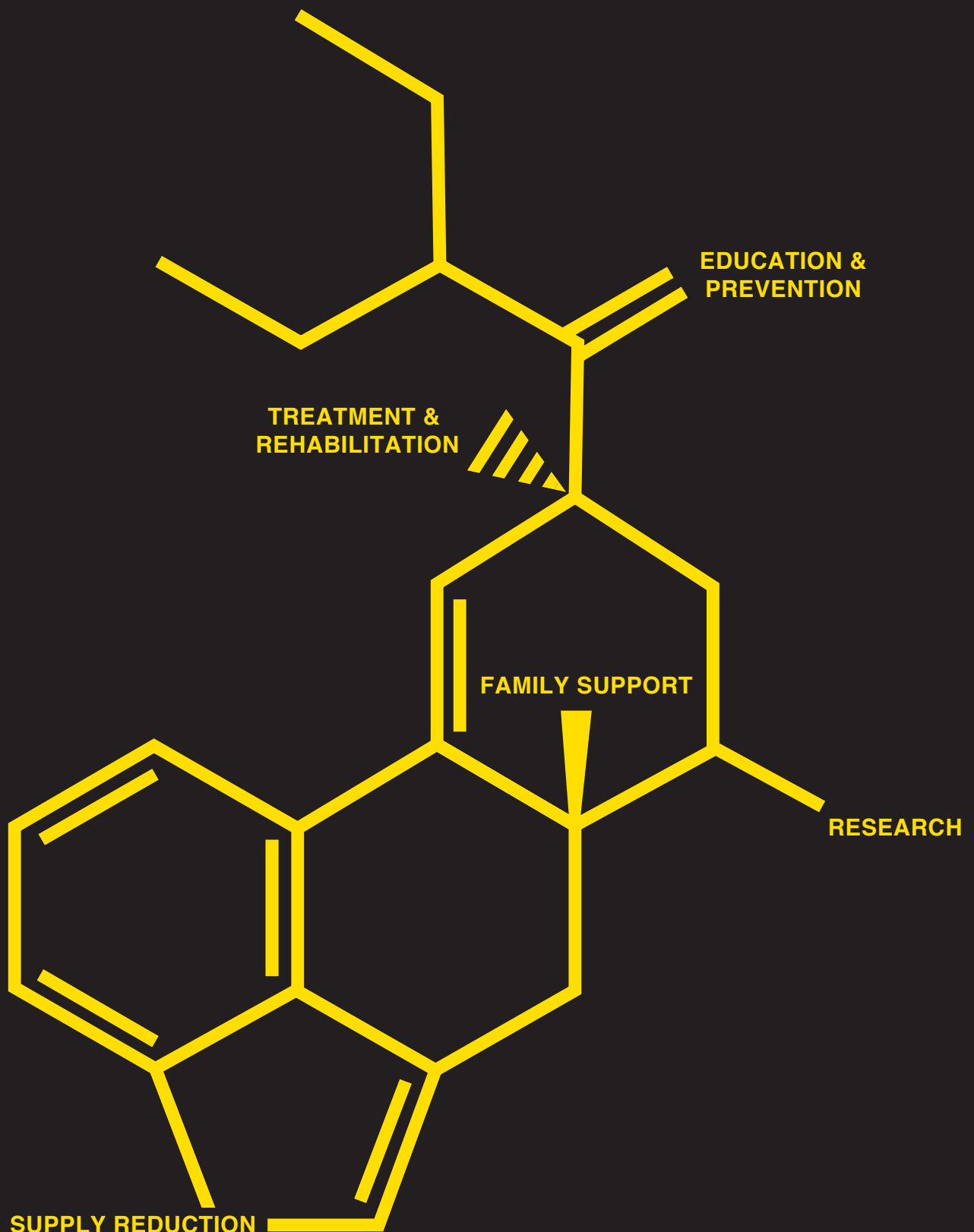


Drug and Alcohol Trends Monitoring System (DATMS) 2018: YEAR 3



Janet Robinson and Jim Doherty
Researchers

CONTENTS

Acknowledgments	2
Introduction	3
1. Executive summary	4
2. Research objectives and model	10
3. Socio-demographic profile of Dublin 15	14
4. Treated drug and alcohol use	22
5. Untreated drug and alcohol use	54
6. Education prevention	66
7. Factors contributing to drug use	75
8. Consequences of drug and alcohol use	89
9. Gaps in service provision	106
References	109
Appendix	110

ACKNOWLEDGEMENTS

We want to thank the research participants for their participation in this research study. We want to acknowledge the local drug and alcohol treatment service providers for providing data and for facilitating the recruitment of research participants. We also want to thank the following organisations for providing data: Health Research Board, Tusla Education Welfare Services, Healthcare Pricing Office of the Economic and Social Research Institute, Neighbourhood Youth Project and Jigsaw Dublin 15. We want to thank the National Advisory Committee on Drugs and Alcohol for permission to use their drug trend monitoring system questionnaire. Thanks are also due to BLDATF staff who contributed greatly to the report: to Ciara Jubani for the provision of data concerning educational psychological assessments, and to Sarah-Jane Leonard, Ann Losty and Linda Silvester for their administrative support.

INTRODUCTION

The Blanchardstown Local Drug and Alcohol Task Force (BLDATF) is one of fourteen Local Drug and Alcohol Task Forces established in 1997 in response to high levels of drug misuse within communities. We are responsible for implementing the National Substance Misuse Strategy, and facilitating a more co-ordinated response in tackling drug and alcohol use and misuse in Dublin 15.

Since 1997, Blanchardstown has greatly developed and grown as an area. Many different services and interventions have been developed by the BLDATF to help the people living in Dublin 15 over that time. Unfortunately, the problems caused by drugs and alcohol have also grown and changed in many ways. Therefore, the interventions that are put in place to ameliorate these problems must also be capable of adapting to this change. A prerequisite for being able to adapt and change services is a thorough, comprehensive and deep knowledge of the problems of the area. We started the Blanchardstown Drug & Alcohol Trend Monitoring System (DATMS) in 2015 to provide us with such an analysis. It is our intention to produce a new report every year to ensure that we will always have a strong, local evidence base for everything that we do.

For the purpose of this study we chose to categorise drug and alcohol use as **treated** and **untreated drug use** rather than as problem and recreational drug use. This is because the question of whether or not drug use is a problem for an individual is a subjective question which can only be properly answered by the individual, their family or close contacts; whereas, the question of whether drug use is treated or untreated is an objective measurement. The term 'recreational' drug use tends to de-emphasise the seriousness of the behaviour. It should be noted that individuals often underestimate the harm to themselves and rarely perceive the harm to the community which results from such behaviours.

1. EXECUTIVE SUMMARY

RESEARCH OBJECTIVES & METHOD

In 2015 we developed our DATMS in Dublin 15. The objective was to establish an evidence base for drug use in Dublin 15 and use this data to inform local service provision. In order to always have current information and to monitor changes over time the study is repeated annually. We published the first report in 2016 (DATMS Year 1), the second in 2017 (DATMS Year 2) and this report documents the third year of our DATMS. The DATMS employs a mixed-method design comprised of primary and secondary data sources.

SOCIO-DEMOGRAPHIC PROFILE OF DUBLIN 15, 2006-2016

- Population increased by 20% from 90,974 in 2006 to 109,895 in 2016
- Population is younger and more ethnically diverse than nationally
- Stabilisation of unemployment levels after an increase during the economic downturn
- Increase in educational attainment of population
- Increase in privately rented housing and decrease in owner occupied housing
- Dublin 15 remains categorised as marginally above average levels of disadvantage; the deprived population decreased from 31% in 2006 to 24% in 2016

TREATED DRUG USE

- Mapping treatment demand identifies that drug and alcohol dependence is a community wide issue affecting all socio-economic groups, though most treated drug users lived in deprived areas

TREATED DRUG USERS AGED UNDER 18s

- Treated cases increased 143% to 124 cases in Year 3
- The majority of cases are male and Irish
- The majority of cases attend secondary schools with DEIS status, identifying the relationship between social deprivation and drug use

- Cannabis herb is the most commonly used drug followed by Alcohol
- Polydrug users account for 93% of cases

TREATED DRUG USERS AGED 18 AND OVER

- NDTRS data reports a reduction in the number of treated cases from 637 in 2016 to 501 in 2017
- The majority of treated cases are Irish, male and aged 25 to 34 years
- 39% of cases are in treatment for drugs for the first time
- The main problem drugs for the majority of cases are Opiates, followed by Alcohol and Cocaine
- The majority of cases are treated for polydrug use
 - Benzodiazepines are the most common second problem drug
- DATMS participants report an increase in the use of Cocaine, Alcohol, Cannabis, Z drugs and Benzodiazepines
- Estimated prevalence rates of substance misuse identify a large proportion of problem drug users in Dublin 15 not in treatment

UNTREATED DRUG USE

All three years of the DATMS report similar profiles of untreated drug use by young people and adults:

- Drug use is reported among all socio-economic groups, a range of ethnicities and in all areas of Dublin 15
- Alcohol, Cannabis herb, MDMA, and Cocaine powder are the main drugs used
- Polydrug use is the norm
- Increases in the use of Cannabis herb, Cocaine powder, Benzodiazepines and Z drugs are reported
- Prevalence rates of drug use estimate 20,015 Dublin 15 residents aged 15 to 34 years recently used alcohol compared with 32,873 aged from 35 years; and 2,771 Dublin 15 residents aged 15 to 34 years recently used illegal drugs compared with 1,011 aged from 35 years

EDUCATION PREVENTION

As a drug prevention measure, in 2017 funding was provided for educational psychological assessments. Sixty young people were assessed; a profile of these cases includes:

- The majority attended primary school, were female, aged from 10 to 15 years and Irish
- Most young people were diagnosed with more than one difficulty or disorder
 - Types of diagnoses included low IQ scores, learning, speech and language difficulties, mental health, emotional and behavioural disorders
- Types of recommendations suggested included learning supports, curriculum modifications or exemptions, and referrals to mental and physical health services
- The need to provide these assessments was evidenced by:
 - Young people waiting two or more years for assessments
 - A significant amount of young people with a range of personal, familial and environmental risk factors for drug use

FACTORS CONTRIBUTING TO DRUG USE

EASY ACCESS TO DRUGS AND ALCOHOL

- Factors contributing to ease of access includes an increase in the number of under 18s dealing drugs
- All three years reported an increase in the availability of Benzodiazepines and Z drugs
- An increase in the availability of Crack Cocaine and Cannabis herb was reported in Year 1 and 3

NORMALISATION OF DRUG AND ALCOHOL USE

- In all three years of the DATMS the normalisation of drug use featured prominently; the common perception is that drugs are widely used, risk free and socially acceptable

FAMILY CONTEXT

- All three years of the DATMS report the family context as a risk factor for the normalisation of drug and alcohol use, the development of inter-generational drug and alcohol dependence, and mental health issues
- Family support services report that 48% of clients sought support due to a family members drug use
- Youth mental ill-health as a risk factor for drug use
 - From Year 1 to Year 3, an increase in the incidence of anxiety related issues among children and young people was reported
 - High prevalence rates of mental health disorders among young Dublin 15 population are reported, along with a large proportion of cases not in treatment

CONSEQUENCES OF DRUG AND ALCOHOL USE

HEALTH CONSEQUENCES

- HIPE data from 2012 to 2017 reports the following:
 - Increase in number of treatment episodes for mental health and behavioural disorders due to drug use among Dublin 15 residents aged 30 and over
 - Increase in number of drug-related poisonings among people living in Dublin 15
- NDRDI data for 2011 to 2015 identifies that actual levels of poisoning deaths in the BLDATF area were lower than expected in most years', except in 2014 when they were higher
- Data suggested that Chemsex was not a significant issue in Dublin 15 among treated drug users

SOCIAL CONSEQUENCES

- All three DATMS years report the negative impact drug use has on family relationships, employment, finances, housing and education
 - Many treated drug users and their family members experience more than one of these issues
 - These social consequences were reported to be a barrier to rehabilitation

DRUG-RELATED CRIME

- All three years of the DATMS report the existence of drug-related crime in Dublin 15
- Year 3 reports drug debt intimidation as the most frequently occurring crime with an increase in its frequency from Year 2 to 3

