2004 to 2011 (N=2,745)

	2004	2005	2006	2007	2008	2009	2010	2011
All poisoning deaths	267	300	326	389	386	374	338	365
Single substances								
Alcohol alone	61	51	54	86	81	61	78	61
Opiates alone	33	34	53	54	54	60	48	37
Analgesic (including an analgesic containing an opiate compound)	22	24	16	6	10	10	7	14
All other specified single substances	36	58	67	66	51	57	37	38
Polysubstances								
Polysubstances (including opiates such as heroin, methadone)	41	64	80	91	120	121	96	128
Polysubstances (including analgesics containing an opiate compound)	28	31	15	16	11	14	25	32
Polysubstances (excluding opiates)	35	29	26	58	50	34	33	44
Psychoactive medication with alcohol	11	9	15	12	9	17	14	11

Source (Health Research Board 2014a)

In 2011, alcohol was, once again, the drug most commonly involved in poisoning deaths (37%) (Table 6.4.1.4). The number of deaths where prescription drugs were implicated increased sharply compared to 2010 figures. The number of deaths where benzodiazepines were implicated increased by 61%, to 166 in 2011 compared to 103 in 2010. There was also a steep increase in the number of deaths where antidepressant drugs were implicated, from 66 in 2010 to 96 in 2011.

Table 6.4.1.4 All drugs involved in poisoning deaths, NDRDI 2004 to 2011 (N=2,745)

	2004	2005	2006	2007	2008	2009	2010	2011	% Total
All deaths*	267	300	326	389	386	374	338	365	100
Alcohol	125	116	111	173	155	142	152	136	40.4
Heroin	29	47	68	80	91	115	72	60	20.5
Methadone	40	43	61	55	80	69	60	113	19
Other opiate†	62	69	55	54	47	52	58	78	17.3

	2004	2005	2006	2007	2008	2009	2010	2011	% Total
Cocaine	19	36	53	66	60	53	21	23	12.1
MDMA	13	10	7	19	7	~	~	11	~
Diazepam	31	41	64	61	66	80	67	129	19.6
Other benzodiazepine	28	25	29	42	38	30	34	69	10.7
Flurazepam	18	13	23	21	20	24	27	48	7.1
Other prescription medication [§]	42	37	39	61	62	59	74	85	16.7
Antidepressant	54	53	43	48	85	67	66	96	18.7
Non-opiate analgesic	13	23	12	19	18	16	15	19	4.9
Other [‡]	9	22	21	26	31	50	37	40	8.6

Source (Health Research Board 2014a)

*This is a multi-response table taking account of illicit use of up to six drugs. Therefore numbers and percentages in columns may not add up to totals shown as individual cases may use more than one drug or substance.

† Includes morphine, codeine, unspecified opiate-type drug, other opiate analgesic.

§ Includes non-benzodiazepine sedatives, anti-psychotics, cardiac and all other types of over-the-counter medication.

‡ includes solvents, insecticides, herbicides, other amphetamines, hallucinogens, cannabis, barbiturates, novel psychoactive substances and other chemicals.

~ Less than five cases.

Of note, the number of deaths where methadone was implicated increased to 113, compared to 60 in 2010. The reasons behind these upward trends are not yet clear and further analysis is needed to begin to understand the factors involved. What is known is that there was no change in the methodology used by the NDRDI between 2010 and 2011. What is also known is that 68% of those who died where methadone was implicated were not registered on the Central Treatment List (of people receiving methadone substitution treatment) at the time of their death.

The number of poisoning deaths in which heroin was implicated continues to decline, falling by 17% to 60 in 2011, compared to 72 in 2010. It is of note that similar trends were observed in Scotland during the same time period (General Register Office for Scotland 2013, National Records of Scotland 2013).

Media reporting of PMA/PMMA deaths

In the first six months of 2014 there were several media reports of deaths apparently due to PMA (para-Methoxyamphetamine) and PMMA (para-Methoxy-N-methylamphetamine) (2014a, 2014b, Brady 2014, Mullally 2014). Although some of these deaths are reported to have occurred in 2013 (Naughton 2014, 18 July) it is not possible to report on the precise number of deaths and characteristics of those who died of these particular drugs as NDRDI data for 2013 deaths are not currently available. In 2012, PMA/PMMA was implicated in less than five deaths recorded in the NDRDI however MDMA was implicated in 11 deaths.

6.4.2 Mortality and causes of deaths among drug users

Currently there are no mortality cohort studies under way. The most recent research on mortality among drug users was a 25-year longitudinal study of a cohort of injecting drug users in inner-city Dublin published in 2013 (O'Connor, *et al.* 2013).

6.4.3 Specific causes of mortality indirectly related to drug use

Non-poisoning deaths 2011

In the eight-year period 2004–2011 a total of 1,861 non-poisoning deaths among drug users met the criteria for inclusion in the NDRDI database (Table 6.4.1.1). The number of non-poisoning deaths recorded among drug users dropped for a second year, to 242, compared to 259 in 2010 (Table

6.4.1.2). These deaths are categorised as being due either to trauma or to medical causes (Figure 6.4.3.1).

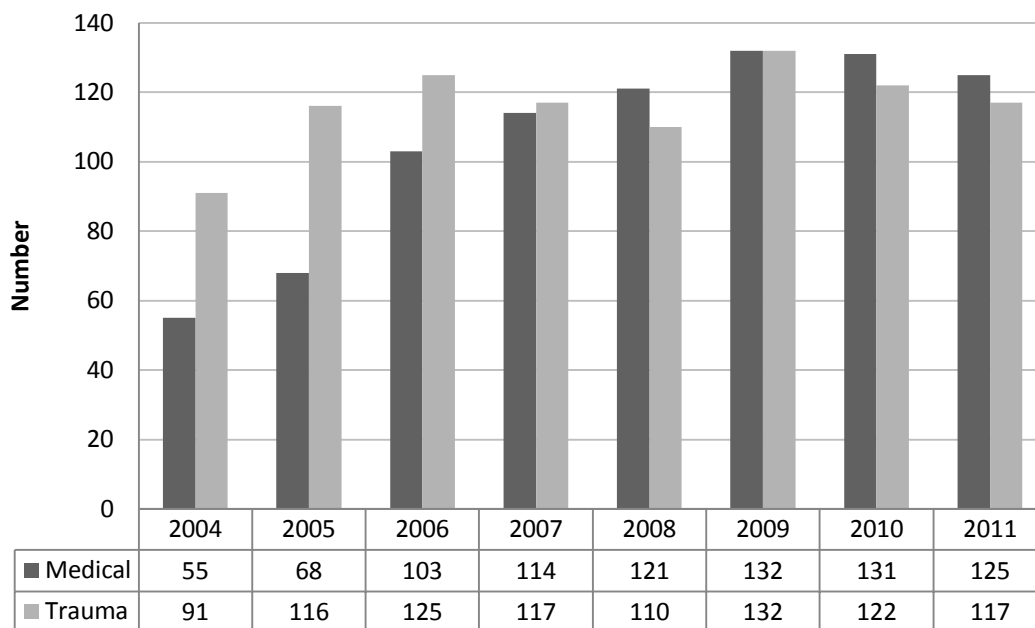


Figure 6.4.3.1 Non-poisoning deaths among drug users, NDRDI 2004 to 2011 (N=1,779)

Source (Health Research Board 2014a)

Deaths due to trauma

The number of deaths due to trauma decreased in 2011, to 117 deaths, down from 122 in 2010 (Figure 6.4.3.1). The majority (71%) of those who died were aged under 39 years. The median age was 29 years. As in previous years, the majority were male (86%). The most common causes of death due to trauma were hanging and road traffic collisions. Even though there has been a slight overall reduction in the number of traumatic deaths, it is notable that there has been a rise in the number of deaths due to hanging, from 49 deaths in 2010 to 65 in 2011.

Deaths due to medical causes

The number of deaths due to medical causes decreased slightly in 2011 (Figure 6.4.3.1). The majority (60%) of those who died were aged between 30 and 49 years. The median age was 43 years. Males accounted for 76% of those who died. The most common medical causes of death were cardiac events and liver diseases.

7. Responses to Health Correlates and Consequences

7.1 Introduction

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

Barnardos is a children's charity. It works with vulnerable children and their families in Ireland and campaigns for the rights of all children.

The **Elton John AIDS Foundation (EJAF)** is an independent AIDS charity. It funds a broad range of services for those living with or affected by HIV/AIDS, including education, peer support, medical care, income generation, counselling and testing. It funds both UK-based and international projects. Particular emphasis is given to the most disadvantaged or high risk groups, both nationally and internationally, and to community-driven programmes that place people living with HIV/AIDS at the centre of service provision.

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 Pharmacy Union (IPU)** is the professional, representative organisation for community pharmacists in Ireland.

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

For the most recent information, see Chapter 7.2 in 2013 National Report (Health Research Board 2013).

7.3 Prevention and treatment of drug-related infectious diseases.

Pharmacy needle exchange in Ireland

In October 2011 the HSE rolled out the national pharmacy needle exchange programme, which was a partnership initiative between the Elton John Aids Foundation, the Irish Pharmacy Union and the HSE. The programme targeted counties outside of Dublin and ran until September 2014. Once pharmacies had signed a service level agreement with the HSE, their contact details were passed on to the relevant HSE services so that they could promote access to sterile injecting equipment at the participating pharmacies and accept referrals for investigation and treatment.

There were 42 pharmacies providing needle exchange at the end of 2011 and this increased to 71 by the end of 2012. There are pharmacies providing needle exchange in each regional drugs and alcohol task force area (Table 7.3.1), apart from those covering counties Dublin, Kildare and Wicklow, which are served by a mix of static and outreach needle-exchange programmes. The data presented here were collected from participating pharmacies by the HSE.

Table 7.3.1 Number of pharmacy needle exchanges, excluding counties Dublin, Kildare and Wicklow, 2011 and 2012

Regional drugs and alcohol task force area	2011	2012
Midland (Longford, Laois, Offaly, Westmeath)	1	414
Mid West (Clare, Limerick, North Tipperary)	20	2464
North Eastern (Meath, Louth, Cavan, Monaghan)	101	1377
North West (Sligo Leitrim, West Cavan, Donegal)	0	4
Southern (Cork and Kerry)	199	3124
South East (Carlow, Kilkenny, Waterford, Wexford. South Tipperary)	250	3424

Regional drugs and alcohol task force area	2011	2012
Western (Galway, Mayo, Roscommon)	0	250

Source: Unpublished data from HSE 2013

An average of 360 individuals attended pharmacy-based needle exchanges each month in 2012. The number of individual drug users using sterile injecting equipment increased by 188%, from 199 in January 2012 to 573 in December 2012 (Figure 7.3.1). Of the individual attenders, 78% were male, and had an average age of 31 years; the average age of female attendees was 29 years.

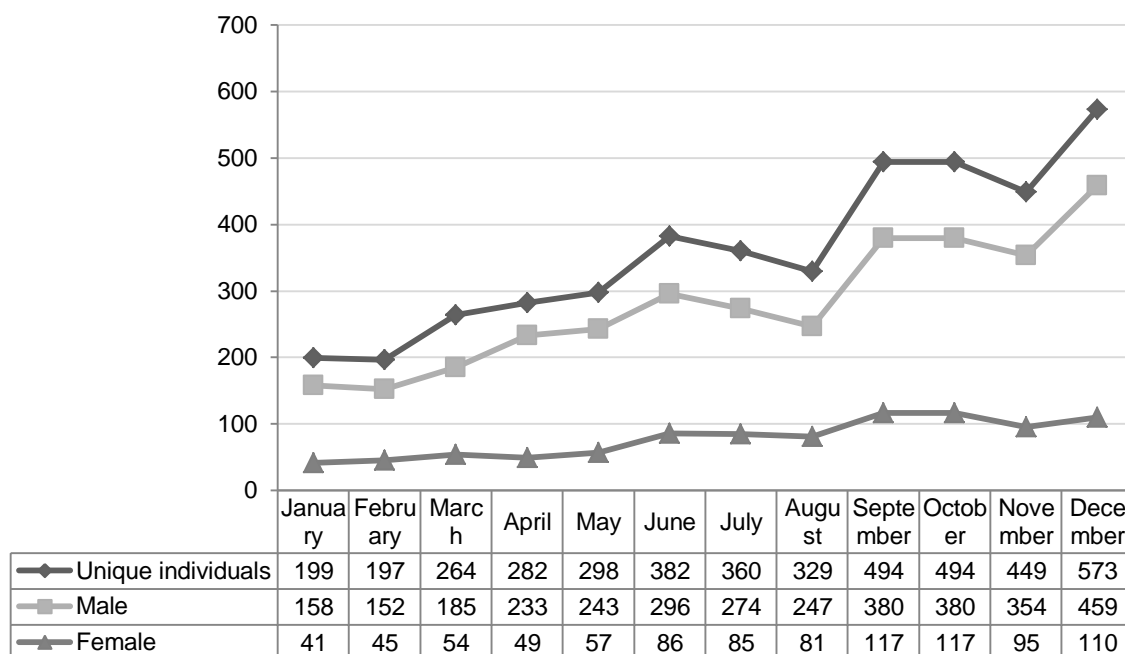


Figure 7.3.1: Number of individuals attending needle exchanges, by gender, 2012

Source: Unpublished data from HSE 2013

The needle exchanges completed 10,601 transactions in 2012, distributing 11,693 packs; each pack contained 10 sets of injecting equipment. The number of transactions increased by 132%, from 522 in January 2012 to 1,209 in December 2012 and the number of packs distributed followed a similar trend (Figure 7.3.2). Each individual user received an average of 2.7 packs (27 needles and syringes) in a calendar month in 2012. Thirty-eight per cent of the injecting equipment provided by pharmacies was returned for disposal.

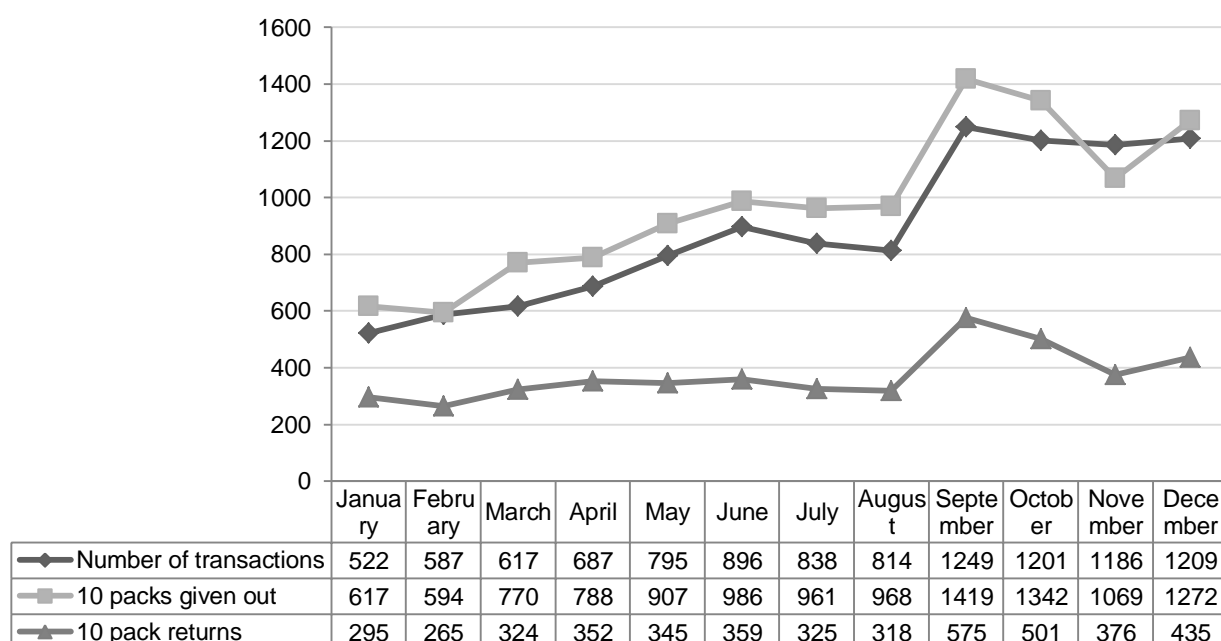


Figure 7.3.2: Number of transactions at needle exchanges, 10-packs distributed, and used 10-packs returned, 2012
Source: Unpublished data from HSE

The pharmacy needle exchanges provided a link between harm reduction services and drug treatment services in 2012 through referring individuals for blood-borne viral testing (253) and hepatitis B vaccination (165), and to tier three and tier four services (261).

7.4 Responses to other health correlates among drug users

National overdose prevention strategy and naloxone demonstration project

One of the key priorities of the HSE's *National Service Plan 2014* (Health Service Executive 2013) is to improve health outcomes for people with addiction issues (see Chapter 5.2.1 earlier in this report for an overview of the service plan). One of the related actions in the plan is the finalisation of the implementation plan for the National Overdose Prevention Strategy (not yet published). Investigating the possibility of enhanced availability of naloxone, a drug used to counter the effects of opiate overdose, is a key element of the HSE's overdose strategy (personal communication, Joe Doyle, national planning specialist, HSE).