SERVICE PROVISION GAPS IDENTIFIED BY RESEARCH PARTICIPANTS

PREVENTION

- Improve drug prevention programmes
- Funding for BLDATF public awareness campaign 'Think before you buy'
- Increase access to skills based mental health wellbeing programmes

TREATMENT

- Improve treatment programmes for young people
- Improve access to detoxification programmes
- Resume community drug and alcohol team and community alcohol programme service provisions
- Improve access to childcare to increase access to treatment and rehabilitation services
- Develop out-of-hours treatment services
- Increase public knowledge of local service provision
- Increase access to mental health services

REHABILITATION

- Improve access to aftercare services, training, employment and housing

FAMILY SUPPORT SERVICES

- Improve support services for families of drug users

SUPPLY REDUCTION

- Develop guidelines for the management of drug debt intimidation without involving the Gardai

GAPS IN DATMS EVIDENCE BASE

- Comprehensive profile of family members affected by drug use and untreated adult drug use
- Create a more robust profile of treated drug use by improving the quality of data returns to the NDTRS

2. DATMS RESEARCH OBJECTIVES & MODEL

DATMS RESEARCH OBJECTIVES

Establish evidence base for drug use in Dublin 15 to inform local service provision	• Profile drug use in Dublin 15 • Identify gaps in service provision
Repeat annually	• Always have current information • Monitor changes in drug use over time

DATMS RESEARCH MODEL

The DATMS model employs a mixed-method design comprised of the following primary and secondary data sources:

PRIMARY QUANTITATIVE DATA: DATMS Year 3 (2017)	
Drug treatment data	• Profile drug users treated in Dublin 15* • Treated drug users area of residence visually represented on Dublin 15 map^ • Changes in drug use and drug related issues~
Drug prevention & education	• Educational psychological assessments: profile of cases and diagnoses
Untreated drug use~	• Drugs used and changes in drug use • Factors contributing to drug use
Family members affected by drug use~	• Profile of family members attending local community services • Impact of drug use on families

* DATMS Year 1 and 2 collected treatment demand data from local services. This method continued for Year 3 concerning treated cases aged under 18. For treated adult cases, Year 3 has utilised treatment demand data from the National Drug Treatment Reporting System (see Secondary Data Sources). The reasons for this change as follows:

- The new NDTRS LINK (online web-based reporting system) has reduced data reporting times. Prior to this NDTRS data was time lagged and DATMS data was used to produce current data.
- To increase the quality of the data. DATMS data did not have unique identifiers and treated drug users were counted more than once if they attended more than one local service. While the NDTRS data has no unique identifiers, the system has the capacity to remove duplicate cases thus providing more robust data.
- To end duplication in data reporting i.e. local services reporting to BLDATF and NDTRS.

^ In Year 2 we mapped treatment demand data in Dublin 15 for two reasons. Firstly, to identify the area of residence for treated drug users. Secondly, to find out the extent of the drug and alcohol dependence throughout Dublin 15. For mapping purposes, the map of Dublin 15 was divided into quadrants that were 0.45 kilometres square (Year 2 reported 0.25 kilometres square in error). We repeated this mapping in Year 3 to identify any changes in the extent of drug and alcohol dependence throughout Dublin 15. Data was provided by five local treatment services. Two of the services are for under 18 year olds: Substance Abuse Service Specific to Youth (SASSY) and Blanchardstown Youth Service Drug Education/Prevention programme. Three of these services are for adults: these services are Mulhuddart/Corduff Community Drug and Alcohol Team, Tolka River Project and Coolmine Therapeutic Community (Coolmine Lodge, Ashleigh House, Community Alcohol Programme).

~ Year 1 and 2 used qualitative methods to collect data concerning treated and untreated drug use and the impact of drug use on families. This method is more resource hungry than quantitative methodologies. Due to limited resources, Year 3 used quantitative methods to collect and analyse this data. A questionnaire was devised to collect data and descriptive statistics were used to analyse it.

RESEARCH PARTICIPANTS

The total number and type of participants that contributed to Year 3 is reported in the table below (Table 2.1).

Table 2.1: Number and type of participants, DATMS Year 3

Participant type	Number of participants
Service providers	44
Treated drug users*~	31
Untreated drug users*~	12
Young people*~	8
Family members affected by drug use~	5
Total	100

*Includes participants aged 16+ years

~Includes participants from the following ethnic backgrounds: Irish, Irish Traveller, Irish African, Irish Eastern European, Irish Asian

METHODOLOGICAL LIMITATIONS

From Year 1 to 3, the recruitment of some target groups was difficult. Accessing untreated drug users was challenging especially those aged 25 years and over. This resulted in the production of limited data concerning this cohort of drug users. Analysis of the NACDA Drug Prevalence survey data (see Secondary Data Sources) is presented which will in some way ameliorate this issue. The recruitment of treated drug users aged 18 to 24 years and family members affected by drug use was also difficult, with limited participants from these target groups.

In comparison with Year 1 and 2, Year 3 participants were more ethnically diverse and provided more data concerning drug use among different ethnicities. Year 3 was the first time data was provided about untreated drug use among young people from an Irish Asian background. Despite this, more participants from different ethnicities are required to increase our knowledge of drug use among different communities.

The establishment of the new Dublin 15 Community Addiction Team will have the following target groups: Young people, families and new communities. Thus, going forward it is hoped that with the assistance of this service the recruitment of participants will be less challenging.

Data collection extended beyond the forecasted timeframe due to delays with data returns from local services and difficulties recruiting participants. This delayed the publication of the report. DATMS Year 4 methodology will be amended to speed up the research process.

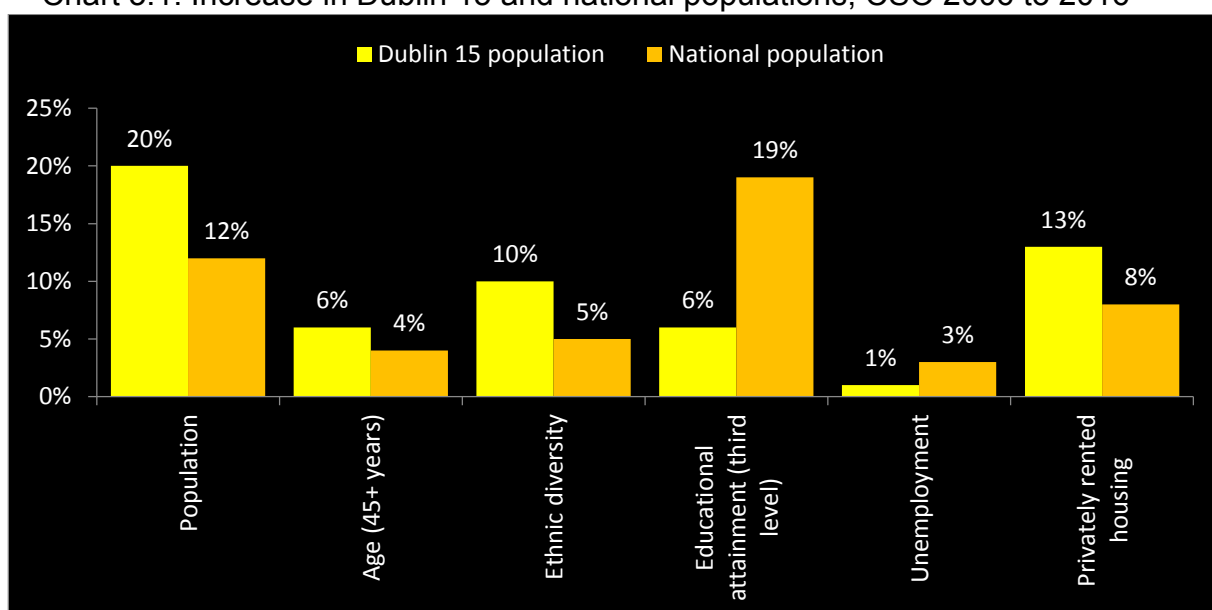
SECONDARY DATA SOURCES	
Drug prevalence indicators	• All-Ireland Drug Prevalence Survey (National Advisory Committee on Drugs and Alcohol): prevalence of drug use among general population aged 15+ years
Drug treatment indicators	• National Drug Treatment Reporting System (Health Research Board): treated drug and alcohol use in Ireland • Central Treatment List (Health Service Executive): methadone maintenance treatment for opiate dependence in Ireland
Other drug-related indicators	• Hospital In-Patient Enquiry Scheme (Healthcare Pricing Office): drug and alcohol related morbidity from in-patient discharges from national acute hospitals • National Drug-Related Deaths Index (Health Research Board): census of drug-related deaths in Ireland
Impact of drug use on education	• Tulsa Education Welfare Service: school absenteeism rates in Dublin 15

See DATMS Year 1 for more detailed information concerning the rationale for the development of the DATMS, its methodology and ethical considerations.

3. SOCIO-DEMOGRAPHIC PROFILE OF DUBLIN 15, 2006-2016

Analysis of the census data provides the socio-economic profile of the Dublin 15 and national populations from 2006 to 2016 (Central Statistics Office (CSO), 2006, 2011, 2016). Over this period, the Dublin 15 and national populations increased (Chart 3.1).

Chart 3.1: Increase in Dublin 15 and national populations, CSO 2006 to 2016



- Dublin 15 population increased more than national level
- Dublin 15 population younger than national level; in 2016, 27% of Dublin 15 population aged 45+ years (37% nationally)
- Dublin 15 population more ethnically diverse than national level; in 2016, 63% of Dublin 15 population White Irish compared with 82% nationally
- Larger increase in educational attainment nationally than in Dublin 15; however, in 2016, proportion of Dublin 15 population with third level qualification larger (54%) than national (48%)
- Similar trend in Dublin 15 and nationally with the stabilisation of unemployment levels after an increase during the economic downturn; in 2016, 8% of Dublin 15 and national population unemployed
- Larger increase in privately rented housing in Dublin 15 than nationally; in 2016, 25% of Dublin 15 households privately rented (18% nationally)

SOCIO-DEMOGRAPHIC PROFILE OF DUBLIN 15, 2006-2016

- Dublin 15 more affluent than national levels; despite this, Dublin 15 remains categorised as marginally above average levels of disadvantage (national population categorised as marginally below average levels of disadvantage)

The following charts report the socio-demographic profile of the Dublin 15 population from 2006 to 2016 (Charts 3.2 to 3.8).

Chart 3.2: Dublin 15 population, CSO 2006 to 2016

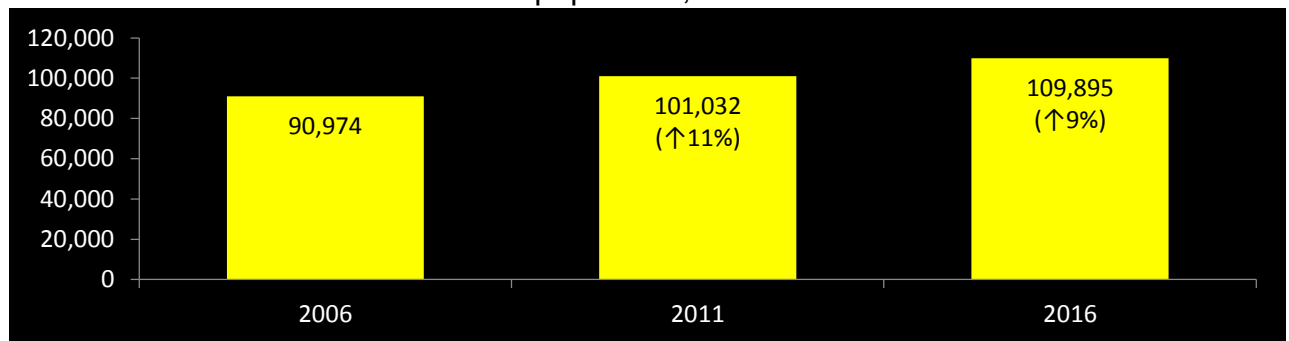


Chart 3.3: Dublin 15 population by age range, CSO 2006 to 2016

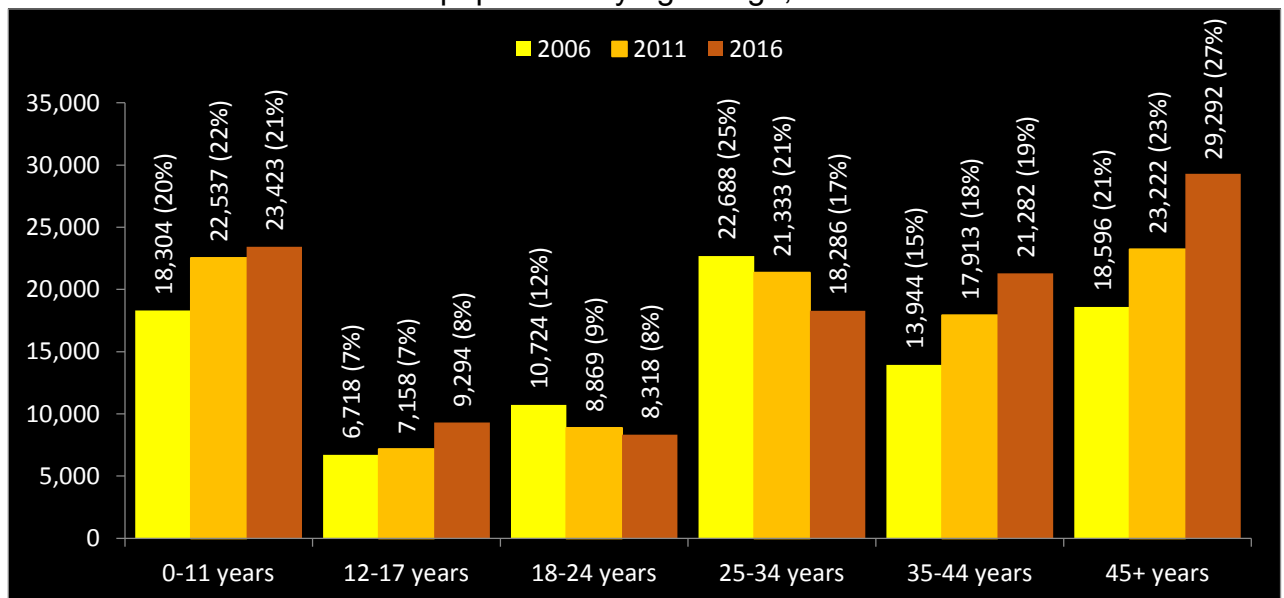
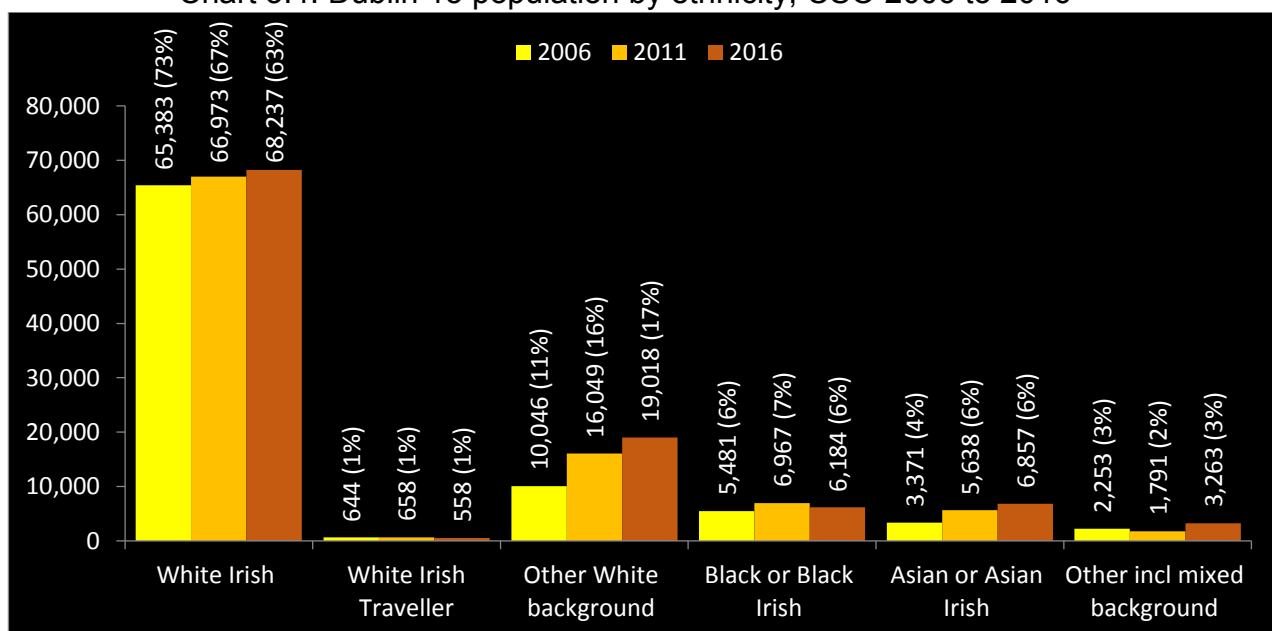
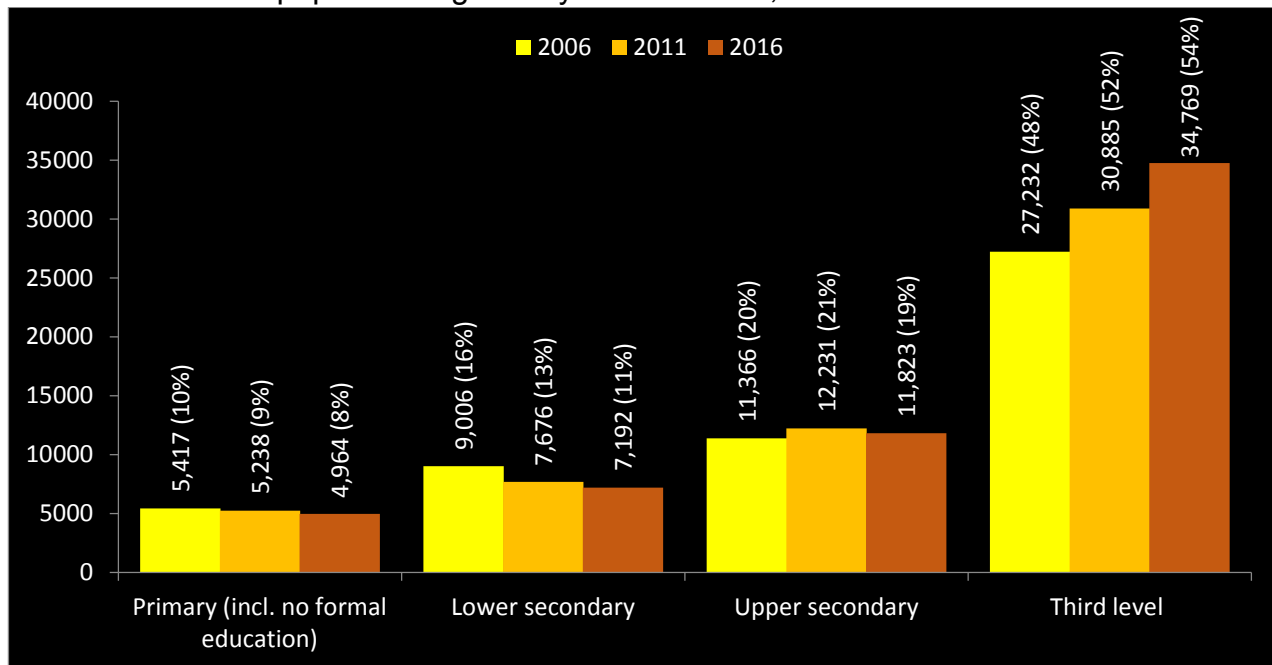


Chart 3.4: Dublin 15 population by ethnicity, CSO 2006 to 2016



Category totals less than population totals as category 'unknown' not included

Chart 3.5: Educational attainment of Dublin 15 population aged 15 years and over, CSO 2006 to 2016



Category totals less than population totals as category 'unknown' not included

SOCIO-DEMOGRAPHIC PROFILE OF DUBLIN 15, 2006-2016

Chart 3.6: Economic status of Dublin 15 population aged 15 years and over, CSO 2006 to 2016