The proposals on how to progress the naloxone demonstration project include:¹²

- identify stakeholders: to include a wide range of organisations, including community, families and voluntary services;
- product choice: e.g. pre-filled syringe or nasal formulation;
- legislative issues: naloxone is a prescription-only medication in Ireland and can only be dispensed by a pharmacist to a named person, for their use only, and can only be administered to that person by a trained healthcare professional (which includes certain ambulance service personnel); and
- cost and evaluation: to include pharma-economic evaluation, costs of training and supply of product.

Youth mental health and substance misuse disorders in deprived urban areas

A recent qualitative study of the experience of young people living with mental health and substance misuse disorders in two deprived urban areas in Ireland highlighted how early intervention in a primary care setting may help to prevent the escalation of symptoms (Schaffalitzky, *et al.* 2014). Semi-structured interviews were conducted with 20 young adults (aged 16 to 25 years) attending health-care settings in areas of extreme social deprivation in the cities of Limerick and Dublin. The aim of the study was to examine the manifestation and experience of mental health and substance misuse disorder from the perspective of the young people.

Young people who participated in the study described initial feelings of anxiety, depression and worthlessness which they recognised as problematic but for which they did not seek help. These symptoms progressed to a point where they became debilitating. As symptoms worsened, young people developed issues which further exacerbated their problems. Substance abuse was common, with some becoming addicted. Self-harm was another coping mechanism.

Despite their deteriorating symptoms, the participants described a reluctance to seek help or to accept help when it was offered. This was particularly the case for those dealing with addiction. Deteriorating life-circumstances such as homelessness was often the motivating factor in seeking treatment.

The young people felt themselves losing control as addiction became a full-time occupation, relationships broke down and negative feelings and thoughts became overwhelming. Nearly half of all participants had serious suicidal ideation. Many felt it would be impossible to get better,

¹² The Take Home Naloxone (THN) demonstration project started in Wales in 2009 is one of a number of UK models that have been documented Bennett, T. and Holloway, K. (2011). *Evaluation of the Take Home Naloxone demonstration project*. Welsh Assembly Government, Merthyr Tydfil. Available at <http://wales.gov.uk/docs/caecd/research/110627naloxonefinalreporten.doc>. Its main aim was to reduce drug-related deaths in Wales and it incorporated an independent evaluation at the end of the first year. The project continues in Wales and has been expanded to different pilot settings. For example, in one major hospital emergency department, staff have been trained to give THN to clients at risk of overdose when leaving the hospital. For further information see <http://tinyurl.com/nkrxmvv>

particularly when they had gone for a long time without treatment or support. They needed to be convinced to seek help and to keep living.

Participants described feelings of shame, embarrassment and isolation. The majority had left school early and some had legal issues. Many were dependent on social welfare and struggling to engage with society. As a result of living in an area of urban deprivation, troubled families, stressful life circumstances and a drug-taking culture had all become the norm. This made it more difficult for the young people to cope with their mental health and substance misuse issues.

The findings from this study outlined progressively deteriorating symptoms, social isolation and stigmatisation among the participants. It highlighted the need for interventions which enhance early identification and treatment of mental health and substance use disorders in young people living in deprived urban areas. These interventions need to be delivered in an environment that is accessible and acceptable. General practice was identified as a less stigmatising environment owing to its availability and familiarity with disadvantaged young people and its ability to target young people who present with physical problems for support around their mental health and substance misuse issues.

Supporting children in families experiencing mental health difficulties

In June 2014 Barnardos published a report entitled *Patients, parents, people – towards integrated supports and services for families experiencing mental health difficulties* (Barnardos 2014). It outlined the experiences of children of parents with mental health difficulties, reviewed current levels of supports and made recommendations for enhancing services. The report reviewed the relevant literature and drew on discussions with parents, carers and professionals in the mental health area.

The report emphasised that parents' mental health difficulties alone present little risk of harm to children but that a lack of appropriate supports can compromise a child's ability to cope. However, parental mental health difficulties are often associated with other risk factors such as poverty or addiction, which can have a huge impact on family life. As a result, the child's social, emotional and cognitive development can be adversely affected. Children are affected by their parents' mood and can become anxious and unsettled, particularly if the situation has not been explained to them by a supportive adult in an age-appropriate way. Moreover, many children take on an unrecognised caring role in the family.

Entrenched societal attitudes and discrimination mean that parents are often reluctant to ask for help as they fear their capacity to parent their children will be questioned. Moreover, the current, predominantly medical, approach to mental health issues leads to a reliance on medication and does not adequately address broader family support needs. As a result, parents and children can feel isolated and the root cause of the distress can be overlooked. Side-effects of medication can further compound problems, with parents who are taking benzodiazepines or other medication experiencing drowsiness and slowed reactions which compromise their ability to respond to children's needs.

The report outlined a need for a holistic approach to supporting families facing complex challenges whereby each family member is heard and their needs considered. Barnardos believe that the present family, health and child support systems need to move from a traditional approach of working in isolation to an integrated inter-agency working model which recognises patients as parents and sees parents and children in a family context. The introduction of a family model approach is called for. Key recommendations arising from the report are:

- challenge mental health prejudice and discrimination,
- adopt a family model approach,
- talk to children,
- expedite the roll-out of community-based services, and
- consult with parents affected by poor mental health.

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.

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

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

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

The **Dublin Region Homeless Executive** is responsible for providing support and services to the Dublin Joint Homelessness Consultative Forum and the Statutory Management Group, both of which were established under the Housing (Miscellaneous Provisions) Act 2009. The Act also requires an action plan to be in place.

The **Community Employment (CE) scheme**, operated from the Department of Social Protection, includes 1,000 places ring-fenced for recovering drug users. The scheme operates through local projects primarily in local drugs and alcohol task force 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 is seen as essential and should be an integral part of the NDS in the future.

8.2 Social exclusion and drug use

8.2.1 Social exclusion among drug users

Data provided by the National Drug Treatment Reporting System (NDTRS) show that there is a slight increase in the proportion of all cases in treatment in 2012 that were early school leavers compared to the previous year; there is also an increase in the proportion of new cases (Table 8.2.2.1). The NDTRS does not collect data on unemployment, but the proportion of both all cases in treatment and new cases entering treatment who report being in employment is reducing.

Table 8.2.1.1 Socio-economic characteristics of cases, by treatment status, NDTRS, 2011–2012

	2011	2012
	n (%)	n (%)
All cases	7372	7169
Early school leaver	1311 (17.8)	1328 (18.5)
Employed (aged 16–64)	656 (9.1)	572 (8.2)
New cases	2948	2972
Early school leaver	361 (12.2)	403 (13.6)
Employed (aged 16–64)	339 (12.0)	294 (10.5)

Source: NDTRS unpublished data, 2014

8.2.2 Drug use among socially excluded groups

Drug use among early school-leavers

Apantaku-Olajide and colleagues (Apantaku-Olajide, *et al.* 2014) analysed data relating to 193 new cases aged 19 years or under who were referred to a treatment centre in Dublin for problems with substance abuse. Of these, 84 (43.5%) were in mainstream education, 46 (23.8%) were in alternative education and 63 (32.7%) had dropped out of school; the 63 young people who were identified as school drop-outs were persons whose highest level of education attained was lower secondary and who had not received education in the four weeks prior to the assessment.

Lifetime use of cannabis, tranquilisers and amphetamines and use of these substances in the last 30 days was higher among the school drop-outs compared to young people continuing in mainstream education. Lifetime use of cocaine and last month use of heroin was higher among the school drop-outs compared to those in mainstream education.

The authors pointed to the high levels of poly-substance use, psychological issues, disruptive family situations and offending behaviours that characterised the school drop-outs. They went on to say that ‘...these results support previous findings of greater levels of substance use and related psycho-social problems among adolescents of school-going ages who had left school without completing secondary education, when compared with school-attending students’ (pp. 171–172).

Drug use among people in prison

The National Advisory Committee on Drugs and Alcohol (NACDA) commissioned a study to estimate the extent of drug use and the prevalence of blood-borne viruses among the prison population in Ireland (Drummond, *et al.* 2014). See Chapter 4.3.2 earlier in this report for an account of the findings of this study with regard to prevalence and patterns of drug use among prisoners; Chapter 5.3 for an account of prisoners’ perceived needs for drug-related treatment; and Chapter 6.2.1 for an account of the findings with regard to the prevalence of blood-borne viruses among the prison population.

In relation to services within prisons, the authors noted that there was a demonstrated willingness on the part of surveyed prisoners to engage with relevant one-to-one services. Some services, such as addiction counselling, whilst needed by 40% of prisoners, were available only 60% of the time and had almost universally high uptake when they were available. The authors highlighted that without the provision of appropriate services and support both inside and outside prison, prisoners face an uphill struggle to achieve sufficient change to help them reintegrate into mainstream society. They concluded:

We cannot again assess the directionality of the relationship between being imprisoned and having limited life chances but we can be clear that these characteristics of social and lifestyle disadvantage certainly limit prospects of rehabilitation and reintegration into mainstream society following release and highlight once again the need for step-down facilities, adequate training and positive lifestyle health promotion initiatives. The rates of re-offence and re-incarceration are also problematic for prisoner populations. This reinforces the vicious, cyclical circle of the situation. Those who are disadvantaged are more likely to slip into an adverse lifestyle including exposure to drugs, in turn are at higher risk of crime and consequent

imprisonment, are exposed to the drug culture in prison and face serious challenges in achieving rehabilitation afterwards. (p. 104)

Drug use among female prisoners

Research was undertaken with female prisoners serving short sentences in the Dóchas Centre, the women's prison in Mountjoy Prison in Dublin (McHugh 2013). Data were collected through in-depth interviews with 16 women and the main focus of the research was the women's needs as they prepared for release.

The use of drugs by the women was explored and the predominant problem drug was heroin, with three quarters of the women who ever had drug problems describing this as their only problem drug or one of their problem drugs. The women also reported problems with using prescription drugs, street methadone and, to a lesser extent, crack cocaine and cocaine powder. Many of the women described having problems with only one drug or a small number of drugs, but their experience of drug use was in most cases substantial and over a long period of time, with many reporting that they had tried everything – 'you name it'.

The prevalence of experiences of homelessness and rough sleeping was extremely high. Fourteen of the women had experienced homelessness at some point in their lives, with five experiencing homelessness for longer than one year. The prevalence of these women staying either with family members or friends at various intervals in their adult lives was also extremely high. Eight of the women had spent time in some form of supported accommodation or housing and five women had spent time in a psychiatric hospital. Eleven of the women had at some point used emergency homeless hostels and nine had slept rough.

The author, in seeking to bring the narratives of these women together, highlighted the degree of marginalisation that connected their lives. However, there was also a signal as to what could bring these women in from the margins: a home, help with their addiction, and structure to their day. McHugh neatly encapsulated these competing parts of their narratives in the following extract:

These women's stories are, as outlined above, in the majority, stories of women who have been marginalised and victimised, who have multiple and complex needs, and who are in need of significant support whether in prison or in the community. These women represented a resource poor network, with little or poor contact and support even within their immediate family circles. Post release needs are thus extensive.... They are looking for accommodation, support for substance abuse, something to keep them busy during the day... (p. 32).

Drug use among the homeless

McGarry House provides temporary supported accommodation for 30 men and women who find themselves homeless in Limerick City. McGarry House also provides long-term supported accommodation for 37 residents in one-, two- and three-bed apartments. This facility provides individuals with a degree of independent living, while offering supports and life-skills programmes where required. Dermody undertook in-depth interviews with 15 residents in McGarry House as part of a study investigating the problem of overdosing and responses to incidents of overdose (Dermody, *et al.* 2014). Interviewees included 10 males and five females; 12 were under the age of 35; nine had been resident for at least six months; and seven were in receipt of prescribed methadone.

When asked to name their primary substance of use (non-prescribed), four reported heroin, four benzodiazepine/Z drugs, three alcohol, two cannabis and one ketamine. One interviewee reported using prescribed methadone and not using any other substance. Eight interviewees reported using benzodiazepines on a daily basis; however, the report did not make clear whether this was prescribed or non-prescribed use. All interviewees reported having used alcohol, cannabis, amphetamines and cocaine or crack at some point in their lives, and 14 had used benzodiazepines at least once. Eight reported injecting drugs frequently.

The study also reviewed documentation relating to the administration of McGarry House. The records showed that of the 114 people who resided in the house at some stage during 2012, 27% presented with drug use, an increase on the 17% who presented with drug use in 2010.

The life histories and experiences of 50 people staying in Cork Simon's emergency shelter over a five-week period in early summer 2013 were analysed (O'Reilly 2013). Three quarters of the people included in the analysis were currently using alcohol and / or drugs problematically, and four out of five of these people also had a mental health condition. Over three in five had spent time previously in a care institution, two out of five had a literacy problem, and almost a third had a learning difficulty. A profile of the people is provided below:

- 92% (46) were unemployed;
- 80% (40) had experience of the criminal justice system;
- 78% (39) were early school leavers;
- 76% (38) were unskilled;
- 76% (38) were using alcohol and / or drugs to the extent that it was causing problems in their lives;
- 68% (34) had a diagnosed mental health condition;
- 60% (30) had a diagnosed mental health condition and were using alcohol and / or drugs problematically;
- 56% (28) had spent some time previously in a care institution;
- 46% (23) require medium or high levels of support with living skills; and
- 44% (22) had a diagnosed physical health condition.

Drug use in disadvantaged communities

A study of current patterns of illicit and licit drug use (including alcohol and prescribed drugs) in Finglas–Cabra was commissioned to fill an evidence gap regarding current trends, as it was perceived that substance use and practices were changing from the days when heroin was the main problem drug in the area (O'Gorman, *et al.* 2013).

Primary data were collected through a series of interviews, conversations and focus groups with people living, or working in drug-related fields, in the Finglas and Cabra areas. Over thirteen focus groups were held with 120 participants. Over 180 hours of ethnographic fieldwork were undertaken. Over 100 contacts were made with drug users. Fieldwork sessions took place at different times and days to try and capture a broad-as-possible sense of drug use in the areas, with each session lasting approximately three hours.

According to the authors, 'A key finding from our interviews and fieldwork with the young recreational drug users was the absolute abhorrence they had of heroin, crack cocaine, and intravenous drug use. As a consequence, they placed a firm boundary around their drug consumption practices in respect to these drugs.' (p. 44) This was a community that in the early 1990s was designated as having acute levels of problematic heroin use; such a designation led to the areas being allocated local drug task force status to address the problem.

The authors provided an insight into the shift that had taken place in the consumption of drugs, particularly among younger and what may be called 'recreational' drug users:

An analysis of key indicator data on drug use, accompanied by evidence from our fieldwork, highlighted a number of new and emerging trends. These included a shift in use from cannabis resin to herbal cannabis with concomitant concerns about its effects on mental health, and an increased diversity in stimulant use which included cocaine, new psychoactive drugs, and more recently ecstasy. Additional trends were noted regarding the pervasiveness of polydrug use and the widespread availability and affordability of 'tablets' which were used, along with alcohol, across drug user groups...evidence is clear that a high risk environment – in terms of economic disadvantage, unemployment and educational disadvantage – such as that inhabited by many residents in the Finglas–Cabra LDTF area, contributes to a high level of drug-related harm.' (p. 52)

Drug use among the Traveller population

The Irish Penal Reform Trust commissioned research with members of the Traveller community who had served a prison sentence (Costello 2014). In-depth interviews were undertaken with 10 Traveller ex-prisoners (5 males, 5 females) between September and November 2013. Access to the interviewees was facilitated by voluntary organisations working with the Traveller community.

Five of the interviewees reported a history of multiple criminal convictions, drug dependence and homelessness; the other five interviewees had served one sentence and did not report drug dependence or being homeless at any stage. The former group also reported experiencing domestic violence in the family home, being placed in care and leaving education at a young age; this group also reported being isolated within the Traveller community owing to their drug use and offending behaviour. Most of the interviewees who reported drug dependence were introduced to drugs at an early age and their use of drugs culminated in using heroin; interviewees reported how they used the proceeds from theft to fund their heroin use.

8.3 Social reintegration

Evaluation of the National Drugs Rehabilitation Framework Pilot

The overarching framework for the social reintegration of drug users is the National Drugs Rehabilitation Framework (NDRF). It was piloted in a number of locations and the evaluation of the pilot was recently published (Barry and Ivers 2014). The NDRF was developed to provide a framework for the implementation of a set of recommendations drawn up by the working group on drugs rehabilitation. (Working Group on drugs rehabilitation 2007) These recommendations, which include the provision of housing, education and employment supports for recovering drug users, are now being implemented under the rehabilitation pillar of the NDS. The evaluation of the NDRF pilots provides a lot of detail regarding the extent to which recovering drug users were supported to access housing, education or employment supports. It is also useful in highlighting the slow progress in implementing the framework. A selection of service providers, service users and key informants were interviewed across 10 volunteer pilot sites. Of the 10 sites, six had begun implementing the framework and four had not.

Data were collected from 14 service users via a questionnaire and interviews. All 14 service users had completed an assessment and all had a key worker; two thirds had a case manager. When asked about their experience with their key workers and case managers, service users were generally very positive and felt supported in the process. Service users spoke about the benefits of connecting with a service and the direct effect that this had on their lives. In terms of the benefits that were more directly attributable to the framework, care planning was the most recognisable practice for service users; the majority of service users had a clear idea of their goals and aspired to build on the current success. Overall, service users reported being satisfied with the service they were receiving.