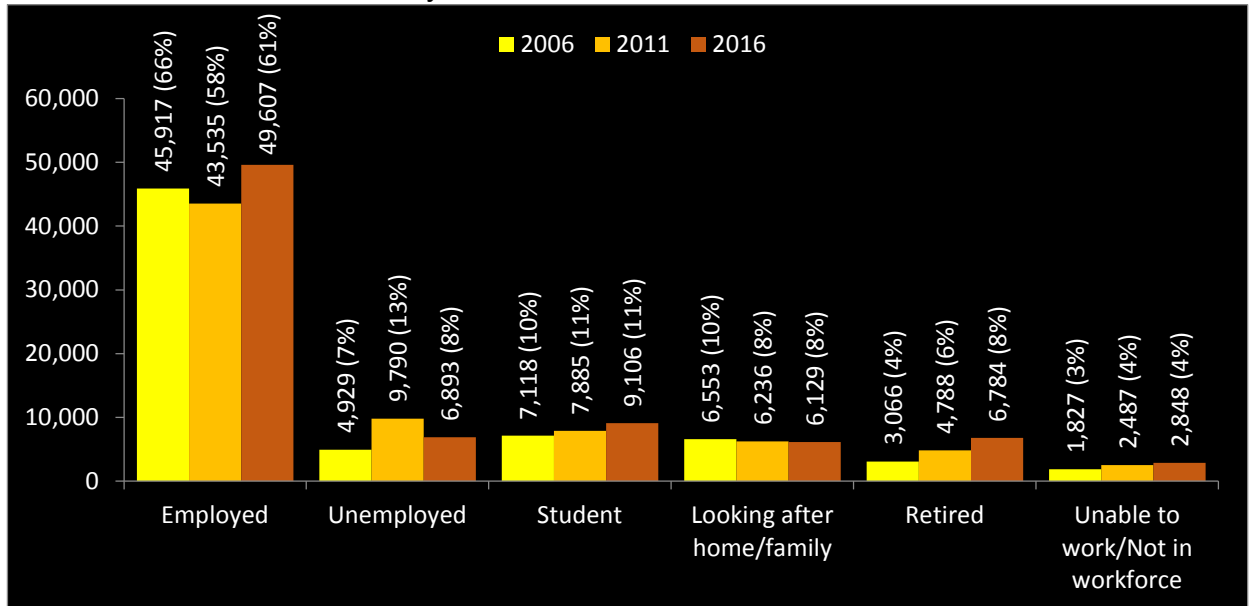


Chart 3.7: Occupational categories of Dublin 15 population, CSO 2006 to 2016

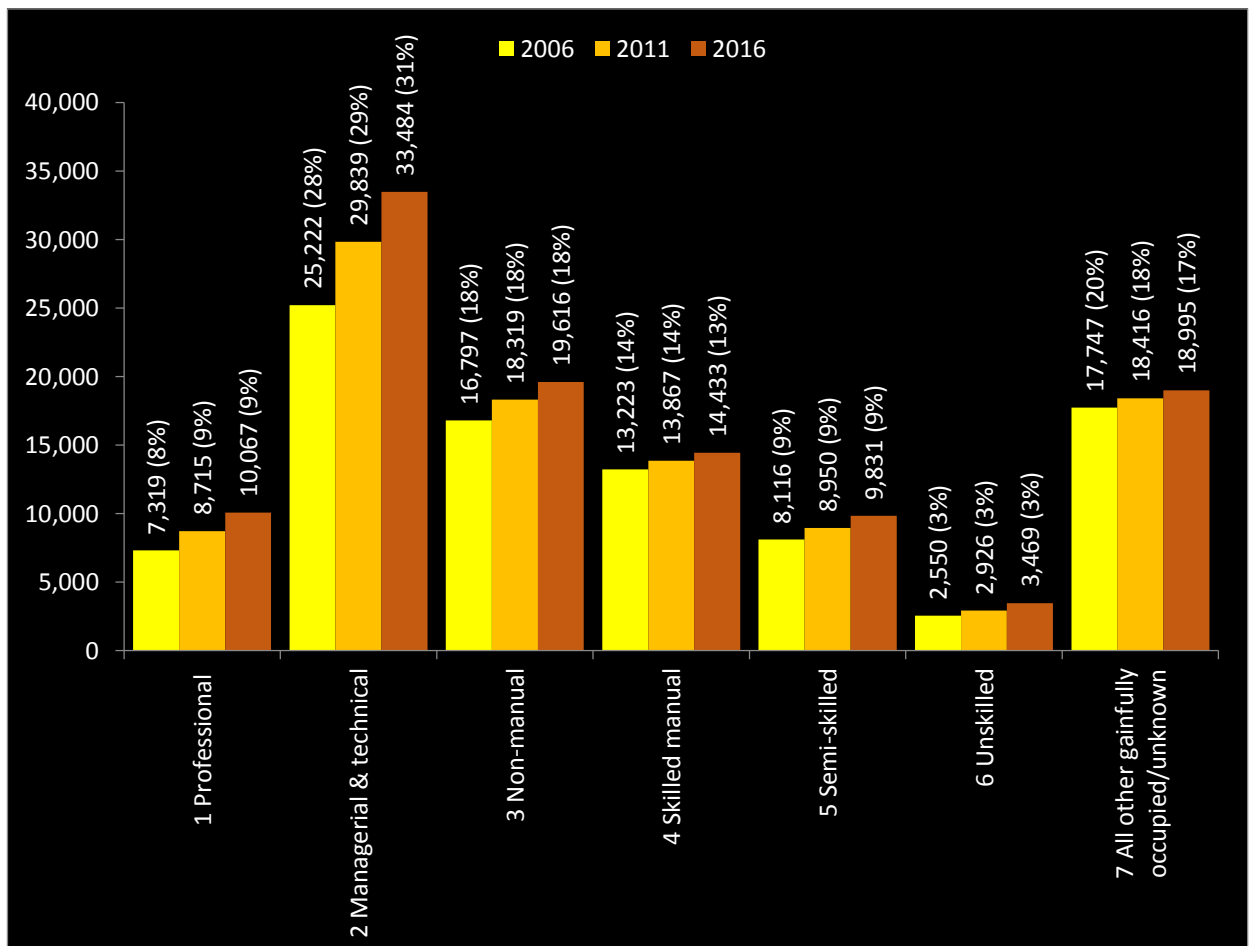
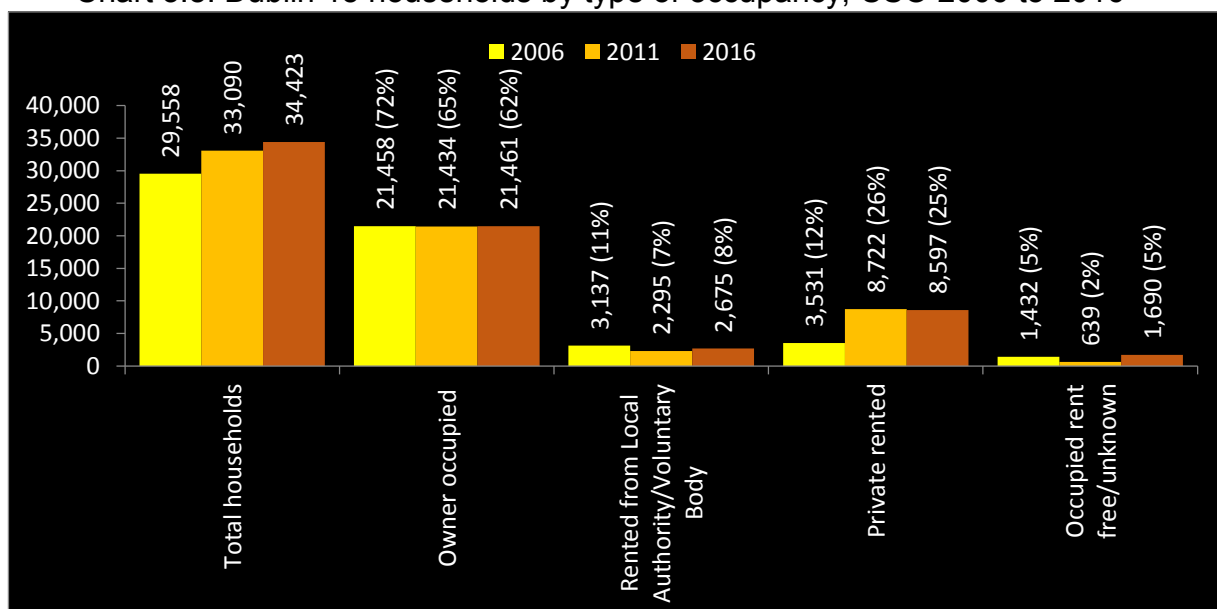


Chart 3.8: Dublin 15 households by type of occupancy, CSO 2006 to 2016



AFFLUENCE & DEPRIVATION IN DUBLIN 15

The Pobal HP Deprivation Index identifies the geographical distribution of affluence and deprivation in Ireland (Central Statistics Office, 2006, 2011, 2016). The deprivation score for Dublin 15 increased from 3.28 in 2006 to 4.26 in 2016, remaining categorised as 'marginally above the average level of disadvantage'. Analysis of the Small Area Population Statistics (SAPS) provides a more comprehensive analysis of levels of deprivation and affluence throughout the area. The analysis reports an increase in deprivation levels between 2006 and 2011 following the economic downturn in 2008, and the partial recovery between 2011 and 2016 (Chart 3.9). In 2016, a quarter of the Small Areas (SAs) in Dublin 15 were classified as deprived.

Chart 3.9: Proportion of Small Areas in Dublin 15 with positive and negative deprivation scores in Dublin 15, 2006 to 2016

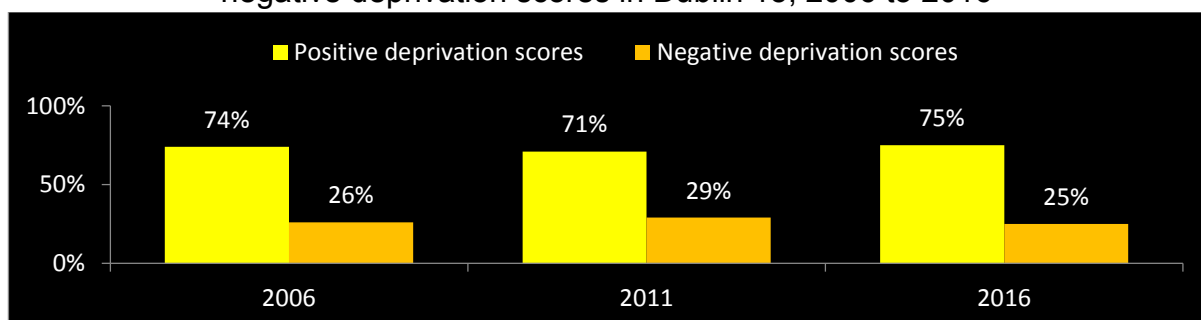
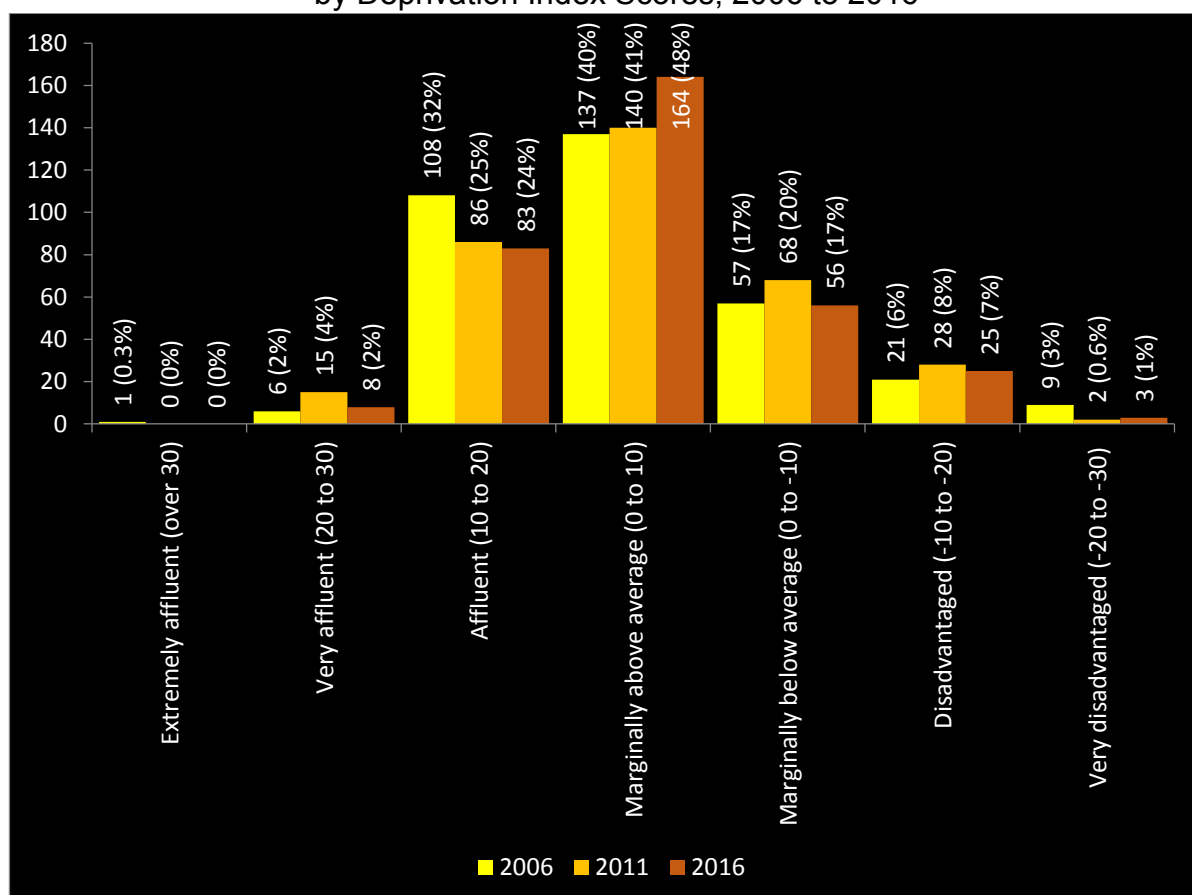


Chart 3.10 reports the changes in deprivation and affluence levels within the 339 SAs in Dublin 15 from 2006 to 2016. The majority of SAs were classified

as ‘marginally above the average levels of disadvantage’; the number of SAs within this classification has increased.

Chart 3.10: Number of Small Areas in Dublin 15
by Deprivation Index Scores, 2006 to 2016



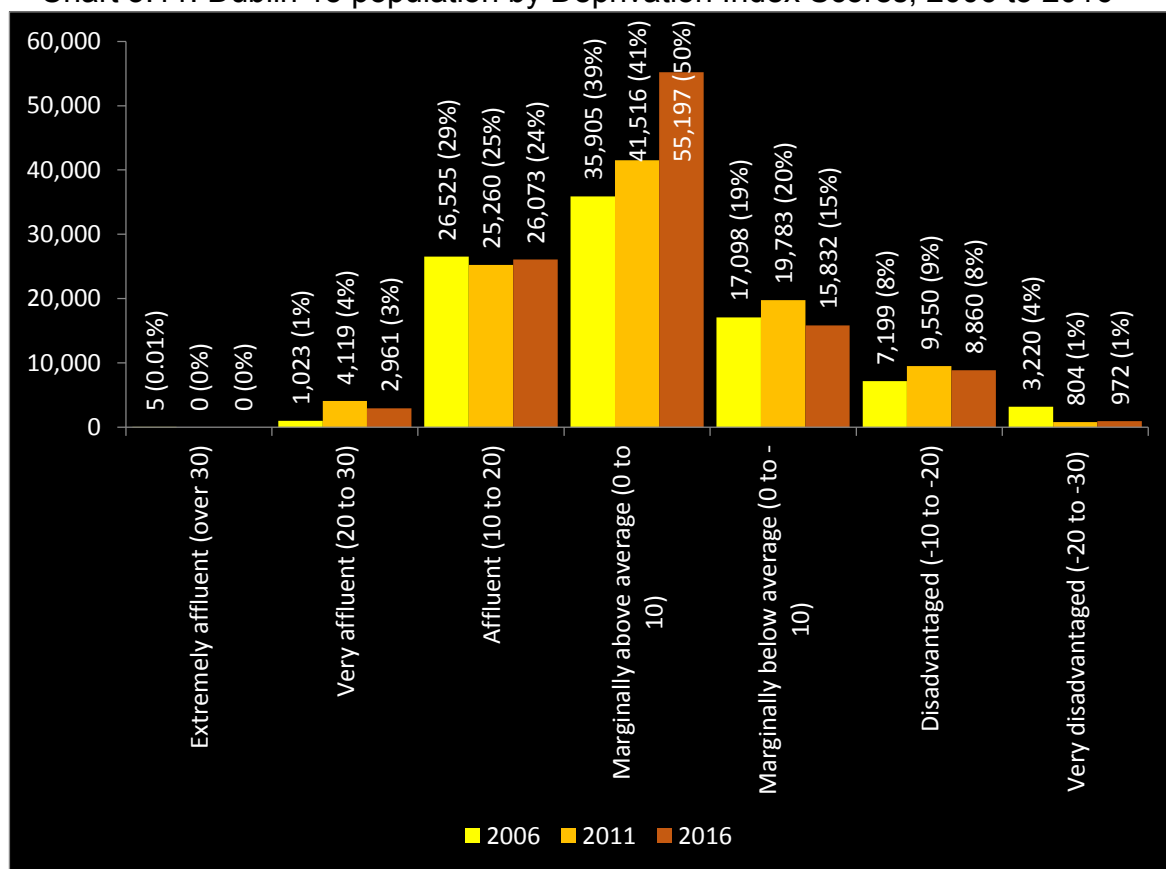
There are eleven electoral divisions (EDs) in Dublin 15. The 2016 SAs identified as disadvantaged are located within eight of these EDs (Table 3.1).