Data were collected from 48 key workers/case managers and 19 service managers. Three quarters of key workers/case managers reported always engaging in care planning, and the remainder sometimes; similar levels of engagement in inter-agency meetings were reported. Service managers reported some difficulty undertaking comprehensive assessments. All bar one service manager said care planning was being implemented but, of those doing so, all except three reported difficulties. Around three quarters of service managers reported some difficulty in implementing confidentiality protocols. Service managers reported varying levels of access to support services including addiction services, education and employment, housing, justice and law reform services. All service managers reported some engagement in inter-agency working but all reported some difficulty implementing service level agreements. Both service managers and key workers/case managers reported an improvement in communication, sharing of information and referrals following implementation of the framework.

As pointed out by the authors in their conclusion, the evaluation was 'an examination of procedures and process rather than outcomes, with input from mostly providers' (p. 80). This means that we know very little about how the majority of service users experienced the practices within the framework and we know very little about how effective these work practices were in delivering identified outcomes for service users. However, what we can say is that for a small number of service users who were engaging with the framework, their experience of care planning seemed beneficial. From the perspective of service providers, there were difficulties in implementing the NDRF; in particular, there is a need for better access to services for clients including housing, education and employment. There is also an identified need for improved inter-agency working within the NDRF.

Review of Dublin North City and County Addiction Service

A recent high-level review of addiction treatment services in the Dublin North City and County area concluded that a substantial reconfiguration of services is needed to respond effectively to population needs and to emerging national policy (Pilling, *et al.* 2013). The report contains 14 recommendations, eight calling for a reconfiguration services and six for a reconfiguration of operational elements. See Chapter 5.2.2.1 earlier in this report for a detailed account of the recommendations.

The authors concluded that ‘in line with international opinion, the principle of recovery should underpin all treatment from the point of first contact’ (p. 20). They defined recovery as ‘an individual, person-centred journey, enabling people to gain a sense of control over their own problems, the services they receive, and their lives and providing opportunities to participate in wider society’ (p. 22). They pointed out that addiction recovery is becoming the guiding principle for substance use treatment in a number of jurisdictions, and in the words of the authors:

Implementing the recommendations in this report will not only bring the service in line with national policy expectations, but will place it in a strong position to become the leader in addiction treatment in Ireland. (p. 34)

Reorienting drug treatment and rehabilitation services towards a recovery-focused paradigm

A report was recently published by Soilse, the drug rehabilitation service in HSE Dublin North City. Entitled *Addiction recovery: a contagious paradigm*, the report made the case for a recovery-focused approach to addiction treatment in Ireland.

The report contained three main sections:

- a review of the evidence underpinning the principles of recovery,
- a review of Irish drug policy in relation to recovery/rehabilitation, and
- the inputs that build policy, and the personal narratives and perspectives of people in recovery.

There are increasing calls in the literature to draw on the experiences of people in recovery as a means of building effective policy and practice. This paper drew on the outputs of a symposium on recovery held in north inner-city Dublin in the summer of 2012. Over 100 people attended the symposium, the vast majority of whom were living with or working in communities deeply stigmatised by opiate addiction. The report also contained the detailed narratives of four people in recovery, plus a number of vignettes from Soilse participants speaking about their recovery journeys. One Soilse graduate talked about how having allies in recovery helped him reconnect with society:

In recovery I began to feel a part of something. For the first time in life I moved around with people who were happy. Felt comfortable and safe and wanted to hold onto it. I got structure into my life for the first time. Up to then had lost job, no prospects, drinking in house, no light in the tunnel, no way out.

The report set out the case for the reorientation of drug treatment and rehabilitation policy and practice towards a recovery-focused paradigm. The authors argued that that such a shift could be achieved by placing the framework of recovery capital at the centre of policy and grounding practice in the principles of recovery. Table 8.3.1 captures the essence of recovery capital: a framework that contains the properties of what initiates and sustains addiction recovery. Recovery capital was referred to in the report as an ‘assets-based model’, i.e. a way of recognising and prioritising the assets that people bring to their recovery and the attributes they need to develop to sustain their journey. This model differs from the ‘deficits-based’ model which seeks to emphasise the reduction of risks and problems such as drug use and crime. The report contained a detailed exploration of this debate.

Table 8.3.1: Four dimensions of recovery capital

1. Social capital	The sum of resources that each person has as a result of their relationships with, support from and obligations to groups to which they belong.
2. Physical capital	Tangible assets such as property and money that may increase recovery options.
3. Human capital	Personal skills and education, positive health, aspirations and hopes.
4. Cultural capital	Values, beliefs and attitudes that link the individual to social attachment and the ability to fit into mainstream social behaviour.

Source: (Cloud and Granfield 2009)

Table 8.3.2 lists the principles of recovery that are based on robust research and inputs from consultations with service users and providers. There is consensus in the literature regarding these principles, a consensus echoed in the testimonies of Soilse participants. These principles recognise that there are multiple pathways and styles of long-term addiction recovery, and all should be cause for celebration. Central to the vision encapsulated in these principles is the recognition that the person in recovery is an ‘active agent’ in their own journey and that change for them via an improved quality of life is the key outcome to be pursued. The report contained an exploration of the evidence from the research to support the transfer of these principles into practice.

Table 8.3.2: Twelve principles of addiction recovery

1. There are many pathways to recovery.
2. Recovery is self-directed and empowering.
3. Recovery involves a personal recognition of the need for change and transformation.
4. Recovery is holistic.
5. Recovery has cultural dimensions.
6. Recovery exists on a continuum of improved health and wellness.
7. Recovery emerges from hope and gratitude.
8. Recovery involves a process of healing and self-redefinition.
9. Recovery involves addressing discrimination and transcending shame and stigma.
10. Recovery is supported by peers and allies.
11. Recovery involves (re)joining and (re)building a life in the community.
12. Recovery is a reality.

Source: (Sheedy and Whitter 2009)

The report concluded with recommendations on how to promote the reorientation of addiction policy and practice towards a recovery-focused paradigm. These included the proposal that recovery replace rehabilitation as the fifth pillar in the NDS.

8.3.1 Housing

There is scant information available on measures to provide housing for people affected by substance misuse. However, there are major shifts in policy around measures to tackle homelessness among the general population, given the increase in the numbers presenting as homeless since the economic downturn. These measures, if implemented, will also address the needs of homeless drug users and people in recovery who are experiencing difficulty in accessing accommodation.

Progress towards 2016 goals on homelessness

The first report of the Homelessness Oversight Group was recently released (Kennedy, *et al.* 2013). The Group was established by the then Minister for Housing, Jan O’Sullivan TD, in February 2013. Its role, as set out in the policy statement on homelessness launched by the minister on the same day (Kennedy, *et al.* 2013), was to monitor and review progress on the housing-led approach to ending long-term homelessness and the need to sleep rough by 2016. This first report, based on consultations with representatives from 36 stakeholders, a review of Pathway Accommodation and Support System (PASS) data on homelessness in the period ending September 2013, and detailed consideration of relevant policy-related material, gave a realistic account of the major obstacles to achieving the 2016 goals and a detailed set of recommendations on how these obstacles can be overcome.

Trends in homelessness

The Homelessness Oversight Group acknowledged that changes to the methods of measuring homelessness over the last 10 years made it difficult to track precisely what progress had been made in reducing either overall homelessness or long-term homelessness. However, the Group suggested that the indicators available pointed to progress being slow. In reviewing the available datasets, including Counted In, 2008 (Homeless Agency 2008), data from the Census 2011 (Central Statistics Office 2012) and the PASS data, the Group signalled that overall ‘it seems likely that no significant reduction in long-term homelessness had occurred between 2008 and 2011. Rough sleepers are on an upward trend... [and] ...little change in the incidence of homelessness seems to have occurred in Dublin in recent years’ (pp. 9–10).

Obstacles to progress to securing permanent housing

The housing-led approach seeks to place homeless people in sustainable rented accommodation as a first step, and provides ‘floating supports’ at the request of the person being housed. Such supports

may include assistance with social welfare enquiries, developing independent living skills or seeking help for addiction problems. The Group’s report was quite explicit in identifying the key obstacle to this approach as a structural one, centred on the lack of integration between two social policy and implementation areas – care and housing. This lack of integration was neatly encapsulated in the following extract from the report:

...housing providers [i.e. local authorities, approved NGOs and the Department of Social Protection] have housing responsibilities which go well beyond the homeless and embrace a wide range of low-income households. ... Their priority targets (such as families with children and elderly households) do not include the single adult males who make up the majority of the long-term homeless. Homeless agencies, by contrast, are more narrowly focused on provision of shelter, social supports and related health services to the homeless but also require access to long-term housing in order to meet what is the core need of their clientele – the need for a permanent home. ... they depend on housing providers since they themselves have little role in housing but they struggle to make successful claims for access in the light of the low priority accorded to their clientele in the wider system of housing allocations. (p.10)

Recommendations to overcome blockages

The Group’s core recommendation was that a high-level team be set up and given responsibility for achieving the 2016 goals. This homelessness policy implementation team would be part of the general housing policy section of the Department of the Environment, and supported by an implementation unit. It is proposed that the team would enter into service level agreements with approved housing bodies capable of accessing capital funding from the Housing Finance Agency in order to supply permanent housing units, and with agencies providing care and support for the homeless people when they are housed.

Are the 2016 goals attainable?

The Group set out four grounds on which the 2016 goals could be realised:

1. The scale of homelessness is not insurmountable. An estimated 1,500–2,000 permanent housing units being made available over the next three years is not an unrealistic target, given that the state currently provides an estimated 250,000 state-supported housing units.
2. There are many under-used housing units and related financial resources which could be used to tackle and reduce long-term homelessness.
3. Current expenditure on expensive short-term accommodation and shelter will be freed-up as the long-term homeless make the transition to permanent housing.
4. Services provided to meet the health and social care needs of homeless people have improved greatly since the early 2000s, providing a platform on which to build an infrastructure of care and support to sustain long-term tenancies when the supply of permanent housing is increased.

Recent research has found that the views of stakeholders in Ireland are in broad agreement with the international consensus that responses to homelessness involve more than just providing housing in the form of ‘bricks and mortar’ (Pleace, *et al.* 2013). Effective responses need to include housing alongside appropriate support, especially for people with high support needs. The Homelessness Oversight Group’s report concurred with these findings, stating: ‘As the long-term homeless are moved into permanent housing between now and 2016...services will need to follow them and provide necessary supports in new ways and in new contexts’ (p. 4).

In direct response to the first report of the Homelessness Oversight Group, on 25 February 2014 the government approved the establishment of a Homelessness Policy Implementation Team and a Central Implementation Unit to implement the recommendations contained in the Group’s report. In addition, the government published a detailed plan to assist in implementing the recommendations and to make the transition from a shelter-led to a sustainable housing-led response to homelessness (Department of Environment and Local Government 2014). The plan contains 80 actions with responsible agents for each action. Three actions, when implemented, will benefit both people engaged in active drug use and people in recovery from drug use (see Table 8.3.1.1).

Table 8.3.1.1: Three actions from the government’s plan on homelessness targeting people with drug and housing problems

Action 1	Action 2	Action 37
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Action 1	Action 2	Action 37
We will provide accommodation for rough sleepers as quickly as possible pending the tendering and delivery of the Housing First service in Dublin.	We will support the planned establishment of a Housing First service in Dublin for the rough sleeping cohort with a view to delivering a minimum of 100 households to independent living with support over the period to 2016. This service, expected to be in place before the end of 2014, will target persons in Dublin who experience enduring and habitual rough sleeping and who manifest chronic mental ill health and/or substance misuse and addiction.	We will continue to ensure that the recommendations of the Working Group Report on Rehabilitation on housing for recovering drug misusers, including homeless drug misusers are implemented appropriately

Source: (Department of Environment and Local Government 2014)

Youth homelessness

The Department of Children and Youth Affairs commissioned and has published a high-level review of the 2001 Youth Homelessness Strategy (Denyer, *et al.* 2013). The objective of the review was to establish the extent to which the Strategy had been successful, identify blockages and challenges to its implementation and make recommendations. The review reported that the number of children considered homeless – or at risk of homelessness – had decreased since the introduction of the Youth Homelessness Strategy. It also reported that instances of children sleeping rough were rare, and that there had been an increase in the range of accommodation options available to children who presented as homeless, including residential beds and emergency accommodation. The review recommended that the use of Garda stations as a means of accessing emergency accommodation for the first time should be avoided and emergency accommodation in Dublin should remain open to children during the day.

8.3.2 Education, training

The Department of Social Protection (DSP) supports the objectives of the NDS for the re-integration of people recovering from substance misuse into the labour market (Department of Social Protection 2013). Central to this support is funding provided by the DSP for 1,000 drug rehabilitation places on both dedicated and mainstream Community Employment (CE) schemes; currently, funding for these 1,000 places is ring-fenced, which provides a certain degree of continuity. The overwhelming majority of these places are taken up through dedicated CE schemes, which the DSP defined as follows: ‘A dedicated drugs rehabilitation scheme is a scheme where participants are referred to the scheme by a recognised drug rehabilitation service or agency. The focus of the scheme is on rehabilitation and training and development; and multi-agency co-operation is important for the achievement for successful outcomes of participants...’ (p. 3).

There are approximately 47 dedicated drugs rehabilitation schemes, 35 in the Dublin region, and participants on these schemes are in recovery from substance misuse. There are also mainstream CE schemes that include drug rehabilitation places; these are schemes which cater predominantly for people not referred by a recognised drug service. The number of clients referred to the dedicated drug rehabilitation CE schemes increased during 2013, the most recent year for which data on referrals is available (see Table 8.3.2.1). When support workers who do not need to be in recovery but who must comply with CE eligibility conditions are excluded from the numbers, just over a fifth of the 1,000 places remain unfilled. There are a number of factors causing this shortfall and these are discussed below in connection with a recent report by the CityWide Drugs Crisis Campaign examining the current operation of dedicated drugs rehabilitation projects/schemes (Citywide 2014).

Table 8.3.2.1: Ring-fenced drug rehabilitation places on CE scheme, 2013

Month	Referred clients	Support workers	Total
January	662	168	830
February	664	159	823
March	676	159	835
April	700	149	849
May	723	157	880
June	737	158	895
July	737	155	892

August	735	151	886
September	733	160	893
October	735	169	904
November	759	163	922
December	790	161	951

Source: (Burton 2013 June 9)

The ultimate aim of using CE schemes as a labour-market activation intervention is to reinforce or replace the skill sets of people experiencing unemployment in order to assist them into employment. However, for people in recovery from substance misuse who are referred to drug rehabilitation places as part of CE schemes, the medium and long-term outcomes can be different owing to the multiple disadvantages that characterise the lives of people in recovery from substance misuse.

According to the Department of Social Protection, ‘...many schemes with drug rehabilitation places operate in communities where significant social problems add to the realities of chronic unemployment...’ (Department of Social Protection 2013), p. 9). For example, the majority of participants who take up drug rehabilitation places on these schemes have experienced educational disadvantage prior to engaging with this service; 58% of people referred to these schemes in 2012 only reached Junior Certificate level or lower in their formal education (see Table 8.3.2.2).

Table 8.3.2.2: Ring-fenced drug rehabilitation places on Community Employment schemes, by education level and gender, 2012

Education level	Male	Female	Total	Percentage
Primary/no education	126	82	208	25.2
Junior Certificate or equivalent	183	92	275	33.4
Leaving Certificate or equivalent	66	79	145	17.6
3 rd -level education	52	53	105	12.7
Unknown	39	52	91	11.0
Total	466	358	824	100.0

Source: (Department of Social Protection 2013)

In 2014 CityWide Drugs Crisis Campaign published a report examining the current operation of dedicated drugs rehabilitation projects/schemes against the recent background of fiscal austerity measures and changes to labour market activation policies and to legislation governing welfare provision (Citywide 2014).

The report highlighted the barriers to social participation that often ensue from experiencing multiple disadvantages. According to CityWide, ‘...these existing barriers to participation are primarily linked to disadvantage and drug use and include low self-esteem, low levels of literacy or modest educational achievements, poor health, insecure housing, weak social networks, poor family relationships and limited access to childcare...’ (p. 13). Participants with this type of profile who are referred to drug rehabilitation places on CE schemes participate in a different way from those enrolled in mainstream CE schemes and the outcomes are also different. The vast majority of drug rehabilitation places are taken up via drug rehabilitation projects which operate in highly disadvantaged communities. By way of addressing the multiple barriers to social participation that participants experience, these projects provide a range of services including personal development and elements of education and training. According to CityWide, this range of services ‘...aims to provide participants with stability in their lives so that they can address their drug use and reintegrate into the lives of their families and communities...’ (p. 9). Although the long-term goal of finding employment may be not be realisable for some people in drugs rehabilitation places, at least for some time during the initial stages of their recovery, their willingness to engage and accrue some medium-term benefits needs to be acknowledged.

As part of their consultation with relevant stakeholders in the sector, CityWide interviewed 11 participants who were currently participating in drug rehabilitation places on CE schemes. Participants identified the main benefits as the stability, structure and routine that the projects provided, the supports provided by key workers and peers which helped to increase coping skills and develop team-working abilities, and an improvement in their self-esteem and confidence. Education was highlighted as a particularly useful mechanism to deliver a range of benefits to participants. For example, according to CityWide, ‘A key confidence building measure was the availability of education

for participants. The transformative and empowering effect of education was noted both by participants and by referral and state agencies. Drug rehabilitation places enabled participants to gain formal qualifications and develop new skills as many participants had little formal education...their involvement in [projects] enabled them to set goals for the first time in many years. Most of these goals involved further education, accessing employment, or working with young people...' (p. 15).

These reported medium-term benefits for participants suggest that the work undertaken with them by the projects in their local communities was beneficial to them, their families and their communities. In particular, the role of education was noted, and CityWide noted the following benefits to families, '...participation in education enhanced the confidence of participants who could then take a greater role in their own children's education, for example, by supporting them with their school work...' (p. 15).

As already reported in this section, participants referred to drugs rehabilitation places on CE schemes have experienced multiple disadvantages and faced numerous personal and structural barriers to social participation. They have also experienced stigma and prejudice. CityWide noted the efforts of the local projects that provide drug rehabilitation places and the achievements of participants that goes some way to reversing this stigma: '...state and referring agencies...referred to events that had been held to mark participants' graduation from education programmes.... such events have had a positive impact on the community in that they can mitigate the negative attitudes towards drug users. Moreover, they highlight that recovery, change and rehabilitation is possible' (p. 16).

Despite the many benefits reported by this small number of participants on drug rehabilitation schemes and endorsed by service providers, there remain major concerns regarding the current operation of these schemes against the background of recent fiscal austerity measures and legislative changes to the provision of state welfare provision. The report concluded that changes introduced to the CE scheme in order to increase its focus on labour market activation have not taken into account the distinct nature of drug rehabilitation projects, which tend to emphasise working with recovering drug users to initiate and sustain their recovery while providing some elements of education and training to improve their employability. In particular, CityWide pointed out that recent budgetary changes have led to a change in the profile of those applying for places on the projects: there have been increases in applications for places on drug rehabilitation projects from people who are on a One-Parent Family or a Disability benefit and also from people who are on a Job Seekers benefit. They also provided a financial incentive for people parenting alone and for those in receipt of disability payments to address their addiction problems. Budget 2012, the report concluded, 'wiped out' this incentive. The majority of projects have seen a decrease in the number of women joining projects and 'a spike in applications from younger men over the past two years; this younger cohort may never have used heroin, but use a cocktail of illegal drugs, tablets and alcohol. This provides a more challenging environment in which to deliver rehabilitation programmes' (p. 30).

Working with women affected by prostitution to achieve social reintegration

Ruhama is a non-governmental organisation that works on a nationwide basis with women affected by prostitution. It provides support and assistance to women who are active in prostitution, have a history of prostitution, or are victims of sex trafficking. Ruhama's latest annual report shows that in 2012 the service worked with 258 women of 32 different nationalities (Ruhama 2013).

Street outreach

The Ruhama street outreach service, comprising 30 outreach workers (including paid staff and volunteers), worked 108 nights during 2012 and supported 72 women, some on multiple occasions; 10 of the women also engaged with Ruhama's casework service. The outreach service uses a purposely adapted vehicle which is referred to as 'the van' by service users throughout the report. The report documents the issues that women involved in street prostitution present with, including addiction, debt, homelessness, poor health, suicidal ideation and violence. Ruhama is particularly conscious of the negative role that addiction plays in the lives of women engaged in prostitution. According to the report:

A majority of women involved in street prostitution who accessed Ruhama services via the Outreach Van in 2012 led chaotic lives due to their drug misuse. Ruhama has noted that this particular cohort of women may not access the full

services offered, particularly those available in education and development. Ruhama has proactively engaged with low threshold drugs services to ascertain what kind of interaction with education best suits the client needs, and with this in mind is developing a number of once-off workshops that women could access without having to sign up for regular classes. (p. 15)

Casework

In 2012, there were 170 women engaged with caseworkers; 45 were new cases in general casework and 18 were new cases in victims of trafficking casework. The other 107 women had been in casework from before the start of 2012. Casework involves the woman working individually with a caseworker to identify goals and address pertinent issues and needs in a planned way; the woman may also receive emotional support through counselling. Women who are deeply traumatised are also offered psychotherapy and some may benefit from art therapy. It usually takes approximately two years for a woman affected by prostitution to work through a care plan.

Education and development

Providing education and development services is a cornerstone of Ruhama's work. In 2012, 88 women engaged with Ruhama's education and development programme, an increase of 14% on 2011. Table 8.3.2.3 provides a breakdown of the numbers of women and the activities they engaged with.

Table 8.3.2.3 Development and education activities offered by Ruhama, and number of participants, 2012

Activity	Participants	Activity	Participants
Developed a career path plan	47	Engaged in group classes	33
One-to-one tuition	33	Engaged in external group classes	20
One-to-one study skills	10	Worked on developing CVs	50
IT training	9	Learned English as second language	22
Started FETAC courses	11	Applied for third-level/further education or training	52
Completed FETAC courses	7	Received financial support to access education	45

Source: (Ruhama 2013)

Resettlement support service

Ruhama employs a worker specifically to assist women to access suitable housing and accommodation; this service also assists women to access social welfare benefits and entitlements. In 2012, 33 women availed of Ruhama's resettlement support service.

Conclusion

Ruhama's mission is to support women to (re)gain their independence and eventually exit the services provided by Ruhama: assisting and supporting women to exit prostitution and to deal with the emotional and material experience of prostitution are key objectives. The annual report shows that, in the course of 2012, Ruhama had been able to close the case files on 49 clients, meaning that the women had worked through their care plans and were no longer reliant on the services. However, work of this kind with vulnerable and marginalised people can rarely be captured by reference to numbers and categories. In the words of the chairperson:

In this report we read many statistics, and behind each one is an individual woman's story, a personal experience, where she has been trafficked, coerced or otherwise socialised into a life which she now wishes to leave, but where her escape may be threatened by danger, fear and absence of options. (p. 3)

8.3.3 Employment

See Section 8.3.3 in 2013 National Report (Health Research Board 2013) for the most recent information.

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, including drug law offences and offences committed as a consequence of a drug addiction. 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. The Road Traffic (No.2) Act 2014 provides, inter alia, new measures to test for driver intoxication. Members of An Garda Síochána will be empowered to require people driving or attempting to drive a mechanically propelled vehicle in a public place, to undertake intoxication impairment testing. This involves non technology-based cognitive tests (e.g. walking a straight line, tipping one's nose, counting while standing on one leg). The results of these tests may be used in evidence in support of the Garda forming an opinion that the person is intoxicated. It will also be an offence to fail to comply with a requirement to undergo intoxication impairment testing. Section 12 amends the Road Traffic Act 2010 to allow for the taking, subject to medical approval, of a specimen of blood from an incapacitated (e.g. unconscious) person following a road traffic collision involving death or injury.

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 Garda Síochána IT system, PULSE (Police Using Leading Systems Effectively).

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. Official crime statistics do not allow one to identify where offences were drug-related. These connections can only be made through specific research in the area. This is reported in this chapter when available.

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 a Local and Community Development Programme, which aims to tackle poverty and social exclusion through partnership and constructive engagement between government and its agencies and people in disadvantaged communities; a Youth Capital Programme, which funds youth cafés; and the Dormant Accounts Fund, which is used to target economic and social disadvantage and educational disadvantage and to provide support for

persons with disability.¹³ In relation to the drug problem, in 1998 local drugs task forces were established in areas identified as having the highest concentrations of drug misuse; without exception, these areas were all also experiencing high levels of socio-economic disadvantage. Recast as local drugs and alcohol task forces (LDATFs) in 2014, their purpose 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 LDATFs 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. In addition to the Garda Youth Diversion Projects, the **Garda Juvenile Diversion Programme (GJDP)** provides an opportunity to divert juvenile offenders from criminal activity. It operates on a nationwide basis under the supervision and direction of the Garda National Juvenile Office. The GJDP provides that, in certain circumstances, a young person under 18 years of age who freely accepts responsibility for a criminal incident be cautioned as an alternative to prosecution. The GJDP employs such strategies and initiatives as formal and informal cautioning, supervision, restorative cautioning and conferencing, community policing and referral to the Garda Youth Diversion Projects (which operate outside the GJDP but in concert with it). 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. Another initiative recently established is a joint initiative of the Family Support Network and the Garda Síochána to assist individuals and families in responding to drug-related intimidation, the incidence of which has increased in recent years, as reported in National Reports.

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

¹³ These programmes are all administered by Pobal, a not-for-profit company with charitable status that manages programmes on behalf of the Irish Government and the EU. For further information, see www.pobal.ie

demand for drugs. The **Probation Service** works in partnership with communities, local services and voluntary organisations to reduce offending and to make communities safer. It funds and supports organisations and projects providing drug treatment to offenders, as well as other important services such as employment placement, accommodation, education and training, restorative justice initiatives. Probation Service staff in the community and in prisons may refer clients to these community-based projects, to enhance their re-integration and resettlement as positive, contributing members of their communities.

9.2 Drug-related crime

The link between drugs and crime in Ireland exists simply by virtue of prevailing legislation which defines as criminal offences the importation, manufacture, trade in and possession, other than by prescription, of most psychoactive substances. Apart from such official statistical indicators, it is eight years since any research and analysis on the connection between illicit drugs and other types of crime such as theft from the person, burglary, larceny and prostitution was published in Ireland (Connolly 2006). Data on drug law offences is presented in Section 9.3 below, and information on other drug-related crime is presented in Section 9.4.

9.3 Drug law offences

Court outcomes for drug offences

The Courts Service Annual Report for 2013 provided statistics on the outcomes of prosecutions for drug offences between January and December 2012 (Courts Service 2014). Table 9.3.1 shows the outcomes of trials for 14,008 drug offence cases, involving 9,297 defendants, prosecuted in the District Court, the lowest court in the system where most drug offences are dealt with. This total represented a 21% decrease on the number of cases prosecuted in 2011 (n=17,715). The most common outcome in 2013 was for cases to be struck out (n=2,784). There were 2,339 offences that resulted in fines. Just 7.7% (n=1,083) cases resulted in imprisonment or detention while 1,803 cases were dealt with by way of community service or probation.

Table 9.3.1 Sentences for drug offences in the District Court, 2012

Sentences	Imprisonment	Fines	Community service/probation	Struck out	Dismissed	Taken into consideration*	Other	Peace bond	Total
Number of offences	1083	2339	1803	2784	225	2317	3323	120	14008

* Taken into consideration: The Criminal Justice Act, 1951, s8, provides that where a person, on being convicted of an offence, admits him- or herself guilty of any other offence and asks to have it taken into consideration in awarding punishment, the Court may take it into consideration accordingly. If the Court takes an offence into consideration, a note of that fact is made and filed with the record of the sentence, and the accused cannot be prosecuted for that offence, unless her/ his conviction is reversed on appeal. Source: (Courts Service 2014)

The Courts Service reported that 1,029 drug offences were tried in the Circuit Criminal Court. The Circuit Court has a higher jurisdiction than the District Court and can thus impose a more severe sentence. Of the prosecutions in the Circuit Criminal Court, 420 led to guilty pleas. Of the 36 cases that went to trial, 17 resulted in convictions and 19 in acquittals. In relation to the penalties imposed on conviction by offence, it was reported that 10 led to community service; 196, suspended sentences; 171, imprisonment; 651, other (including community bond, taken into consideration, struck out, forfeiture of goods/money/drugs/weapons, disqualification from driving) (Courts Service 2014).

Prison committals for drug offences

The Irish Prison Service (IPS) annual report for 2013 provided statistics on the number of persons in custody under sentence (i.e. not on remand) on a given day in the year (30 November) and also on the number of committals under sentence by sentence length (Irish Prison Service 2014). Table 9.3.2 shows that the number of persons in custody for controlled drug offences comprised 17% (n=589) of the total prison population, which was 3,474. The majority of drug offenders (n=308) were serving sentences of 5 to 10 years (n=207), with 101 serving more than 10 years. Just 19 prisoners were reported to be serving less than 12 months in prison.

Table 9.3.2 Persons in custody on 30 November 2013 for controlled drug offences by sentence length

Months			Years					Life	Total drug offenders	Total prison population	Drug offenders %
<3	3 to <6	6 to <12	1 to <2	2 to <3	3 to <5	5 to <10	10+				
-	6	13	26	64	172	207	101	-	589	3474	17%

Source: (Irish Prison Service 2014)

Table 9.3.3 shows the number of committals under sentence for the whole of 2013 for drug offences, by sentence length. When compared with Table 9.3.2, it can be seen that just more than 50% of committals were for a period of less than three months (n=429), while more than 70% of committals were for less than a year (n=594). It should be noted that some of the committals for less than three months could have related to the same persons being imprisoned more than once during the year.

Table 9.3.3 Committals under sentence for controlled drug offences, by sentence length, 2013

Months			Years					Life	Total drug offenders	Total committals	Drug offenders %
<3	3 to <6	6 to <12	1 to <2	2 to <3	3 to <5	5 to <10	10+				
429	84	87	36	59	98	41	12	-	846	12489	6.7%

Source: (Irish Prison Service 2014)

9.4 Other drug related crime

Probation Service study on drug and alcohol use among young offenders

In 2012, the Probation Service published the findings of the first large-scale, nationwide survey of drug and alcohol misuse among the adult offender population on probation supervision ((Health Research Board 2013): Chapter 9.4). This was followed in late 2013 by the report of a similar survey of young offenders (aged 20 years or under) who were on probation supervision (Horgan 2013). A better understanding of the nature of the connection between drug use and offending has implications for drug and crime prevention and for treatment and criminal justice interventions. A major impediment in this area in Ireland, however, has been the absence of research and data from within the criminal justice system. Although, as shown in Section 9.3 above, annual data have been available from the CSO and the Courts Service on the number of drug offences (infringements of drug laws such as possession and supply) that are committed, and from the IPS on the number of prison committals for drug offences, data have not been routinely available on the number of drug-related offences committed as a consequence of substance misuse, such as thefts by dependent drug users to feed their drug habit. The development of a knowledge base of this kind requires further analysis of the data compiled within agencies of the criminal justice system.

The objectives of the young offenders' survey were to:

- determine the number of young offenders under probation supervision who had misused drugs and/or alcohol,
- investigate the nature and frequency of drug and alcohol misuse,
- examine the context within which drug and alcohol misuse occurred,
- ascertain whether a relationship exists between drug misuse and offending behaviour and alcohol misuse and offending behaviour, and
- identify the range and nature of engagement with drug and alcohol treatment services.

The survey population was identified by means of the Probation Service electronic case tracking system. Probation officers completed and returned survey questionnaires relating to 721 offenders on their casebooks on 3 December 2012, of whom 647 (89.7%) were male and 74 (10.3%) were female. Of the 721 cases surveyed, 628 (87%) were identified as having misused drugs, alcohol or a combination of both; 12% had misused drugs only, and 12% had misused alcohol only. Male and female offenders had relatively similar rates of substance misuse. Alcohol was the substance most often misused on a weekly basis (39.8% of males and 43.6% of females), followed by cannabis (20.4% of males and 14.5% of females). Females were less likely than males to have misused both drugs and alcohol, and significantly less likely to have misused drugs alone (1%). However, females were more likely than males to have misused alcohol only (16% vs 12%). Twenty-six per cent of females were reported to have abstained entirely from either drug or alcohol abuse, compared to 11% of males. A higher percentage of females (14.5%) than males (8.9%) misused prescription drugs.

The study also explored the 'gateways and influences' which surround the misuse of drugs and alcohol by young offenders. Alcohol was recorded as the most common substance first misused, followed by cannabis. A higher percentage of females than males were reported to have started with alcohol (70.9% vs 55.7%), while cannabis as the first substance used was higher for males (35.3% vs 23.6%). While substance misuse was reported as commencing among individuals as young as nine years, the median age was 14 years. Consistent with most other studies in this area, more than 80% of offenders first engaged in substance misuse with their peers. Of the 628 offenders who had misused a substance, 38.9% had parents with a history of substance misuse, while 55.6% did not. In explaining this phenomenon, and citing a UK study, the report stated that 'alcohol consumption in Great Britain and Ireland can only be appreciated in the context of a "wet culture", whereby young people's drinking is essentially "normal" behaviour, part of a wider socialisation process, reflecting adult practices' (p. 25).

With regard to the link between substance misuse and crime, in more than 80% of cases substance misuse was linked, in the opinion of the probation officer, to current offending. Alcohol was the substance most frequently linked to offending for 61.7% of females and 43.8% of males. Drug misuse on its own was linked to a relatively small amount of offending. Public order was the most common offence category linked to offending and 'in nearly 70% of those cases alcohol was the substance of misuse' (p. 30). In cases of assault, over half the cases identified alcohol as the substance of misuse. Again, these findings are consistent with those of earlier Irish research in this area (Institute of Criminology 2003). Over half the survey population had attended some form of drug/alcohol treatment, the majority when they were aged between 18 and 20 years.