Table 3.1: 2016 Dublin 15 Electoral Divisions with Small Areas categorised as deprived

Dublin 15 Electoral Divisions	
Blanchardstown-Coolmine	Blanchardstown-Corduff
Blanchardstown-Abbotstown	Blanchardstown-Blakestown
Blanchardstown-Mulhuddart	Blanchardstown-Delwood
Blanchardstown-Roselawn	Blanchardstown-Tyrrelstown

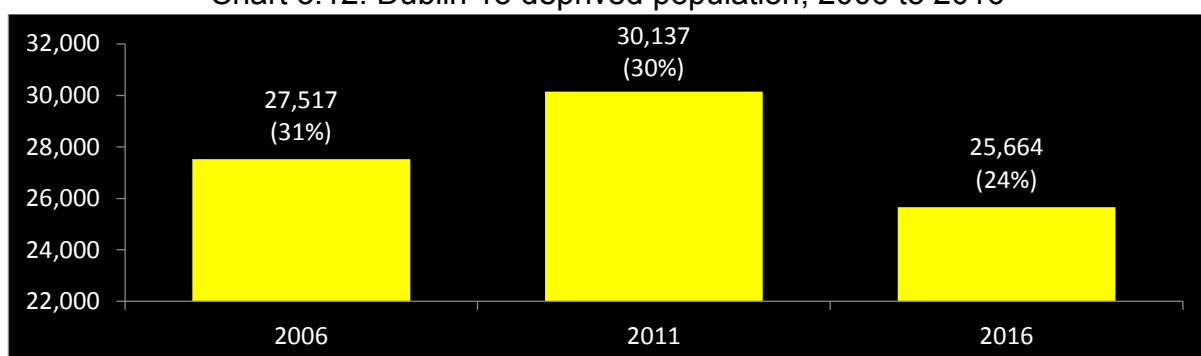
The SAs analysis has been used to calculate the population of Dublin 15 living within different levels of affluence and deprivation (Chart 3.11).

Chart 3.11: Dublin 15 population by Deprivation Index Scores, 2006 to 2016



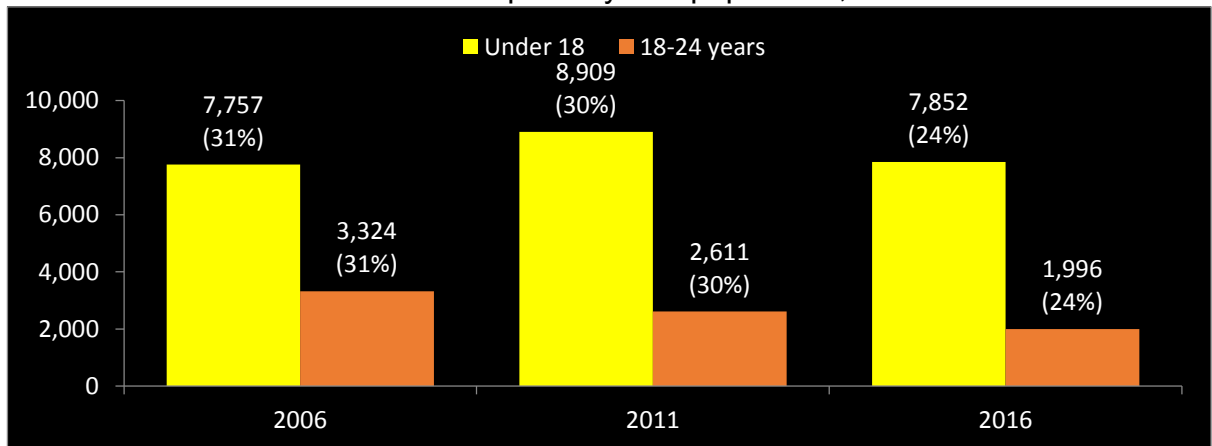
From 2006 to 2016, there was a 7% decrease in the proportion of Dublin 15 population classified as deprived (Charts 3.12 & 3.13). In 2016, levels of deprivation in Dublin 15 were less than the national average (49%).

Chart 3.12: Dublin 15 deprived population, 2006 to 2016



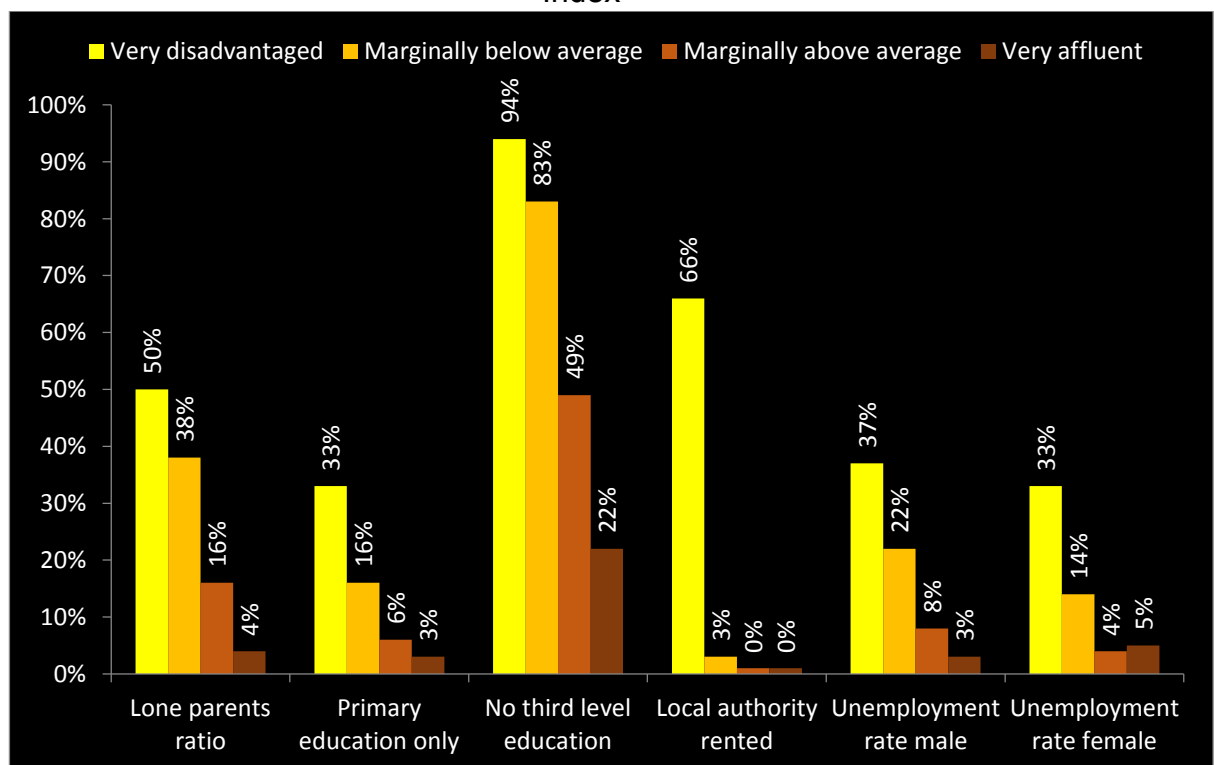
SOCIO-DEMOGRAPHIC PROFILE OF DUBLIN 15, 2006-2016

Chart 3.13: Dublin 15 deprived youth population, 2006 to 2016



The following chart describes the socio-demographic and economic characteristics associated with different levels of deprivation and affluence (Chart 3.14). It identifies that the most disadvantaged have the lowest levels of educational attainment and the highest rates of lone parents, unemployment and local authority housing; as affluence increases the converse is reported.

Chart 3.14: Socio-demographic and economic characteristics of four Small Area deprivation and affluence categories in Dublin 15, 2016 Deprivation Index



4. TREATED DRUG AND ALCOHOL USE

Treatment demand data contains no unique identifiers and treated drug users may be counted more than once. Thus, the Year 3 profile of treated drug use reports the number of treatment episodes or cases rather than the number of people treated.

MAPPING TREATMENT DEMAND

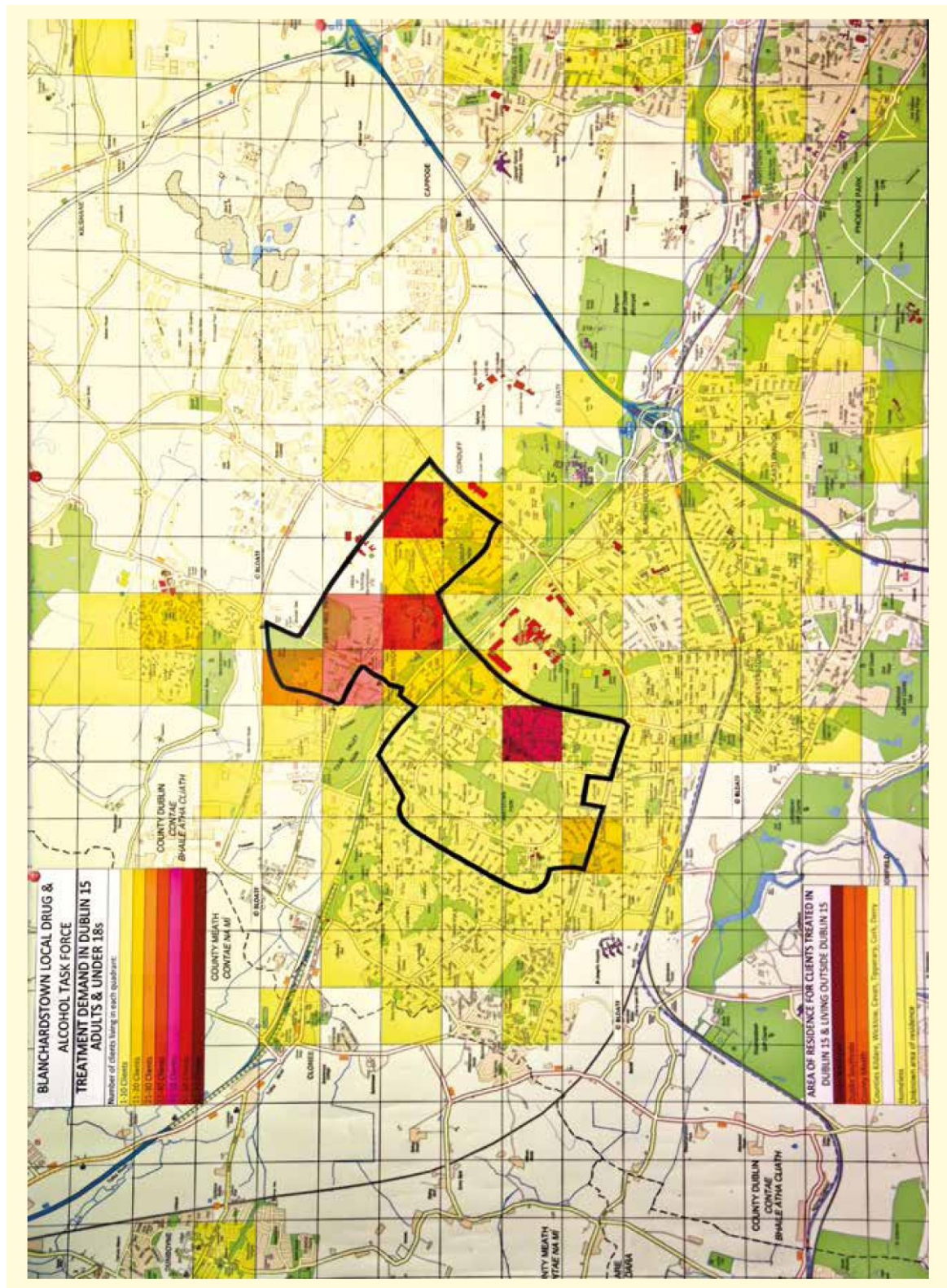
Mapping treatment demand in Year 3 identifies that treated cases were from Dublin 15, other Dublin suburbs and counties, with some cases homeless. The majority of cases were from Dublin 15. Mapping this data identifies the extent of drug and alcohol dependence throughout Dublin 15 (see maps: Year 3 Treatment Demand in Dublin 15 for Adults and Under 18s & Year 3 Treatment Demand in Dublin 15 for Under 18s). It shows that treated drug users were from every community in Dublin 15, though most treated drug users lived in deprived areas (Mulhuddart and Corduff). Thus, drug and alcohol dependence is a community wide issue that crosses all socio-economic boundaries.