One of the key performance indicators under the research/ information pillar of the National Drugs Strategy 2009–2016 (NDS) is comprehensive and timely reporting systems for the 'progression of offenders with drug-related offences through the criminal justice system'. Action 55 proposes as an area of research 'the impact of alcohol and drugs on the Irish health and justice systems'. This initiative by the Probation Service makes an important contribution in this respect.

Drug-related intimidation and community violence

The issue of drug-related intimidation, much of it related to drug debt, has emerged as a major concern for many communities in Ireland in recent years ((Health Research Board 2012): Chapter 9.4). It has also been identified as a key issue in the NDS, where Action 5 aims 'to develop a framework to provide an appropriate response to the issue of drug related intimidation in the community'. A study of the issue in Blanchardstown, West Dublin, undertaken by the co-ordinator of Safer Blanchardstown (the local community policing forum), sought to identify those most likely to engage in local intimidation and those most likely to be victimised (Jennings 2013). The research also investigated the causal factors underlying intimidation with a view to informing possible interventions and responses by partner agencies and the wider community. Primary research involved a series of interviews with senior outreach staff from a number of local agencies, including youth projects, community drug teams, family support services, social workers, health workers and the local Garda drugs unit. These interviews, conducted in late 2011, were supplemented by minutes of local residents meetings on community safety and a literature review.

The resulting report highlighted the complex and multi-layered nature of the phenomenon and recommended that responses should be systematic, co-ordinated and directed along a continuum of different 'orders' of intimidation – lower, middle and higher. The report used the metaphor of an iceberg to link these different levels of intimidation, as illustrated below.

Lower order intimidation, according to the report, involves:

... young children [aged 8–16] bullying, assaulting, stealing, vandalising and spreading fear within the community, often directed to do so by older siblings and friends. Children may be directed to intimidate those who are thought to be talking to the Gardaí/Local Authority. This intimidation can take the form of breaking of windows, property damage, name calling, racial slurs and harassment of [other] children in the street. (p.11)

Young people at this level, the study found, are sometimes supported in such behaviour by older siblings, family and friends, and experience a 'lack of parental control, boundaries or direction in their lives'. In relation to lower-order intimidation the report highlighted the importance of early interventions for young people who may be likely to become involved in such behaviour. One local initiative currently being piloted is the Interagency Working Agreement Group (IWA) for Mulhuddart/Corduff. This group has developed protocols for the sharing of confidential information between all agencies working with young children and their families in order to provide them with appropriate supports. The report recommended the following:

The principal aim of the IWA should be, through the provision of appropriate supports, an increase in educational attainment, the reduction in the number of young people with a low school attendance, at risk of suspension/exclusion from school or who have come to the attention of Fingal County Council/Gardaí in relation to anti-social behaviour harassment or intimidation. (p.14)

The report also noted the potential of problem-oriented policing methods, with 'Garda problem solving' training currently being rolled out across Blanchardstown, targeting agency staff and residents. This is a model of problem solving referred to as SARA (Scanning, Analysis, Response, Assessment) to inform multi-agency interventions.¹⁴

Middle-order intimidation, involving those aged between 13 and 20, some of whom are dependent drug users and dealers, was reported as the level at which 'most of the drug-related intimidation takes place and from which stems the criminal activity that financially supports those caught up in addiction' (p.16). The report recommended the development of a Prolific and Priority Offender (PPO) approach, defined as 'an approach that effectively manages offenders who are identified as committing a disproportionate amount of crime and harm in their communities' (p.17). This approach involves a 'catch and convict' strand which 'requires that the criminal justice agencies work together to ensure effective investigation, charging and prosecution' of PPOs in as short a timescale as possible. It also incorporates a 'rehabilitate and resettle' strand, whereby PPOs are provided with a 'simple choice – the opportunity to reform or face a very swift return to court should they re-offend or fail to comply with the conditions of court orders' (p.18). This latter strand, the report stated, must be supported through 'locally agreed and implemented rehabilitation plans'.

Higher-order intimidation is described as 'where the serious players reside', that is, 'those gang members and leaders who actively defend and try to expand their share of the drugs market' (p. 20). In describing the recreational demand side of the illicit drugs market, the report provided an interesting analogy with the local pub:

People who go to the pub daily or on a regular basis enable the landlord to pay the rent, heat, light and staff wage bills. It's at the weekend however; when the casual drinkers come out that the publican makes the real money. Likewise with the drug suppliers, it's at the weekend when the casual recreational users order their small bit of hash/cocaine etc. that the real money is made and it is this real money that attracts the serious violence. (p. 20)

The report also employed the iceberg metaphor to illustrate the local impact of so-called gangland murders. When such a murder is committed, 'as a consequence of the interrelated nature of intimidation residents will attribute a relationship between those at the lower orders and those at the higher order even where this is not warranted. This fear will be picked up by those in the lower order whose swagger and power to intimidate will increase' (p. 20). This in turn leads to further fear and community submission and silence. The report stressed the need to expose the link between casual recreational drug use and such violence in communities.

One of the major consequences of drug-related intimidation is that its victims (both direct and indirect) refuse to engage with state authorities because of fear of reprisal from those involved in the drug trade. The report advocated the establishment of a community information network to gather information on intimidation whereby people could provide information to the gardaí and local

¹⁴ For further information on such techniques, see the Centre for Problem Oriented Policing at www.popcenter.org

authorities without committing to going to court. This would enable the authorities to build a profile of those involved and, by encouraging people to talk about the issues, it could enhance initiatives such as the support service provided by the National Family Support Network and the Garda National Drugs Unit to individuals and families facing intimidation.¹⁵ This report is an important local contribution to an issue that is not only of increasing national significance but also under-researched. The final recommendation highlighted the need for further research ‘in order to better inform workers, local communities and wider Irish society on how best to tackle this devastating behaviour’ (p. 25).

Another study on drug-related intimidation was completed by the North Dublin Inner Local Drugs and Alcohol Task Force in October 2013 (North Inner City Drugs Task Force 2013). This trends and behaviour survey on violence, intimidation and threats involved an online survey of individuals and groups engaging with community-based projects in the north inner-city. The survey was issued to 20 local projects and there was a 70% response rate (14 projects). Of the projects that responded, 11 worked primarily with adults, one mainly with youth (aged 12 to 23) and their families, and two with children and their families. The following were some of the key findings of the survey:

- There was a significant level of engagement with services about violence, intimidation or threats in the area: 18% of service users (501/2,752) of 13 projects expressed concern about these issues in the last 12 months.
- Violence, intimidation or threats were most often directed at the individual reporting the issue (32%), or a family member (54%).
- Those most commonly affected were between 26 and 35 years of age.
- The violence, intimidation or threats took place mostly on the street (17%) and at home (17%), although 14% took place via the phone and 9% via the internet.
- The most often cited reason for the violence, intimidation or threats was drug-related (28%).
- The issues affected individuals in a variety of ways, with financial problems the most significant single effect cited (13%).
- About 50% of those affected sometimes/often/always reported the issue confidentially to An Garda Síochána.
- Two thirds (64%) of respondents said they were concerned at least some of the time about their own and a colleague’s safety when supporting individuals/groups with issues relating to violence, intimidation or threats.
- Almost 72% of the projects that responded had a working policy to support staff when dealing with issues of violence, intimidation or threats.

The CityWide Drugs Crisis Campaign, in association with the Health Research Board, is currently conducting a national audit of drug-related intimidation and community violence in drugs and alcohol task force areas throughout the state.¹⁶ The purpose of this project is to develop an evidence-base in order to establish sustainable locally-based responses to the issue.

Drug-facilitated sexual assault: an Irish perspective

A recent journal article provides an Irish perspective on drug-facilitated sexual assault (DFSA) (McBrierty, *et al.* 2013). It discusses the various ways in which DFSA is defined, the limitations associated with establishing its prevalence in Irish society, the various substances that have been found to be associated with it in other jurisdictions, and the complex evidential issues that can arise in trying to establish its basis in law. DFSA was defined by the authors as ‘sexual assault that is facilitated by alcohol, drugs or other intoxicating agents where consent cannot be obtained due to lack of capacity of the victim’ (p. 190). Rape that is facilitated by alcohol, drugs or other intoxicants has often been confused with so-called ‘date rape’. However, the authors explained that ‘date rape’ is just one specific form of DFSA ‘where the victim is on a date with the perpetrator’ and that there are ‘many other situations where drugs and alcohol may be used to facilitate a sexual assault’. The authors explained further that terms such ‘date rape drugs’ have been used to describe drugs that can cause specific biological effects that ‘facilitate sexual assault’ (p. 189). Rape is generally defined in legislation as ‘unlawful sexual intercourse or certain sexual activity perpetrated on an individual where consent is not present, or where consent is not valid due to a lack of capacity of that individual to

¹⁵ For further information about the drug-related intimidation reporting programme, see the National Family Support Network at www.fsn.ie

¹⁶ For further information about CityWide, see www.citywide.ie

consent...due to intoxication'. The article identified three separate circumstances where DFSA can occur. These are where:

- (i) there is an involuntary ingestion of an intoxicating substance by the victim,
- (ii) there is both voluntary and involuntary ingestion of an intoxicating substance by the victim,
- (iii) there is voluntary ingestion of an intoxicating substance by the victim (p.190)

With regard to the prevalence of DFSA in Ireland, the authors highlighted the general under-reporting of rape and sexual assault to An Garda Síochána. In particular, they noted a report of the Rape Crisis Centre (RCC) to the effect that less than one in five victims of rape reported the offence to the gardaí. Furthermore, from an analysis of 10,155 phone calls to the RCC in 2007, 2.3% related to 'drug rape'. This figure, according to the authors, was misleading and related to a confusion between drug rape, date rape and DFSA. As explained above, DFSA is sexual assault facilitated by alcohol, drugs or other intoxicating agents. The substance most commonly involved in DFSA is alcohol, and this is not included in figures presented for so-called drug rape. In Ireland, according to the study, 'alcohol is involved in about half of all adult sexual assaults' (p.191). Consequently, the offence of DFSA is 'hugely underestimated' in Ireland. From a brief analysis of UK case law regarding consent in rape cases where the complainant/victim is self-intoxicated with alcohol, the courts generally hold that 'drunken consent is still considered consent' (p. 192).

One of the major challenges in legally establishing DFSA, however, is the failure to test for the presence of specific substances in victims. In particular, samples need to be taken from victims in a timely manner, while the drugs or alcohol are still detectable. This, according to the authors, is 'especially relevant with drugs such as GHB and ethanol, which clear rapidly from the body'. The study includes a table showing the length of time different drugs generally associated with DFSA remain detectable in urine samples, and this can vary from 7 to 12 hours in the case of alcohol, to 30 days for long-acting benzodiazepines. The authors concluded their analysis by highlighting the under-reporting of crimes of sexual violence in Ireland. DFSA is, they suggested, an issue that cuts across various disciplines including forensic science, medicine and law. Further education of frontline service providers, facilitating a greater awareness of the legal and forensics issues involved, might, the authors suggested, be a positive step towards addressing the general under-reporting of offences in this area.

9.5 Prevention of drug-related crime

The *Youth Justice Action Plan 2014-2018* was launched in October 2013 (Irish Youth Justice Service 2014). It included an analysis of Garda statistics on youth crime and found that alcohol- and public-order-related offences accounted for 40% of youth crime while simple drugs possession offences accounted for 4%, although it was assumed that the latter category of offending was likely to be more prevalent given difficulties in the detection of such offences. In addition, the document suggested that 'a small number of young people may be in drugs supply chains, either through choice or coercion' (p. 9). The action plan identified five general high-level goals and 15 objectives. An action under high-level goal 2, which aimed to strengthen and develop the evidence base about youth offending and the performance of the youth justice system, was to 'profile substance misuse among young people subject to community sanctions/ probation service supervision'. This profiling would, according to the action plan, assist the Probation Service to develop more effective interventions. The action plan also sought to promote early intervention and prevention programmes targeting those at risk of offending behaviour through the Garda Juvenile Diversion Programme (GJDP) and the Garda Youth Diversion Projects (GYDPs.)

The GJDP operates under the Children Act 2001. Published in 2014, the *Annual report of the committee appointed to monitor the effectiveness of the diversion programme* (Committee appointed to Monitor the Effectiveness of the Diversion Programme 2013) reported the following outputs of the GJDP in 2012:

- The total number of individual children referred to the GJDP was 12,246, compared to 12,809 in 2011.
- 25% of children referred to the GJDP were female, while 75% were male, the same as in 2011.

- Public order offences (29%), theft and related offences (24.9%) and damage to property and to the environment offences (10.4%) constituted the three main categories of offences for which children were referred, similar proportions to 2011.
- Controlled drug offences accounted for 1,205 or 5% of the total number of referrals. Of these offences, 965 (4%) involved simple possession, while 194 (0.8%) involved possession for supply.

9.6 Interventions in the criminal justice system

9.6.1 Alternatives to prison

Women in prison

A position paper by the Irish Penal Reform Trust (IPRT),¹⁷ *Women in the criminal justice system – towards a non-custodial approach*, called for a non-custodial approach to be adopted for women offenders and, in the few cases where prison is necessary, for the negative impact of imprisonment on women, and those they care for, to be minimised (Irish Penal Reform Trust 2013).

The position paper began with a review of recent trends in the imprisonment of women in Ireland. In the past decade, the number of women imprisoned had doubled while community-based alternatives remained under-explored. The number of women imprisoned had increased from 1,459 in 2009, representing 11.8% of the prison population, to 2,151 in 2012, representing 15.1% of the prison population. Most women were committed to prison for defaulting on fines, with the bulk of the remainder imprisoned for non-violent offences against property or for theft or road traffic offences. According to the position paper, 'in 2012, out of 2,071 female committals under sentence, 1,687 were for non-payment of court-ordered fines' (p. 4). As a consequence of the high rate of female imprisonment, women's prisons were overcrowded, and temporary release was being over-used. In January 2011, for example, the Dóchas Centre, opened in Dublin in 1999 as a model for women's prisons, was operating at 64% over capacity. A more recent report on the Dóchas Centre by the Inspector of Prisons stated: 'On the 19th June 2013 there were 141 prisoners in the Centre, when the maximum should have been 105' (Reilly Michael 2013) (p. 9). According to the position paper, the other female prison in Ireland, based in Limerick, was also overcrowded, 'with doubling up taking place in up to 10 of the 24 cells' (p. 5), which were designed and only suitable for single occupancy.

The position paper went on to examine the complex needs of many women convicted of offences and the excessive use of remand for women offenders. In addition, many women have caring responsibilities for children and other dependent relatives. These needs and responsibilities were summarised as follows:

Women offenders tend to come from a background of social disadvantage and poverty, and often suffer from mental health problems, substance dependency, accommodation problems and poor family relationships. These issues can make it difficult for women to adhere to bail conditions, which has led to an overuse of remand for women offenders. This in turn has negative implications for children of women who are imprisoned on remand and the employment prospects of these women. A high proportion of women in prison have children. Women also play an important role in caring for dependent relatives. Women who are imprisoned can no longer fulfil their caring responsibilities and the consequences of this can be significant. This is particularly an issue for mothers with babies, due to the absence of a mother and baby unit in either female prison in Ireland. (pp. 11–12)

Problems associated with substance use among women offenders are not just related to drug dependency. The Inspector's report on the Dóchas Centre highlighted the 'serious problems of drugs in the centre' (Reilly Michael 2013). The position paper outlined a number of challenges faced by women leaving prison, particularly related to housing, accommodation and stability, with women ex-prisoners 'at high risk of reoffending'.

¹⁷ The IPRT is a non-governmental organisation campaigning for the rights of people in the penal system in Ireland, with prison as a last resort. For further information visit www.iprt.ie

The position paper reviewed some emerging models of good practice in other jurisdictions, focusing in particular on community-based approaches to women offenders. It also considered models recently developed in Ireland. It concluded with two primary recommendations.

1. In relation to adopting a non-custodial approach to women offenders, future policy and legislative development should be informed by a number of principles, including the following:
 - Where a woman is accused of a minor, non-violent offence, the default position should be that she will have a non-custodial sanction imposed...such as community service orders, gender-specific diversion programmes, and holistic support services in the community.
 - If a person convicted of an offence is the primary carer of young children, an issue that affects more female than male offenders, the best interests of the children should always be taken into account in determining an appropriate sentence.
2. The negative effects of imprisonment on 'the small number of cases where prison is necessary for women who have been convicted of an offence', and their families, should be minimised. According to the position paper, achieving this will require a number of reforms including:
 - establishing a truly open prison for women,
 - addressing overcrowding in both female prisons,
 - introducing mother and baby units at Limerick prison, and
 - ensuring visiting facilities are non-threatening, child-friendly and permit physical contact and play.

Following on from the position paper, in early 2014 the Probation Service and the Irish Prison Service published a joint strategy – *An effective response to women who offend 2014-2016* (Probation Service and Irish Prison Service 2014). This strategy committed both services to developing a 'range of options which provide an effective alternative to custody, enhance reintegration and reduce re-offending' and to promoting 'awareness and confidence amongst key stakeholders of the significant role of community sanctions in the reduction of re-offending by women' (p. 7).