Year 2 mapping data reported similar findings (see maps: Year 2 Treatment Demand in Dublin 15 for Adults & Under 18s & Year 2 Treatment Demand in Dublin 15 for Under 18s). The only difference was that Year 3 reported less treated drug users from Clonsilla, Carpenterstown and Castleknock.

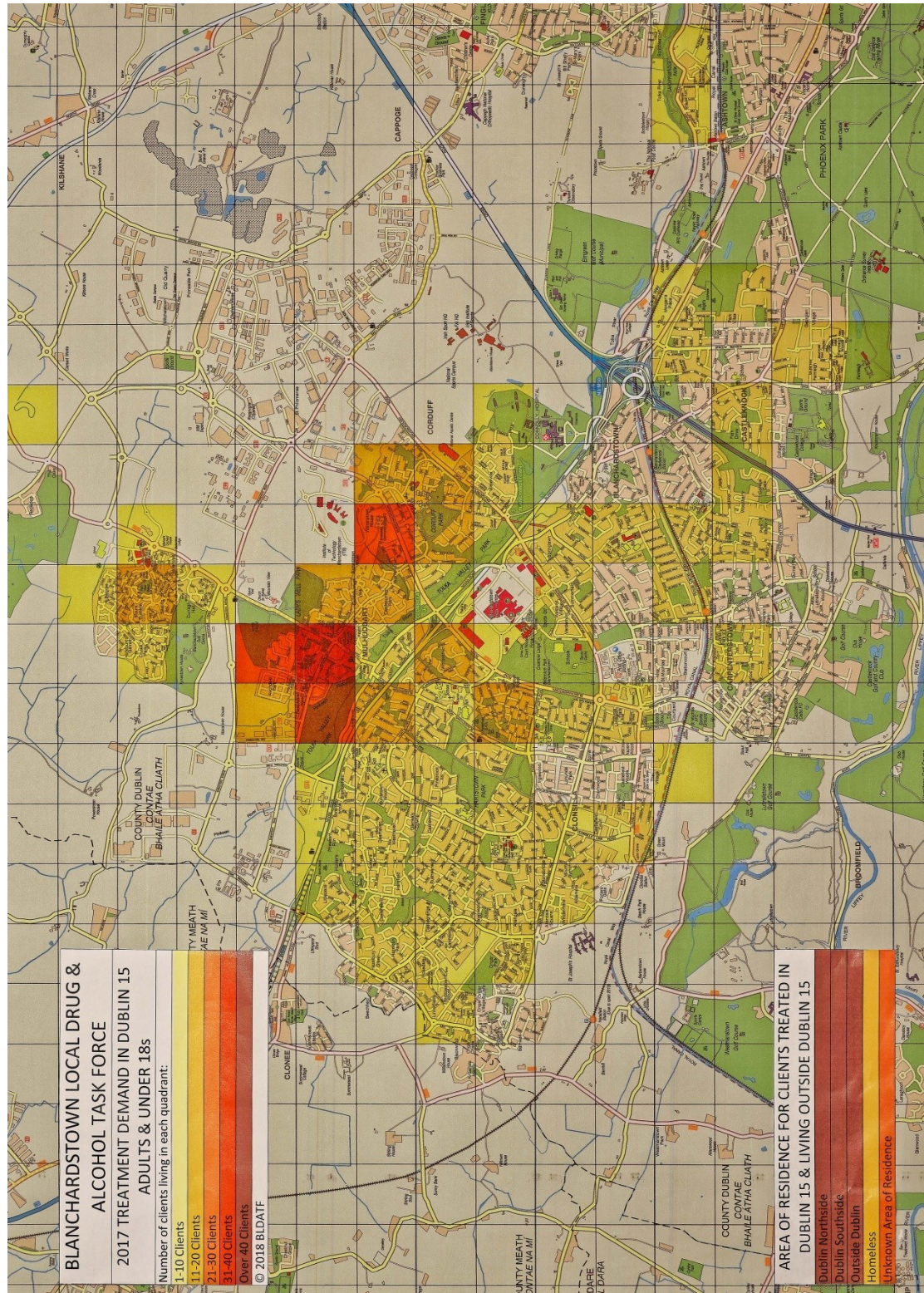
In Year 2 (June 2015 to May 2016), there were 728 treated cases and this reduced to 671 cases in Year 3 (2017). This does not reflect a decline in treated drug use but rather a change in methodology of the DATMS. Year 2 data was based on the following 7 services: Mulhuddart/Corduff Community Drug and Alcohol Team, ADAPT Community Drug and Alcohol Team, Tolka River Project, Coolmine Therapeutic Community, Substance Abuse Service Specific to Youth (SASSY), Blanchardstown Youth Service Drug Education/Prevention programme and HSE Addiction Psychiatry service. Year 3 data was based on 5 of these services and no data was provided by the HSE Addiction Psychiatry service or the ADAPT Community Drug and Alcohol Team due to its closure. However, while ADAPT closed, the services it provided were re-distributed to other services in the area.

BLDATF
2017 TREATMENT DEMAND IN DUBLIN 15
ADULTS + UNDER 18s

Year 2 Treatment Demand in Dublin 15 for Adults + Under 18s



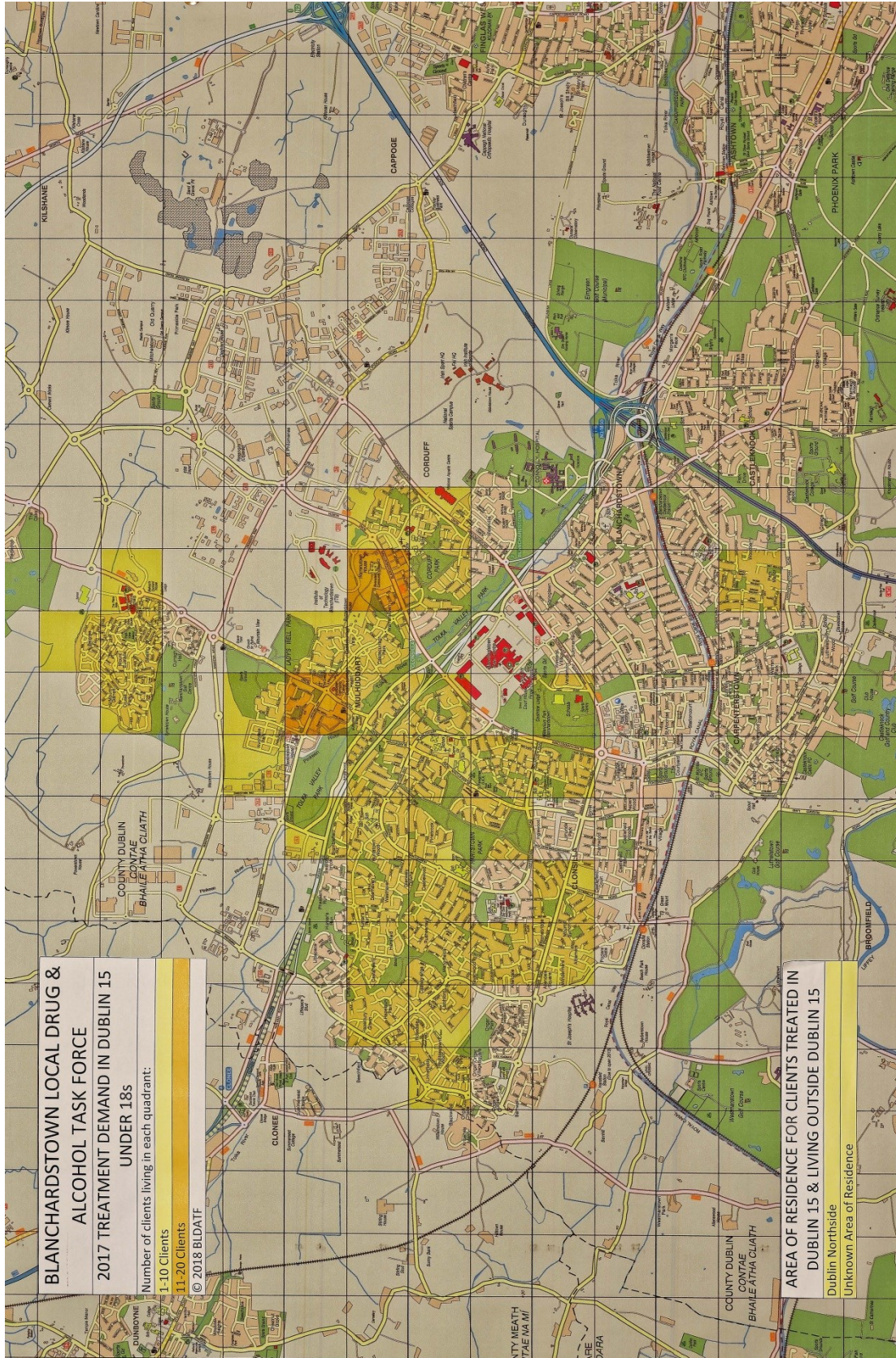
Year 3 Treatment Demand in Dublin 15 for Adults + Under 18s



Year 2 Treatment Demand in Dublin 15 for Under 18s



Year 3 Treatment Demand in Dublin 15 for Under 18s



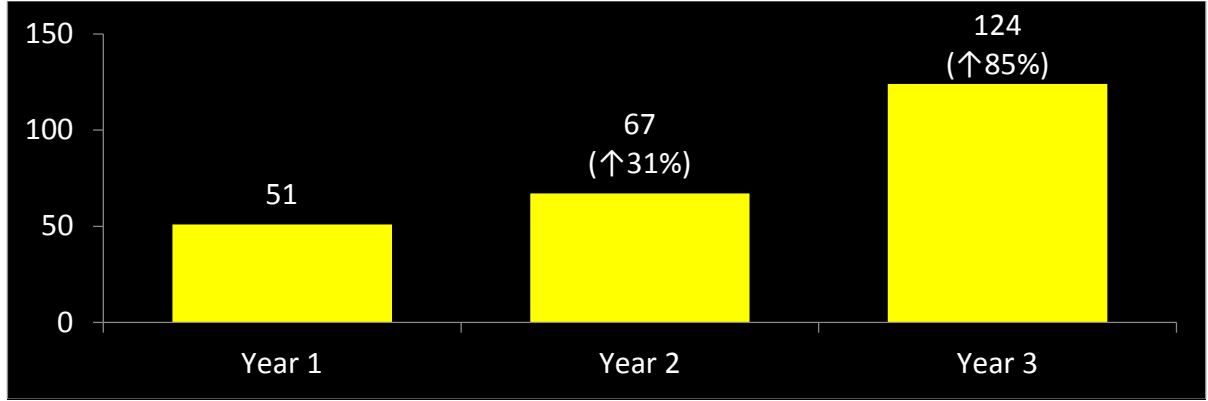
BLDATF
2017 TREATMENT DEMAND IN DUBLIN 15
UNDER 18s

TREATED DRUG USERS AGED UNDER 18

The profile of treated drug use reports three years of data. Year 1 reporting period began June 2014, Year 2 began June 2015 and Year 3 was 2017. Data was provided by the Blanchardstown Youth Service Drug Education Prevention programme and Substance Abuse Service Specific to Youth (SASSY).

The number of treated cases aged under 18 increased 143% from 51 in Year 1 to 124 in Year 3 (Chart 4.1). This increase may be due to an increase in the prevalence of drug use and also an increase in service provision.

Chart 4.1: Treated cases aged under 18, DATMS Year 1 to 3



CSO 2016 data has been employed to estimate of the percentage of the Dublin 15 population aged 12 to 17 years in treatment (Table 4.1). As CSO data relates to individuals and treatment demand data relates to cases, this estimate is not without its flaws. However, as there are no unique identifiers in the treatment demand data this analysis has been completed for service planning purposes.

Table 4.1: Percentage of Dublin 15 population aged 12 to 17 year olds treated in local community and statutory services, DATMS Year 3 and CSO 2011 and 2016

	D15 population aged 12 to 17 (CSO data)	% of D15 population aged 12 to 17 in treatment
Year 1	7,158*	1%
Year 2	7,158*	1%
Year 3	9,294^	1%

*CSO 2011

^CSO 2016

It is probable that this is an underestimate of treatment demand as it does not include young people treated outside Dublin 15, privately or those not accessing any services.

SOCIO-DEMOGRAPHIC PROFILE OF TREATED DRUG USERS AGED UNDER 18

Over the reporting period, the majority of cases were male and white Irish (Charts 4.2 and 4.3).

Chart 4.2: Treated cases aged under 18 by gender, DATMS Year 1 to 3

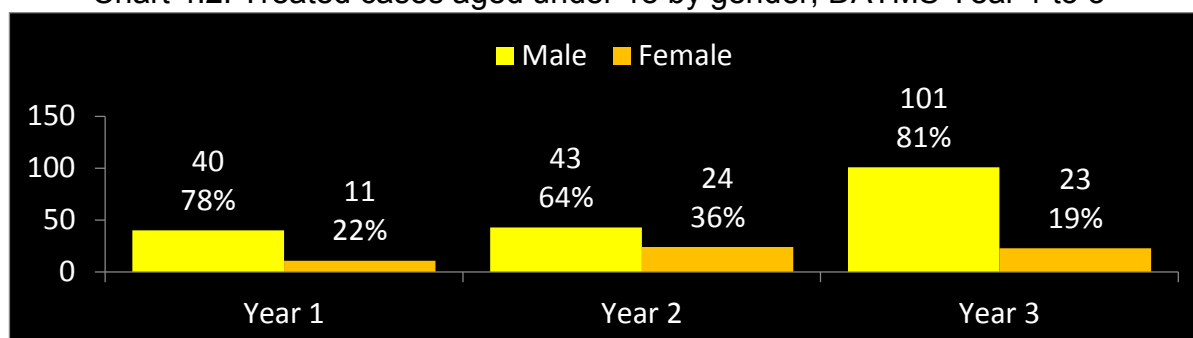
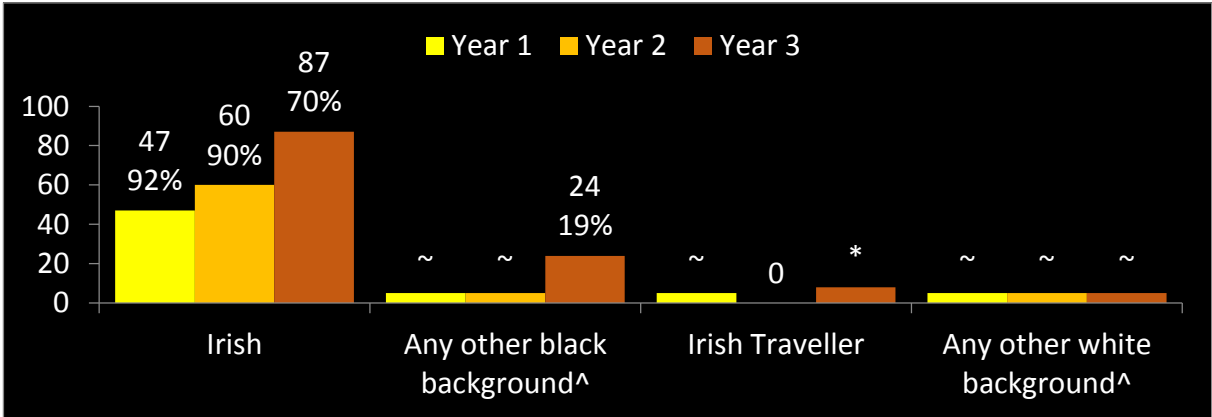


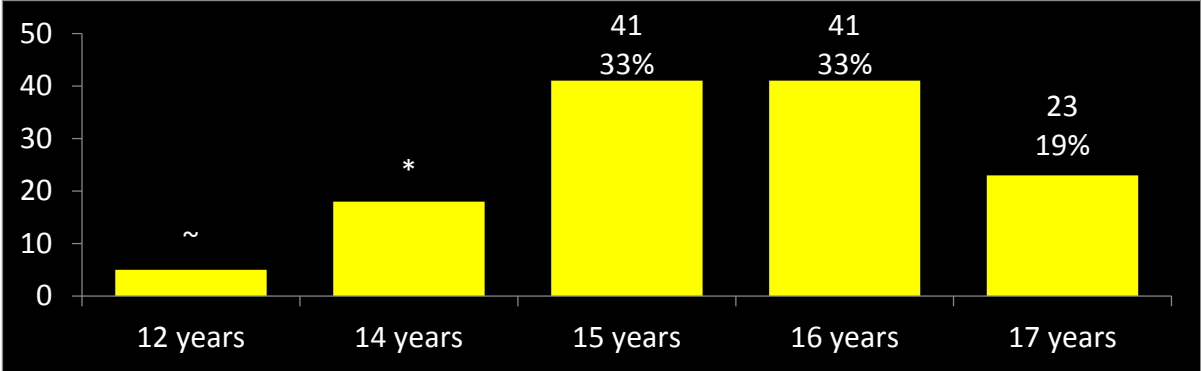
Chart 4.3: Treated cases aged under 18 by ethnicity, DATMS Year 1 to 3



~ Number of cases too small to be reported (5 or less)
* Number of cases greater than 5 and suppressed to ensure cases with 5 or less are not disclosed
^ Ethnic category 'Any other black background' includes African Irish and the category 'Any other white background' includes Eastern European Irish

In Year 3, treated cases were aged from 12 to 17 years, with the majority aged 15 and 16 years (Chart 4.4). Limited data concerning the age of treated cases was available for Year 1 and 2.

Chart 4.4: Treated cases by age, DATMS Year 3

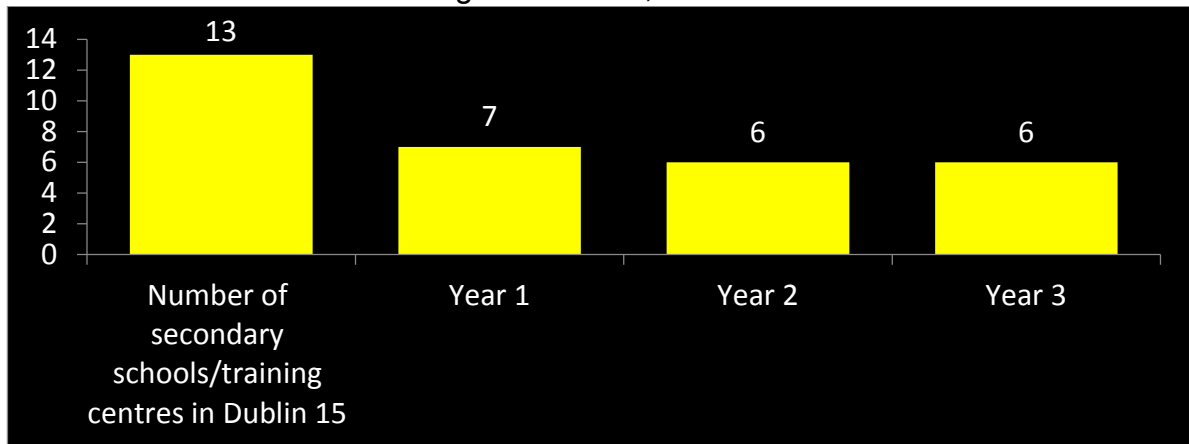


~ Number of cases too small to be reported (5 or less)
*Number of cases greater than 5 not reported to ensure cases with 5 or less are not disclosed

There are ten mainstream secondary schools and three training centres in Dublin 15¹. Chart 4.5 reports the number of secondary schools and training centres in Dublin 15 attended by treated cases aged under 18 during DATMS Year 1 to Year 3.

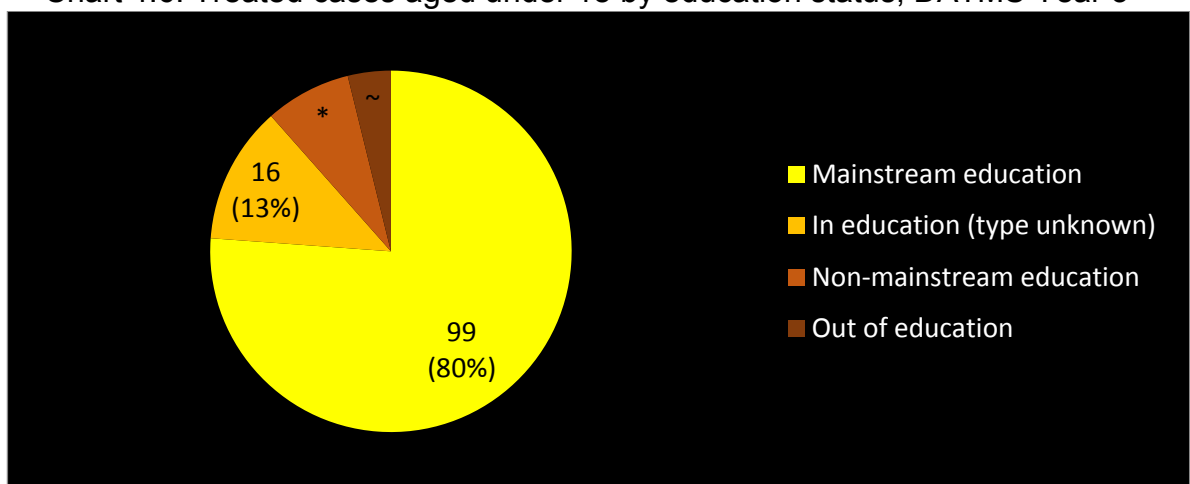
¹ Training centres include: Blanchardstown Community Training Centre, Blanchardstown Youthreach, Blanchardstown Youth Service Early School Leavers Programme

Chart 4.5: Secondary schools/training centres in Dublin 15 attended by treated cases aged under 18, DATMS Year 1 to 3



In Year 3, the majority of treated cases aged under 18 were in mainstream education (Chart 4.6).