9.6.2 Other interventions in the criminal justice system

Community courts

The Dublin City Business Association (DCBA) has called for the establishment of a community court as a means of addressing low-level crimes such as vandalism, theft, anti-social behaviour, drug use and drug dealing in the capital. Addressing a seminar organised by the DCBA in January 2014, its CEO, David Brennan, said:

We seek a system that manages the individual.... We envisage a non-adversarial justice system that deals with the underlying causes of the offences and seeks to help the person and provide relevant support services to the perpetrators of these low level crimes and reduce reoffending. We ask the Government to consider establishing a working committee to establish a pilot for Community Courts in the capital. (Dublin City Business Association 2014, 29 January)

The seminar also heard presentations from Julius Lang of the Centre for Court Innovation in New York and from Phil Bowen of its affiliate organisation in the UK.¹⁸ After the seminar both speakers addressed the Joint Oireachtas Committee on Justice, Defence and Equality, which had convened a meeting to discuss the feasibility of introducing such a community court system in Ireland (Lang and Bowen 2014, January 29). There are currently more than 60 community courts in operation internationally, mostly in the United States where they began, and more recently in South Africa, England, Wales, Scotland, Australia and Canada. In a 2007 report making the case for community courts in Ireland, the National Crime Council (NCC) recommended the establishment of such a court in Dublin's inner city to deal with 'quality of life offences committed in the Store Street and Pearse Street Garda station catchment areas' (National Crime Council 2007).

Community courts, sometimes called community justice centres, have a number of characteristics that differentiate them from traditional courts. In particular, according to the NCC report, community courts:

- are designed to help defendants to solve the problems that underlie their criminal behavior,

¹⁸ Both presentations can be downloaded from the website of the DCBA at www.dcba.ie

- hold defendants to account for the specific incidents that brought them to court,
- consult with local stakeholders in setting and accomplishing priorities,
- are pro-active in preventing crime rather than merely responding when a crime has occurred,
- bring the criminal justice agencies (courts, prosecutors, defence lawyers and police) into close co-ordination to address community issues, and
- strive to create an atmosphere which is conducive to engaging communities.

With regard to the last objective, community courts are normally located in a particular locality and their jurisdiction is limited to that neighbourhood. They are presided over by a dedicated judge who can, as a consequence, develop an in-depth understanding of the problems in the area and a familiarity with local stakeholders, supports and services. The logic behind this approach was explained by Julius Lang, in his presentation to the Oireachtas Committee where he referred to the setting-up of the first community court in Times Square, New York, in the early 1990s (Lang and Bowen 2014, January 29). The crime problem in Times Square was 'a combination of complex social, economic, health and other issues and, as such, it defies easy solutions. ... It was a type of crime that did its damage through an accumulation of relatively small but constant insults to the social fabric' (p. 3). Times Square had become a 'mecca for the small and ugly, including street prostitution, open-air drug dealing, drunken brawling, assaults, shoplifting and illegal street trading' (p. 4). The model adopted in response was described as:

... a court with a geographic focus which would harness the power of the justice system to work with the community to solve local problems. ... typical punishment consists of a combination of a community restitution assignment and mandated social services. These responses are delivered quickly, not days or weeks after the fact, often on the same day or next day after sentencing. (p. 4)

Evaluations of community courts have provided mixed results (Henry and Kralstein 2011). Philip Bowen, in his presentation to the Oireachtas Committee, explained that various evaluations had found that community courts can lead to reductions in the use of jail sentences, increased compliance with community-based court orders, decreases in crime such as prostitution and illegal street trading, and positive cost-benefit outcomes (Lang and Bowen 2014, January 29). On the other hand, the recent closure of the North Liverpool Community Justice Centre was prompted by the low caseload coming before the court and the finding that the project did not reduce re-offending at a greater rate than the UK average.

In advocating the establishment of a community court in Dublin, the NCC recommended that its remit should primarily involve responding to public order offences, most of which, the evidence shows, are alcohol-related (Institute of Criminology 2003). (See also the report on the Probation Service survey on youth offending, described in Section 9.4 above, in which alcohol figured prominently.) In response to drug-related offences, a community court could also function as a gateway to treatment services, or indeed, to the Drug Treatment Court, which has been operating in Dublin for many years ((Health Research Board 2013): Chapter 9.6). Substance-related crime and anti-social behavior in Dublin city centre are not new phenomena, but they have attracted a great deal of attention in recent years (Strategic Response Group 2012). The establishment of a community court would represent a novel approach to this old issue.

In July 2014 the Joint Oireachtas Committee on Justice, Defence and Equality published its report on community courts and recommended that a pilot community court be established in central Dublin 'under the supervision of a single judge, supported by an implementation group and with the support of local community groups and services' (Joint Committee on Justice Defence and Equality 2014). Responding to the recommendation, the Minister for Justice and Equality, Frances Fitzgerald TD, stated her intention to bring forward proposals for the establishment of such a court: 'I believe that appropriate planning is the key to getting an effective court in place and it will also entail significant consultation with all stakeholders including the community itself.' (Department of Justice and Equality 2014)

9.7 Drug use and problem drug use in prison

Drug use in Irish prisons, 2011

The NACDA has published the results of a survey estimating the extent of drug use and the prevalence of blood-borne viruses among the prison population in Ireland (Drummond, *et al.* 2014). The survey questionnaire was completed by a random sample of prisoners between February and April 2011. Oral fluid samples were obtained to assess use of specific drugs (cannabinoids, opiates, methadone, cocaine and benzodiazepines) in the 24 to 72 hours preceding the survey and to detect the presence of hepatitis B, hepatitis C and HIV infections.

See Chapter 4.3.2 earlier in this report for a detailed account of the methodology, and of the findings with regard to prevalence and patterns of drug use among prisoners. Chapter 6.2.1 gives an account of the study's findings with regard to the prevalence of blood-borne viruses among the prison population.

9.8 Reintegration of drug users after release from prison

Need for drug treatment in Irish prisons, 2011

As part of the NACDA's survey estimating the extent of drug use and the prevalence of blood-borne viruses among the prison population in Ireland in 2011 (Drummond, *et al.* 2014), participants were asked about their need for drug treatment. See Chapter 5.3 earlier in this report for an analysis of the responses.

Drugs, alcohol and substance use/misuse: policy for children detention schools

The Irish Youth Justice Service (IYJS) published a document setting out a policy framework within which children detention schools should manage issues relating to substance use/misuse (Drugs Policy Working Group and Irish Youth Justice Service 2013). The policy was informed by two key objectives: (1) to keep children detention centres/schools drug- and alcohol-free and free of substance use/misuse, and (2), in respect of young people actively involved in drug and substance use/misuse prior to admission or who are dependent on drugs/alcohol, to provide access to counselling and medical services. The policy document stated that 'individual programmes of care for each child will actively reflect these two key objectives' (p. 4). The policy document covered health, welfare and rehabilitation, education and training issues in relation to substance use/misuse and also provided details on procedures for conducting drug searches and testing.

9.8.1 Drug treatment

The number of clients registered for methadone maintenance treatment (MMT) in prisons on 31 December each year is reported by the Central Treatment List (CTL) (see Standard Table 24 and Chapter 5.3.1 earlier in this report). On 31 December 2013, 9,640 clients were registered for MMT (including those receiving methadone in prison) (personal communication, Caroline Comar, CTL). Of these, 524 (5.4%) received treatment in prisons. The number of clients registered as receiving MMT in prison has increased from 345 in 2004 to 524 in 2013. However, the proportion of clients treated in prison has remained relatively stable over the past number of years. In 2013, the vast majority were male (94%) and the largest proportion (29%) were aged between 30 and 34 years, the same as in 2012.

As part of the NACDA's survey estimating the extent of drug use and the prevalence of blood-borne viruses among the prison population in Ireland, participants were asked about their need for drug treatment (Drummond, *et al.* 2014). They were asked if they ever needed different types of drug treatment while in prison, and whether those services were available to them (within a reasonable time frame) and, if available, whether they used those services. See Chapter 5.3 earlier in this report for an account of the findings.

Drug treatment pharmacists were introduced in Mountjoy Prison in 2008, primarily to ensure the safe, accurate and efficient dispensing of methadone. The pharmacists currently dispense in 13 different locations in the Mountjoy complex. While the safe dispensing of methadone remains the priority, since 2010 pharmacists have also been supervising and managing pharmacist-patient structured methadone detoxification, otherwise known as self-directed detoxification (SDD). Anecdotally this

system has proved successful. However, a review of the outcomes of all pharmacist–patient structured methadone detoxifications in Mountjoy Prison in Dublin between June 2010 and May 2014 was undertaken in order to determine the exact number of prisoners involved in SDD and to assess the outcomes. For the results of this review, see Chapter 5.2.2.2 earlier in this report.

9.8.2 Prevention and reduction of drug-related harm

See Chapter 5.3 earlier in this report for recommendations relating to harm reduction in prisons, contained in the recent NACDA survey on the extent of drug use and the prevalence of blood-borne viruses among the prison population in Ireland (Drummond, *et al.* 2014).

Drug-free units

In October 2013 the Jesuit Centre for Faith and Justice (JCFJ) published a report on the progress achieved under the Irish Prison Service's (IPS) three-year strategic plan 2012–2015 (Jesuit Centre for Faith and Justice 2013); ((Health Research Board 2013): Chapter 9.8.1). With regard to drug-free units (DFUs), the JCFJ stated that DFUs currently existed in seven closed prisons, with 417 spaces available in these units. Despite a commitment by the IPS to establish DFUs in all prisons by the end of 2013, the JCFJ report stated that they were still not available to approximately a quarter of the prison population: 'With no drug-free unit in either prison of the midland complex, which includes Ireland's largest prison, more than 1,000 prisoners do not have access to drug-free accommodation' (p. 19). The report also noted that, according to the Department of Justice, 91% of national drug-free accommodation places were filled. The IPS in its annual report for 2013 stated that the establishment of DFUs in these prisons was a priority for early 2014 (Irish Prison Service 2014).

9.8.3 Prevention, treatment and care of infectious diseases

In 2014 the National Advisory Committee on Drugs and Alcohol (NACDA) published the findings of a study it commissioned 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 study was conducted in 2011 (Drummond, *et al.* 2014). The findings are reported on in this national report as follows:

- Chapter 4.3.2: survey methodology, and the demographic characteristics and prevalence of drug use in the sample population;
- Chapter 5.3: survey respondents' perceptions of their need for drug treatment, and the availability of those services; and
- Chapter 6.2.1: prevalence of blood-borne viruses in Irish prisons.

The authors of the study made the following recommendations for drug treatment services in prison:

- Prisoners on MMT should be placed on an HSE clinic list or GP list to ensure that there is continuity of treatment on release from prison. This would reduce the risk of overdose or early relapse.
- If a prisoner is engaging with counselling, where possible there should be continuity of this treatment on release in order to support transition out of prison and into the community.
- A full range of drug treatment options, encompassing an integrated clinical and psychological approach, should be available in all closed prisons.
- There is a need for drug-free wings and drug-free areas not only for prisoners who do not use drugs but for those who wish to avoid relapse.
- As the women's prison was included in the 'very high'¹⁹ drug-use prison category, it is recommended that there be a specific strategy for the needs of women in order to improve their outcomes.

9.8.4 Prevention of overdose-risk upon prison release

The report by the JCFJ, discussed above in Section 9.8.2, also argued that, despite the IPS strategic plan, there was 'inadequate planning for the continuation of drug treatment on release' and that this 'continues to hamper the effectiveness of drug treatment services in the Irish prison system'. The

¹⁹ See Chapter 5.3 earlier in this report for an explanation of 'very high' drug-use prison category.

report recommended the provision of custodial drug treatment, as provided for in section 28 of the Misuse of Drugs Act, 1977:

Custodial drug treatment, as set out in the act, allows the court to order that a person convicted of certain drug offences be detained in a custodial drug treatment centre for up to one year, and that on successful completion of such a programme, a period of probation or suspended sentence would be imposed in lieu of imprisonment.the existing provisions in legislation should be considered by the courts in the sentencing of drug-related offences. ((Jesuit Centre for Faith and Justice 2013): p.18)

9.9 Reintegration of drug users after release from prison

Research on recidivism

The IPS, the Probation Service and the CSO have established a partnership to conduct research on prisoner recidivism and on re-offending rates among offenders on supervision in the community ((Health Research Board 2013): Chapter 9.9). Two studies were published by the CSO in December 2013. The first study, of probationer recidivism, was based on an analysis of individuals who were placed on probation orders or community service orders in the year 2008 and their subsequent levels of re-offending (Central Statistics Office 2013a). Recidivism, in this context, relates to the probationer's first subsequent conviction. The study found that over 40% of offenders re-offended within three years. Re-offending rates differed significantly, however, 'when considering demographic factors, type of probation service supervision and the initial offence' for which the offender was placed on probation. Recidivism was higher among males than females, and among younger offenders. When compared with a recidivism study of a 2007 cohort (Irish Prison Service and Central Statistics Office 2013) and ((Health Research Board 2013): Chapter 9.9), the study showed that the recidivism rate among the 2008 cohort fell for most offence groups, including controlled drug offences, where it decreased by 3.3%. However, there was a rise in recidivism for fraud, deception and related offences. With regard to the type of probation, of those placed on community service orders (n=1,205), 38.4% re-offended within three years, while among those issued with probation orders, the rate was 42.3%. In terms of offence type, the highest rates of recidivism were for burglary and related offences and weapons and explosives offences.

The second study, of prisoner recidivism, found that in 2008, 5,489 individuals were released from the custody of the IPS and, of these, 2,802 (51%) re-offended within three years (Central Statistics Office 2013b). Most of those who re-offended did so within six months of their release. When compared with a 2007 cohort of released prisoners, the study found that there was a 4.35 decrease in the recidivism rate; the recidivism rate fell among all age groups and most offence groups. However, unlike the study of probationer recidivism, the study of prisoner recidivism showed there was a rise in recidivism for controlled drug offences between 2007 and 2008, from 43.8% to 49%.

Community return

The Community Return scheme is a joint Probation Service and IPS initiative whereby selected prisoners are granted temporary release on condition they perform unpaid supervised work in the community ((Health Research Board 2013): Chapter 9.9). Both services report continued success in the development of this scheme in 2013, with 396 structured releases provided, exceeding the annual target of 300 (Irish Prison Service 2014), (Probation Service 2014).

10. Drug Markets

10.1 Introduction

The first comprehensive study of illicit drug markets in Ireland is due to be published by the National Advisory Committee on Drugs and Alcohol (NACDA) and the Health Research Board (HRB) in late 2014. A detailed summary of the relevant findings from this study were presented in the National Report for 2011 (Health Research Board 2011) (Chapter 10). Most of the data from that study are not yet available, however. Data from several other information sources which give indications of the nature and size of the illicit drugs market in Ireland are presented here.

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 Chapter 2.1 of this report, asks respondents how they obtained individual substances (who from and under what circumstances), where did they obtain them (in what type of location) and how easy were they to obtain. The European School Survey Project on Alcohol and Other Drugs (ESPAD), reported in the National Report 2012 (Health Research Board 2012) (Chapter 2.3), contained a question, the answer to which indicated 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)?’

Data on drug seizures by **Customs Drug Law Enforcement** (CDLE) and the Garda Síochána sometimes 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. 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.

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 (An Garda Síochána or CDLE) 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. Occasionally, the FSL conduct ad hoc studies on drug seizures and purities and these are reported when available.

Drug prices are not regularly reported on in Ireland. However, An Garda Síochána monitor drug markets on a nationwide basis annually and record current drug values. These are also reported when available.

10.2 Supply to and within the country

10.2.1 - Drugs origin: national production versus imported

See National Report 2013 for most recent information (Health Research Board 2013).

10.2.2 Trafficking patterns, national and international flows, routes, modi operandi; and organisation of domestic drug markets

Forced labour in the production of cannabis is the subject of a research report by the Migrant Rights Centre Ireland (MRCI) (Migrant Rights Centre Ireland 2014). According to MRCI, this phenomenon involves human trafficking for the purpose of criminal exploitation. The study examined trafficking for cannabis production 'specifically focusing on cases and reports where Vietnamese and Chinese nationals were involved' (p.1). The research is part of a wider European study led by the Anti-Slavery International (ASI) Race in Europe project. ASI has identified a trend of victims being trafficked from Vietnam to Ireland via the UK in recent years.

In Ireland, human trafficking for criminal exploitation has only recently been criminalised, under the Criminal Law (Human Trafficking) (Amendment) Act 2013. Consequently, there is limited available

data on the effect of the legislation. The MRCI study involved semi-structured interviews with members of the legal profession, the Anti-Human Trafficking Unit (AHTU) of the Department of Justice and Equality, which was established in 2008, the Human Trafficking Investigation and Co-ordination Unit within An Garda Síochána, established in 2009, and the Chaplain Service at Mountjoy Prison in Dublin. An analysis of media articles and press releases was also conducted and a number of case studies were presented in the MRCI report.

The report highlighted the increase in domestic cannabis cultivation in Ireland in the last five years, noting the dismantling of 500 cannabis cultivation sites by the gardaí during 2011. It referred to a recent EU drug market study by the EMCDDA and Europol which reported the involvement of Vietnamese and Chinese organised crime groups (OCGs) in cannabis cultivation in Ireland (European Monitoring Centre for Drugs and Drug Addiction and Europol 2013). (For a review of this study, see Chapter 10.2.2 of the 2013 National Report (Health Research Board 2013).) According to the MRCI, there were 80 people of Asian origin in Irish prisons in 2013 for drug-related offences, with 50 of these in custody for cannabis cultivation. The report referred to numerous newspaper and online media articles about cases involving Vietnamese and Chinese nationals, and presented two case studies, of which abridged versions are given here:

- MR W was offered the opportunity to move to Ireland from the UK, where he had been paid below the minimum wage for a number of years. He was offered work in a Chinese restaurant as a porter. On arrival in Ireland, he was taken to a small house in a rural location. He was told to water the plants in the house and that, if he tried to escape, he would be killed by the recruiter's boss, who was Irish. W escaped and contacted An Garda Síochána. He was hospitalised for a number of days suffering from exposure. He was then arrested on drugs charges and later imprisoned. The courts requested An Garda Síochána to conduct an assessment of human trafficking. Trafficking was not identified by the relevant Garda in this case.
- Mr B, a Vietnamese national, was offered a job in Ireland as a gardener. He was smuggled out of Asia and ended up in an industrial estate in rural Ireland. He was locked in a barn and ordered to look after hundreds of plants and control the hoses, lights and heaters. He slept on a mattress and was brought food once a week. He had no idea what country he was in, but he knew he was minding a cannabis factory. When police located the barn, they found Mr B locked inside. Through an interpreter he told them he had been kept as a slave, forced to tend to the plants and threatened with violence. He told them he had received no money. Mr B was charged with possession of the plants and faces a mandatory minimum ten-year prison sentence.

The report stated that, 'out of all the Vietnamese nationals who have been arrested and charged with cannabis cultivation since 2010, no cases of trafficking for forced labour have been identified by An Garda Síochána' (p. 5); as a consequence, 'potential victims are being prosecuted, convicted and imprisoned for crimes they may have been forced to commit – while their traffickers enjoy impunity' (p. 5). MRCI argued that the inability of An Garda Síochána to identify victims in such circumstances has created the need for such victims to be 'formally identified' by an agency such as the Health Service Executive, with the co-operation of MRCI, so that victims can receive the care and attention they require.

Among the study's recommendations were the following:

- All cases of potential trafficking for forced labour in cannabis production should be investigated for human trafficking by An Garda Síochána.
- An independent national rapporteur should be appointed by the government to identify trends in human trafficking and address problems of lack of identification and prosecution.
- Victims should be provided with a reflection and recovery period, safe accommodation, health care, counselling and financial supports where they have been identified as a suspected victim of human trafficking.
- Training needs to be provided by ASI and MRCI for investigators, prosecutors, judiciary, and the legal profession to equip them with the skills to identify such victims.
- A non-punishment clause should be included in the Criminal Law (Human Trafficking) Act 2008 to ensure victims of trafficking are exempt from prosecution for offences they were forced to commit.

MRCI intends to conduct further research in this area in the future as more information becomes available.

10.3 Seizures

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).

10.3.1 Quantities and numbers of seizures of all 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 2004 and 2013. The total number of drug seizures increased from 5,299 seizures in 2004 to a peak of 10,444 seizures in 2007. Between 2008 and 2010, the number almost halved, to 5,477. This decrease can be explained primarily by the significant decrease in cannabis-type substances seized. Although, as explained in Section 10.1 above, not all drugs seized by law enforcement are necessarily analysed and reported by the FSL, it is difficult to know if the reduction in cannabis-related seizures reflects a decline in cannabis use or a reduction in law enforcement activity. Following a slight increase in 2011, cannabis seizures have trended downwards slightly.

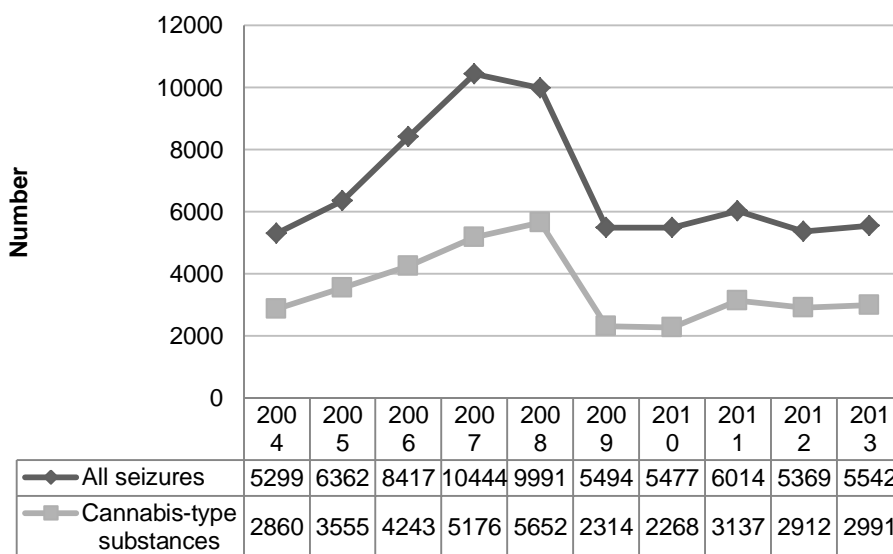


Figure 10.3.1.1 Trends in the total number of drug seizures and cannabis seizures, 2004–2013

Sources: FSL 2005–2014 unpublished data

The decrease in cannabis seizures between 2008 and 2010 may also be partly explained by a change in the nature of cannabis use, with people moving from resin to more potent forms of cannabis, such as herbal cannabis. For example, Figure 10.3.1.2 shows that although seizures of cannabis resin decreased between 2009 and 2013, seizures of cannabis plants increased steadily between 2007 and 2011, with a slight decrease between 2011 and 2013. Herbal cannabis seizures almost doubled between 2009 and 2011, from 981 to 1,833, and plateaued in the two subsequent years. That there has been a move in consumption away from cannabis resin and towards more potent forms of cannabis is supported by the findings of the 2010/11 all-Ireland prevalence survey on drug use (National Advisory Committee on Drugs and Alcohol 2013).

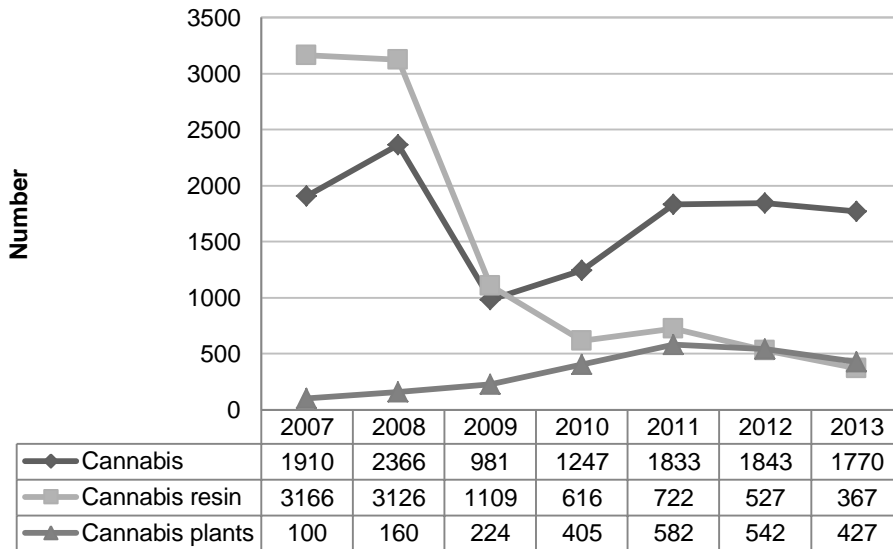


Figure 10.3.1.2 Trends in the total number of drug seizures by cannabis type, 2007–2013

Sources: FSL 2008–2014 unpublished data

Other controlled drugs

The reduction in the total number of reported seizures since 2008 shown in Figure 10.3.1.1 above may also be explained by a reduction in the number of seizures of other drugs. Figure 10.3.1.3 shows trends in seizures for a selection of drugs, excluding cannabis, between 2007 and 2013. There was a significant decline in seizures of cocaine and heroin between 2007 and 2011. Although heroin seizures increased slightly in 2012, they decreased again in 2013. Cocaine seizures have continued on a downward trend since 2008. Seizures of ecstasy-type substances also decreased significantly between 2008 and 2010. However, in 2011, they increased by more than 900%. This upward trend continued in the subsequent two years.

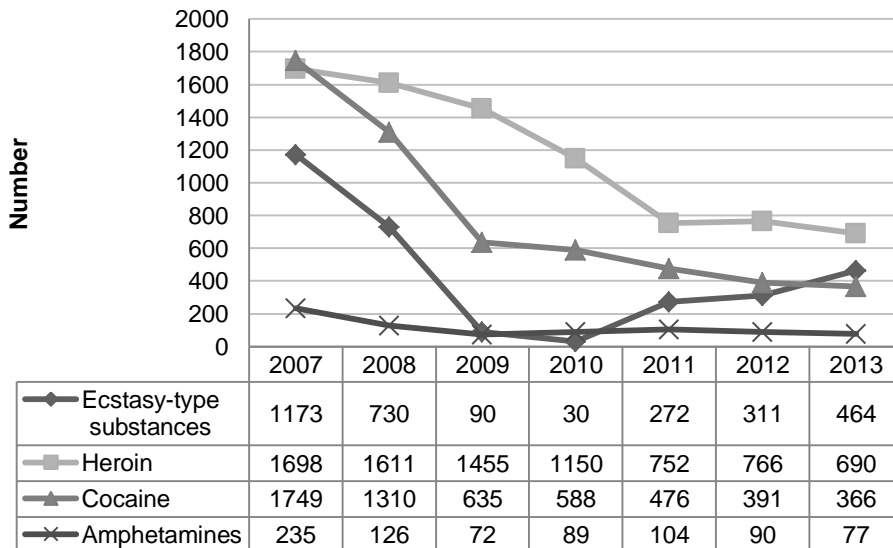


Figure 10.3.1.3 Trends in the number of seizures of selected drugs, excluding cannabis, 2007–2013

Sources: FSL 2008–2014 unpublished data

Illicit street-level retail market in prescription drugs

Another factor that may be impacting on the seizure trends for illicit drugs is the illegal street sale of prescription drugs. This has emerged as an important issue in the Irish drug scene in recent years (see the 2012 and 2013 National Reports (Health Research Board 2012) (Chapter 1.2), and (Health Research Board 2013) (Chapter 10.3). The government is currently reviewing the Misuse of Drugs Regulations with a view to introducing additional controls on certain prescription drugs being traded illicitly (Health Research Board 2013) Chapter 1.2.2).

Table 10.3.1.1 shows trends for some of the main prescription drugs, primarily benzodiazepines and Z-hypnotics, seized by An Garda Síochána and analysed by the FSL in recent years. There has been

a significant increase in the seizures of alprazolam and diazepam since 2009, while seizures of zopiclone have trebled since 2009.

Table 10.3.1.1 Seizures of a selection of benzodiazepines and z hypnotics 2009-2013

	2009	2010	2011	2012	2013
Alprazolam	42	89	121	111	145
Diazepam	270	448	479	463	450
Flurazepam	34	37	46	52	35
Zopiclone	67	138	155	0	205

Source: FSL 2010–2014 unpublished data

Table 10.3.1.2 All drugs seized that were reported on by the FSL, 1 January–31 December 2013

Drug	Quantity	No.Cases
Alprazolam	155,665 tablets	145
Amphetamine	22, 735 grams	77
Buprenorphine	145 tablets	2
BZP	1,245 tablets, 14.63 grams	7
Cannabis	1,101,745.625 grams	1770
Cannabis resin	677,246.359 grams	367
Cannabis plants*	6,309 plants	427
Chlorpheniramine	241 tablets	2
Clonazepam	2,032 tablets	16
Cocaine	65,975.100 grams	366
Diamorphine (Heroin)	60,663.689 grams	690
Diazepam	96.766 grams 92,049.034 tablets	450
Dihydrocodeine	281 tablets, 1.5 gram	7
Ephedrine	226 tablets	3
Ecstasy MDMA	462,934 tablets	434
Elephedrone	13.057 grams	1
Flunitrazepam (Rohypnol)	1,639 tablets	6
Flurazepam	44 tablets 783 capsules	35
Fluoroamphetamine	317.946 grams	5
JWH-018	1,042.180 grams	4
JWH-073	3.150 grams	1
Ketamine	60.229 grams	19
LSD	889 squares	10
MDEA	2,149 tablets	30
Methandienone**	434 tablets	9
Methadone	7,062 mls	26
Methylamphetamine	2,936.019 grams 4 tablets	37
Methylone	1,347.855 grams	12
Methyltestosterone	805 tablets	11
Morphine	409 tablets	2
Phenacetin	12,763.827 grams	5
PMA	216 tablets	5
PVP	22,096.144 grams	81
Sildenafil**	1116 tablets	19
Stanozolol**	502 tablets	5
Temazepam	707 tablets	6
Triazolam	140 tablets	7
TFMPP	5,313 tablets	26
Zolpidem	5,379 tablets	7
Zopiclone**	16,226 tablets	205

The list of drugs is a record of main categories of drugs delivered to the FSL and reported on for 2013. There may be some large cannabis/cannabis resin cases without a suspect, in relation to which no analysis was conducted and no weight was determined.

*The number of cannabis plants does not reflect the total number detected as only a sample of the plants is sent for analysis.

** These drugs were not controlled under the Misuse of Drugs Acts, 1977 and 1984.

Source: FSL unpublished data 2014

10.3.2 Quantities and numbers of seizures of precursor chemicals used in the manufacture of illicit drugs

See 2010 National Report for most recent information (Irish Focal Point (Reitox) 2010).

10.3.3 Number of drug production sites (and related facilities) dismantled; description of methods of production; and precise type of illicit drugs manufactured there

The annual report of An Garda Síochána for 2013 reported that there were 28,851 cannabis plants seized from a total of 394 cultivation and/or manufacture incidents as part of ongoing Operation Nitrogen. (For a discussion of this operation, see Chapter 10 in the 2013 National Report (Health Research Board 2013) and page 4 of the 2013 annual report of An Garda Síochána (An Garda Síochána 2014).) The annual report also reported that 157 grow houses were detected during 2013 (p. 40).

10.4 Availability

10.4.1 Perceived availability of drugs, exposure, access to drugs *e.g. in general population, specific groups/places/settings, problem drug users*

As part of a recent Flash Eurobarometer survey on young people and drugs, described in Chapter 1.3.3 earlier in this report, respondents were asked about the perceived availability of drugs. Around a quarter of respondents believed it would be easy to obtain cocaine, new substances that imitate the effects of illicit drugs, and ecstasy; over half believed it would be easy to obtain cannabis.

Table 10.4.1.1 presents the responses from Ireland and the UK, of which Ireland is sometimes regarded as a sub-market for certain drugs, and the EU average with regard to ease of access. The proportion of Irish respondents who responded that it was 'very easy' to obtain certain substances was above the proportion across all EU member states for all substances, except tobacco. Of the Irish respondents, 40% said cannabis was 'very easy' to obtain compared to 29% of respondents across all member states. Ecstasy was regarded as very easy to obtain by 19% of Irish respondents compared to 7% across all member states. Perceived availability of heroin was broadly similar across Ireland, the UK and the EU. In Ireland, relative to the UK, perceived availability was higher for all substances except for new substances that imitate the effects of illicit drugs.

Table 10.4.1.1 Flash Eurobarometer June 2014, number (%) who responded 'Very easy' to the question 'How difficult or easy do you think it would be for you personally to obtain the following substances within 24 hours?'

Substance	EU average	United Kingdom	Ireland
Cannabis	3807 (29%)	167 (33%)	202 (40%)
Alcohol	10561 (81%)	404 (80%)	419 (84%)
Cocaine	1033 (8%)	68 (14%)	74 (15%)
Ecstasy	916 (7%)	55 (11%)	96 (19%)
Tobacco	10439 (79%)	369 (73%)	390 (78%)
Heroin	503 (4%)	21 (4%)	26 (5%)
New substances that imitate the effects of illicit drugs	964 (7%)	66 (13%)	45 (9%)

Source: (TNS Political and Social 2014)

Table 10.4.1.2 presents the answers to a question about the supply of 'new substances that imitate the effects of illicit drugs' during the previous 12 months. Most respondents across the EU reported receiving them from a friend. The second main supply source was a 'drug dealer', with Ireland below the EU average (24%/ vs 27%) but the UK, at 39%, was 12 percentage points higher than the EU average. Only 3% of respondents reported buying new substances via the internet. In Ireland, the proportion was 5%.

Table 10.4.1.2 Flash Eurobarometer June 2014, responses to the question 'Thinking about your use of new substances in the last 12 months, how did you get them?' by number (%)

Country	EU average	United Kingdom	Ireland
Total respondents	508	27	44
I was given or bought them by a friend	347 (68%)	16 (58%)	27(61%)
I bought them from a specialised shop	49 (10%)	5(18%)	7(16%)
I bought them from the internet	15 (3%)	2(6%)	2(5%)
I bought them from a drug dealer	136 (27%)	10 (39%)	11(24%)
Other	29 (6%)	1 (2%)	1(2%)
Don't know/ no answer	7 (1%)	0	0

Source: (TNS Political and Social 2014)

10.4.2 Price of illicit drugs at retail level and wholesale level

It was reported in the media that payments made to prostitutes and the money made from illicit drug deals are to be included in the official record of the wealth generated by the country each year. This story appeared in the printed version of the Irish Examiner on 31 May 2014 (2014c). The CSO, the article reported, 'confirmed that the gross domestic product figures it will release at the end of June will be higher as a result of the inclusion of what the EU describes as "production forbidden by law, e.g. prostitution and production of drugs".' The article stated that the 'move to include illegal trade follows new Eurostat guidelines for countries to include all economic transactions in the statistics, so that those with differing legislation around drugs and prostitution can compare their total economic activity'.

Responding to a Parliamentary Question on the issue, Minister for Finance Michael Noonan TD, stated:

Section 13 of the 1993 Statistics Act provides that the Director General of the Central Statistics Office (CSO) has sole responsibility for, and is independent in, the exercise of the functions of deciding the statistical methodology and professional statistical standards used by the Office, as well as the content of statistical releases and publications issued by the Office. Regarding the challenge of accurately measuring illicit activities, I am informed by the CSO that this is difficult. Statisticians use any available data that can produce a repeatable estimate for these activities over time. The illegal nature of these activities makes it particularly difficult to estimate their level and value. Consequently, the estimation methods used can only be expected to deliver approximations of the actual levels and value of activity. Data are obtained from a range of sources, including the Gardaí and organisations involved in the welfare of prostitutes or drug addicts. International research in these matters is also reviewed by the CSO. The CSO also inform me that there have been no changes to the methodology relating to the measurement of illicit activities recently. (Griffin 2014, 10 June)

National accounts are compiled in the EU according to the European System of National and Regional Accounts (ESA) framework. All EU member states had to adopt ESA 2010 by September 2014. In addition to the ESA 2010 changes, extended estimates for illegal economic activities are also included. A press release issued by the CSO in June 2014 stated:

There has been a requirement to include illegal activities in the National Accounts since the ESA 95 version of the national accounting standards were introduced but a lack of detailed and comprehensive data sources for these activities have been the cause of significant measurement difficulties for all EU member states. The European statistical agency, Eurostat, has agreed recommendations on the estimation and recording of these activities in recent years and now requires each member state to include estimates for illegal activities in their National Accounts before September 2014. To comply as far as possible with the Eurostat requirement, the revised and additional estimates for illegal activities for Ireland are included in CSO's Quarterly National Accounts (QNA) in respect of Q1 2014 and the annual National Income & Expenditure accounts (NIE) 2013 releases (Central Statistics Office 2014) .

The percentages in respect of illegal activities supplied in Table 10.4.2.1 include estimates of not only the smuggling and production of drugs but also fuel and cigarettes and prostitution. It is not possible at present to clarify either the proportion of the total that represents earnings derived from illicit drugs or how this figure was calculated.

Table 10.4.2.1 Ireland's gross domestic product (GDP) on an ESA 2010 basis at current market prices

	2010	2011	2012	2013
GDP	€164.9bn	€171.0bn	€172.8bn	€174.8bn
contribution of:				
Illegal economic activities	0.73%	0.72%	0.70%	0.72%

Source: (Central Statistics Office 2014)

For the latest information on drug prices, see Chapter 10.4.1 and Table 10.3.1.2 in the 2013 National Report (Health Research Board 2013). The only difference from the process reported last year is that

the price of GHB/GBL is currently €1 per ml (Garda National Drugs Unit, personal communication, July 2014).

10.4.3 Purity/potency of illicit drugs

An analysis of heroin and cocaine seizures submitted to the FSL between April 2010 and March 2012 sought to assess the current status of these particular drug markets, 'in order to track changes in the markets, and for comparison to reported European data' (Boyle, *et al.* 2014). This study also sought to establish whether purity plays a role in the pricing of street drugs. This is particularly important in the Irish context as, under the terms of Section 15a of the Criminal Justice Act 1999 (as amended), a mandatory minimum sentence of 10 years applies where a person is convicted of possession of drugs with a market value of €13,000 or more. (For a recent review of this legislation, see Chapter 1.2.2 of the 2013 National Report (Health Research Board 2013)). For the purposes of this legislation, the market value is interpreted as the maximum value a drug could realistically be expected to obtain at street level when purchased by an end user.

Street-level purity data give an indication of the purity of the substance reaching the end user. Unlike markets for legitimate goods, in the illicit drug trade the quality of the commodity is not regulated or guaranteed and therefore is something that can only be assessed by the user after consumption. As a consequence, just like restaurant meals or used cars, illicit drugs are referred to as 'experience goods', as their quality is only fully knowable after use (Reuter and Caulkins 2004). A further complicating factor is that adulterants are added to drugs not only to bulk them up for sale but also to enhance or mimic the effects of the drug for the user. For example, where a user might believe the drugs s/he consumes are of a good quality, this does not necessarily mean that they are of a higher purity. (For further discussion of the role of adulterants in drug markets, see (Coomber 2006).)

In Boyle's analysis of FSL data (Boyle, *et al.* 2014), quantitative analysis to determine drug purity was carried out on randomly selected street-level seizures on a monthly basis during the two-year period of the study. Data were also collected on the type and frequency of adulterants detected in the seizures. Price information for a subset of the cases quantified and also for a number of cases not quantified was obtained from An Garda Síochána. Below, the findings of this analysis are compared with an analysis by Connolly and O'Donovan of earlier seizure purity data conducted by the FSL as part of a national study of illicit drug markets (Connolly and Donovan In press).

Findings in relation to heroin seizures

Connolly and O'Donovan's analysis found an average heroin purity of 45% in a sample of 131 heroin seizures from four distinct markets in 2008/2009. In the Boyle analysis, in a sample of 239 diamorphine (heroin) cases, the mean purity was 47% for 2010, 30% for 2011 and 24% for the first three months of 2012. The study revealed 'a general decline of diamorphine purity over the time period, with the 2012 average being nearly half the average purity obtained for 2010' (p. 2).

Of the 239 heroin samples analysed, 81% contained adulterants/dilutants. The frequency of detected adulterants increased from 67% of cases in 2010 to 100% in 2012. This may help explain the drop in purity during the same period as it was also found that 'the mean purity of heroin samples with no detected adulterants was 58%, whereas the mean purity...containing adulterants was 31%' (p. 2). The main adulterants found were caffeine and paracetamol, usually together.

In a discussion of drug adulteration, Coomber points out that one of the reasons caffeine is commonly found with heroin is that, when heroin is smoked or 'chased', caffeine has been shown 'to enable a higher amount of the heroin (around 76%) to be recovered (i.e. the amount of heroin left available in the 'smoke' which is inhaled), after volatilization (the heating, melting and then vaporization of the drug for inhalation or 'chasing') than when compared to pure heroin alone' (Coomber 2006) (p. 73). Heroin is also commonly adulterated with paracetamol because the latter has approximately the same melting point as heroin and also has analgesic (pain-killing) properties.

As part of the Boyle study described above (Boyle, *et al.* 2014), the Garda National Drugs Unit (GNDU) provided price data for 144 street-level heroin cases submitted to the FSL between 2010 and 2011. The powder weights for these packs ranged from 0.097g to 1.862g, with an average price per gram of €116.71. The most frequent street-pack prices were €20, €25 and €50. There was a

correlation between pack sizes and prices, leading the authors to conclude that ‘the driving factor for diamorphine prices may not be perceived quality, but perhaps the quantity of drug sold, or customer demand in times of limited diamorphine supply’ (p. 3).

Findings in relation to cocaine seizures

In the Connolly and O’Donovan study (Connolly and Donovan In press), a forensic analysis of 93 samples of cocaine found that purity levels were generally very low, averaging 14% across the four local drug markets studied. The Boyle study (Boyle, *et al.* 2014), in which purity was determined for 217 cocaine cases over the 2010–2012 period, made a similar finding, with the average purity remaining fairly stable, at 15% for 2010, 19% for 2011 and 17% for the first three months of 2012. The study also recorded a larger degree of variation in the purities of cocaine samples when compared to those for diamorphine. Ninety-nine per cent of samples contained one or more adulterants, with the main ones being lignocaine, levamisole, phenacetin, caffeine and benzocaine. Similar findings have also been reported from research on the UK drug market, which, given that these are all substances that have either analgesic and/or stimulant properties, showed the ‘purposive nature of such cutting’, or adulteration (Coomber 2006) (p. 76). As part of the Boyle study described above (Boyle, *et al.* 2014), pricing data were obtained from the GNDU for 17 cocaine seizures for which purity was determined during the study period but no correlation was found between price and purity.

When the findings of the study for 2010 were compared to similar data compiled by the EMCDDA, it was found that Ireland’s mean purity of diamorphine was the second highest after Turkey and that it ranked as the third most expensive after Sweden and Latvia. With regard to cocaine data for 2010, it was found that the mean purity of cocaine in Ireland was the lowest reported to the EMCDDA, while the price per gram was the second highest after Luxembourg. The compilation and reporting of drug purity trend data in studies such as this can enhance our understanding of illicit drug markets and also the impact of drug law enforcement interventions on the behaviour of such markets. Studies such as this also enable us to provide some context to changes in the behaviour of street-level drug markets. For example, it is worth speculating whether the decline in heroin purity since 2010 identified in the Boyle study may be linked to the heroin drought of that year, and also whether the poor quality of heroin may have contributed to the rise in the street sale and use of benzodiazepines by opiate users in recent years (see Chapter 1.2 in the 2011 National Report (Health Research Board 2011)).

Comprehensive chemical profiling of drug seizures can also indicate links between seizures in different locations, thereby providing intelligence on patterns of drug supply. Information on the types of adulterants used to bulk up drugs for street sale and/or to enhance their quality for the end user can provide important public health information. At present, however, the purity of drugs in Ireland is not routinely tested (quantified) owing to the resource requirements.

10.4.4 Composition of illicit drugs and drug tablets

These data have never been reported in Ireland.

Part C

13. Bibliography

The National Documentation Centre (NDC) on drug use is Ireland's national alcohol and drugs library. We have a comprehensive collection of drug and alcohol publications which can be accessed at www.drugsandalcohol.ie. The NDC staff compile the bibliography of this National Report on behalf of the authors and link to full text publications where possible.

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13.2 List of relevant databases available on internet

- Central Statistics Office interactive tables Census 1996, 2002, 2006 and 2011
www.cso.ie
- National Drug Treatment Reporting System interactive tables 2004–2012
<http://www.drugsandalcohol.ie/>

For descriptions of relevant databases not currently available on-line, see introductions to chapters 5, 6, and 7.

13.3 List of relevant internet addresses

<http://aldp.ie>
<http://addictionireland.ie>
<http://www.alcoholforum.org/>
<http://alcoholireland.ie/>
<http://www.barnardos.ie/>
<http://www.citywide.ie>
<http://www.cso.ie>
<http://www.dcy.gov.ie/viewdoc.asp?DocID=120>
<http://www.drugsandalcohol.ie/>
<http://www.drugs.ie/>
<http://www.emcdda.europa.eu/>
<http://www.fsn.ie/>
<http://www.garda.ie/>
<http://health.gov.ie/healthy-ireland/national-drugs-strategy/>
<https://www.hellosundaymorning.org/>
<http://www.hpra.net>
<http://www.hpsc.ie>
<http://www.hrb.ie>
<http://www.hse.ie>
<http://www.irishsentencing.ie/>
<http://www.lawreform.ie>
<http://www.ncpe.ie/>
<http://www.popcenter.org/>
<http://www.sphe.ie/>

14. Annexes

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 Misuse of Drugs (Amendment) Regulations 2010 (S.I. 200 of 2010)
 Misuse of Drugs (Designation) (Amendment) Order 2010 (S.I. 201 of 2010)
 Misuse of Drugs (Exemption) (Amendment) Order 2010 (S.I. 202 of 2010)

Bills

Public Health (Alcohol) Bill 2014

Acts

Criminal Justice (Psychoactive Substances) Act 2010 (PSA)
 Criminal Justice Act 2006
 Criminal Justice (Amendment) Act 2009
 Criminal Law (Human Trafficking) (Amendment) Act 2013
 Civil Law (Miscellaneous Provisions) Act 2011
 Fines (Payment and Recovery) Act 2014
 Health Identifiers Act 2014
 Housing (Miscellaneous Provisions) Act 2009
 Misuse of Drugs Acts (MDA) 1977 and 1984
 Misuse of Drugs Regulations 1988
 Road Traffic (No.2) Act 2014
 Road Traffic Act 2002
 Road Traffic Act 1994

14.5 List of abbreviations

ADHD	Attention-Deficit Hyperactivity Disorder
AHTU	Anti-Human Trafficking Unit
AIDS	Acquired Immunodeficiency Syndrome
ALDP	Ana Liffey Drug Project
ANS	Ante-natal screening
ASI	Anti-Slavery International
ATS	amphetamine-type stimulants
BBVs	Blood Borne Viruses
CAMHS	Child and Adolescent Mental Health Service
CDLE	Customs Drug Law Enforcement
CE	Community Employment
COFOG	classification of functions of government
CRC	capture-recapture
CSO	Central Statistics Office
CTL	Central Treatment List
DAIRU	Drugs and Alcohol Information and Research Unit (DHSSPS, NI)
DATFs	Drugs and Alcohol Task Forces
DCBA	Dublin City Business Association
DCYA	Department of Children and Youth Affairs
DD	Dual Diagnosis
DES	Department of Education and Skills (since March 2010)
DEIS	Delivering Equality of Opportunity in Schools

DFSA	drug-facilitated sexual assault
DFUs	drug-free units
DHSSPS	Department of Health, Social Services and Public Safety (NI)
DLM	Drug Liaison Midwife
DoH	Department of Health
DSP	Department of Social Protection
DTCB	Drug Treatment Centre Board
DTF	Drugs Task Force
DUID	Driving Under the Influence of Drugs
ED	Emergency Department
EJAS	Elton John AIDS Foundation
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESA	European System of National and Regional Accounts
ESPAD	European School Survey Project on Alcohol and Other Drugs
ETBs	Education and Training Boards
EU	European Union
FSL	Forensic Science Laboratory
FSN	Family Support Network
GDP	gross domestic product
GJDP	Garda Juvenile Diversion Programme
GNDU	Garda National Drugs Unit
GP	General Practitioner
HBSC	Health Behaviour in School-aged Children Survey
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HIPE	Hospital In-Patient Enquiry scheme
HPRA	Health Products Regulatory Authority
HPSC	Health Protection Surveillance Centre
HRB	Health Research Board
HRDU	High Risk Drug Use
HSE	Health Service Executive
HSM	Hello Sunday Morning
IBDI	Irish Bishops Drugs Initiative
IDUs	Injecting Drug Users
ILP	Individual Learner Plan
IPRT	Irish Penal Reform Trust
IPS	Irish Prison Service
IPU	Irish Pharmacy Union
IYJS	Irish Youth Justice Service
JCFC	Jesuit Centre for Faith and Justice
JPC	Joint Policing Committee
KPI	Key Performance Indicator
LDTF	Local Drugs Task Force
LDATF	Local Drugs and Alcohol Task Force
LRC	Law Reform Commission
LPF	Local Policing Fora
MDA	Misuse of Drugs Act
MMT	Methadone Maintenance Programme
MRCI	Migrant Rights Centre Ireland
MS	Multiple Sclerosis
MTP	Methadone Treatment Protocol
MQI	Merchants Quay Ireland
NACD	National Advisory Committee on Drugs
NACDA	National Advisory Committee on Drugs and Alcohol
NATP	National Addiction Training Programme
NAS	Neonatal Abstinence Syndrome
NCC	National Co-Ordinating Committee
NCC	National Crime Committee

NCPE	National Centre for Pharmacoeconomics
NDRDI	National Drug Related Death Index
NDRIC	National Drugs Rehabilitation Implementation Committee
NDS	National Drug Strategy
NDTRS	National Drug Treatment Reporting System
NGO	Non-Government Organisation
NICC	National Co-ordinating Committee for Drug and Alcohol Task Forces
NICU	Neonatal intensive care unit
NIE	National Income & Expenditure accounts
NPIRS	National Psychiatric Inpatient Reporting System
NSRF	National Suicide Research Foundation
NVDS	National Voluntary Drug Sector
OCGs	organised crime groups
OFD	Oversight Forum on Drugs
PHIRB	Public Health Information and Research Branch
PPO	Prolific and Priority Offender
PQ	Parliamentary Question
PULSE	Police Using Leading Systems
PSA	Psychoactive Substances Act
QNA	Quarterly National Accounts
QuADS	Quality Standards in Alcohol and Drugs Services
RCC	Rape Crisis Centre
RDTF	Regional Drugs Task Force
RSE	Relationship and sexuality education
SDD	self-directed detoxification
SHAHRP	School Health and Alcohol Harm Reduction Project
SLÁN	Survey of Lifestyle, Attitudes and Nutrition in Ireland
SPHE	Social, Personal and Health Education
STI	Sexually Transmitted Infection
TD	Teachta Dála (Member of Parliament)
TDI	Treatment Demand Indicator
THN	Take Home Naloxone
WHO	World Health Organization
WSEs	whole-school evaluations
YoDA	Youth Drug and Alcohol service
YPFSF	Young People's Facilities and Services Fund