Chart 4.6: Treated cases aged under 18 by education status, DATMS Year 3

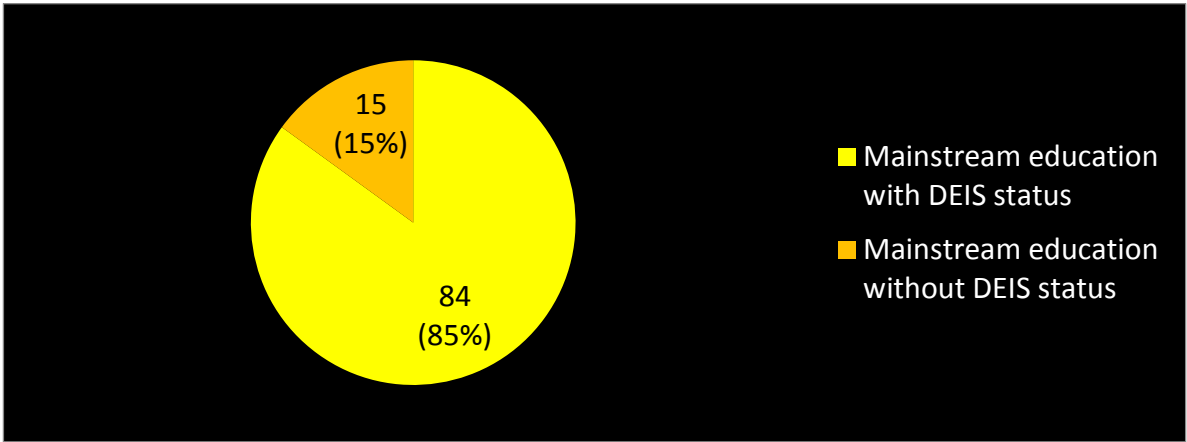


~ Number of cases too small to be reported (5 or less)

* Number of cases greater than 5 and suppressed to ensure cases with 5 or less are not disclosed

Young people in treatment were from all socio-economic groups though the majority attended local secondary schools with DEIS status (Chart 4.7). This identifies the relationship between social deprivation and drug use. Limited data concerning the education status of treated cases was available for Year 1 and 2; data reported treated cases attended DEIS and non-DEIS status mainstream secondary schools, and training centres.

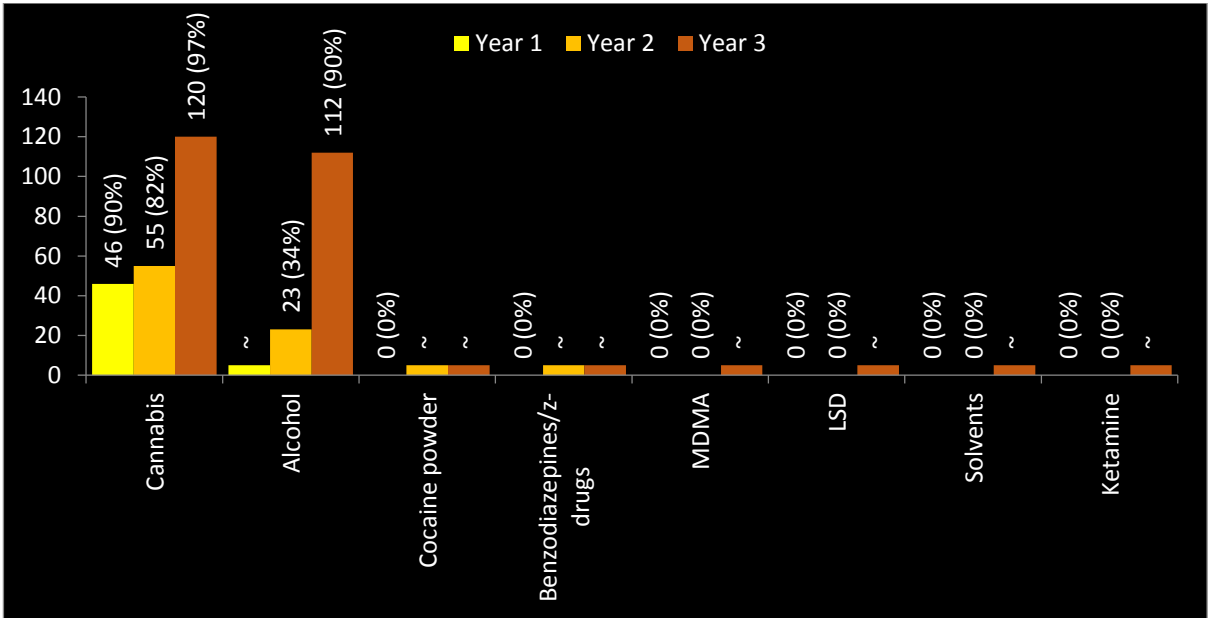
Chart 4.7: Treated cases aged under 18 by DEIS status of mainstream education, DATMS Year 3



MAIN PROBLEM DRUGS

The drugs used by treated cases were similar for all data reporting periods with Cannabis herb the most commonly used drug, followed by Alcohol (Chart 4.8).

Chart 4.8: Treated cases aged under 18 by main problem drug, DATMS Year 1 to 3



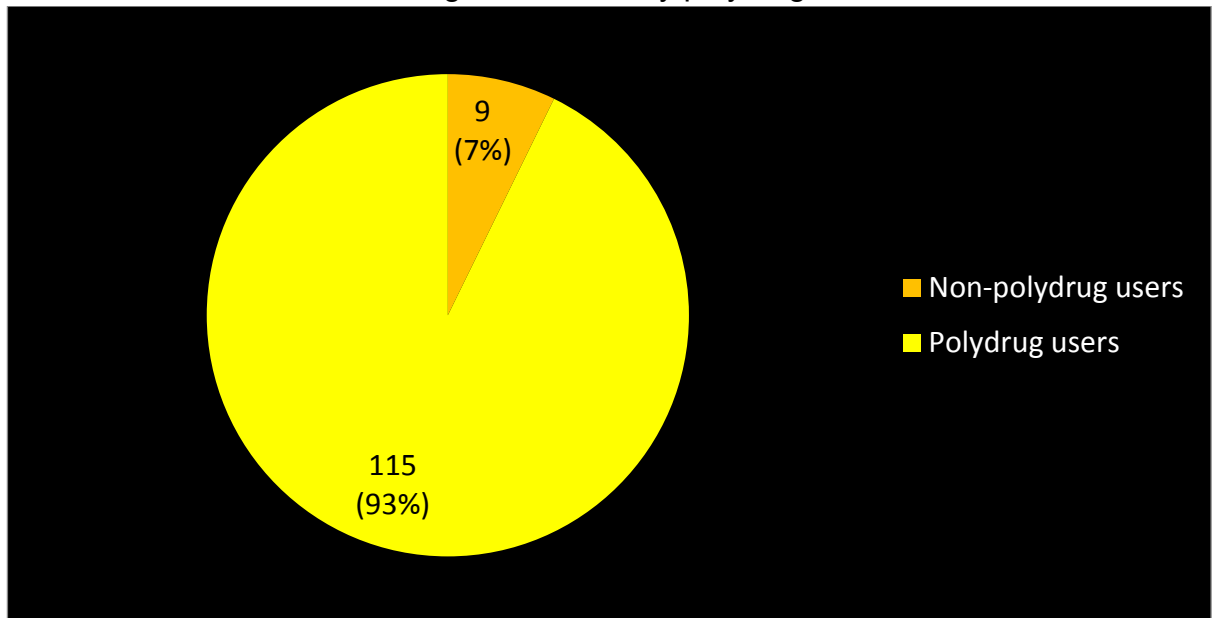
~ Number of treated drug users too small to be reported (5 or less)

As drugs are generally used without completing an analysis of their composition it is probable that synthetic types (New Psychoactive Substances) are used with or without users' knowledge. Synthetic drug types

include Cannabis, Opioids, Benzodiazepines, Z drugs, Amphetamines and Cocaine.

The majority of treated cases were polydrug users (Chart 4.9). Cannabis and Alcohol was the most common form of polydrug use.

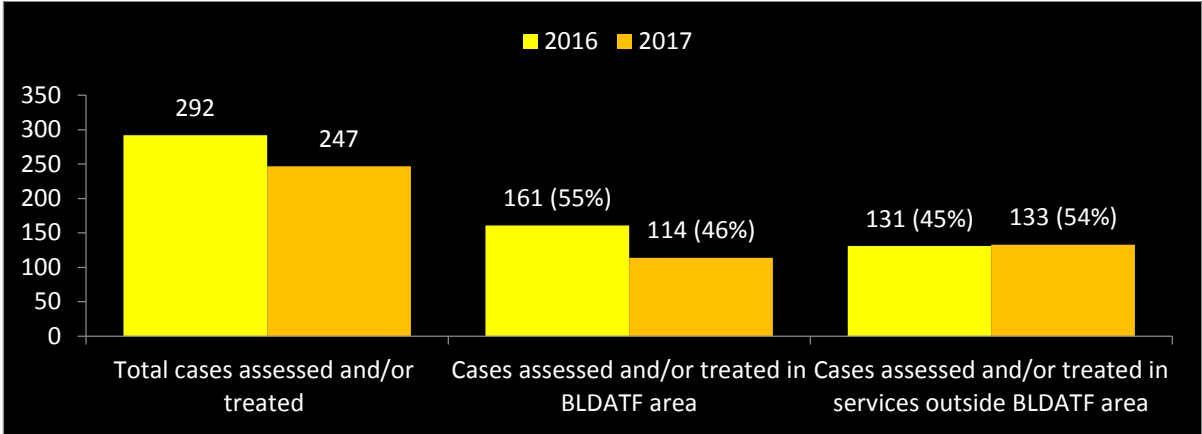
Chart 4.9: Treated cases aged under 18 by polydrug use, DATMS Year 3



ADULT TREATED DRUG USERS NATIONAL DRUG TREATMENT REPORTING SYSTEM (NDTRS)

The NDTRS is an epidemiological database on treated drug and alcohol misuse in Ireland. Analysis of NDTRS data for 2016 and 2017 provides the profile of adult treated drug use for Year 3. The data identified that treated cases who lived in the BLDATF area were assessed and/or treated in services within and outside the BLDATF area (Chart 4.10). The services attended were both day and residential programmes and included stabilisation, detoxification, treatment and rehabilitation services.

Chart 4.10: Cases living in BLDATF area and assessed and/or treated in or outside BLDATF area, NDTRS 2016 & 2017

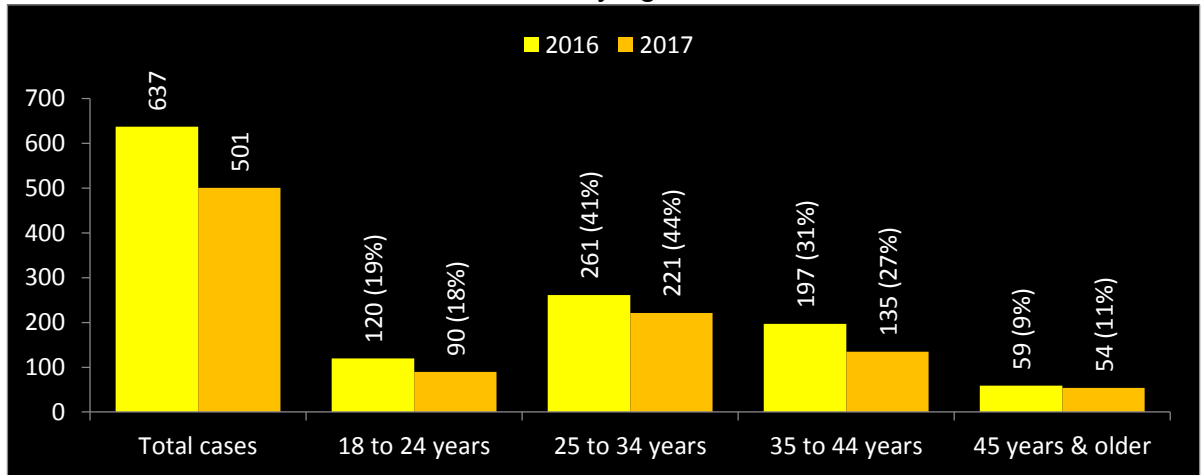


The total number of cases living in the BLDATF should be higher as knowledge of local services provision has identified that some local services were either under-reporting or not reporting any data to the NDTRS. Also, this data is based on the BLDATF area and does not include cases from Tyrrelstown, Carpenterstown and Castleknock. Our mapping data (reported above) identified treated cases from these areas. Therefore, the following NDTRS data reports all cases treated in three BLDATF funded services², including cases living in the BLDATF area and cases living outside of the area.

There was a reduction in the number of cases treated from 637 in 2016 to 501 in 2017 (Chart 4.11). The reason for this reduction may include under-reporting to the NDTRS.

² Coolmine Therapeutic Community, Tolka River Project, Mulhuddart/Corduff Community Drug and Alcohol Team

Chart 4.11: Treated cases by age, NDTRS 2016 & 2017



2017 category totals less than 100% as category 'unknown' removed

A demographic profile of these cases reports that the majority of treated cases were Irish (Chart 4.12), male and aged 25 to 34 years (Chart 4.13).

Chart 4.12: Treated cases by ethnicity, NDTRS 2016 & 2017

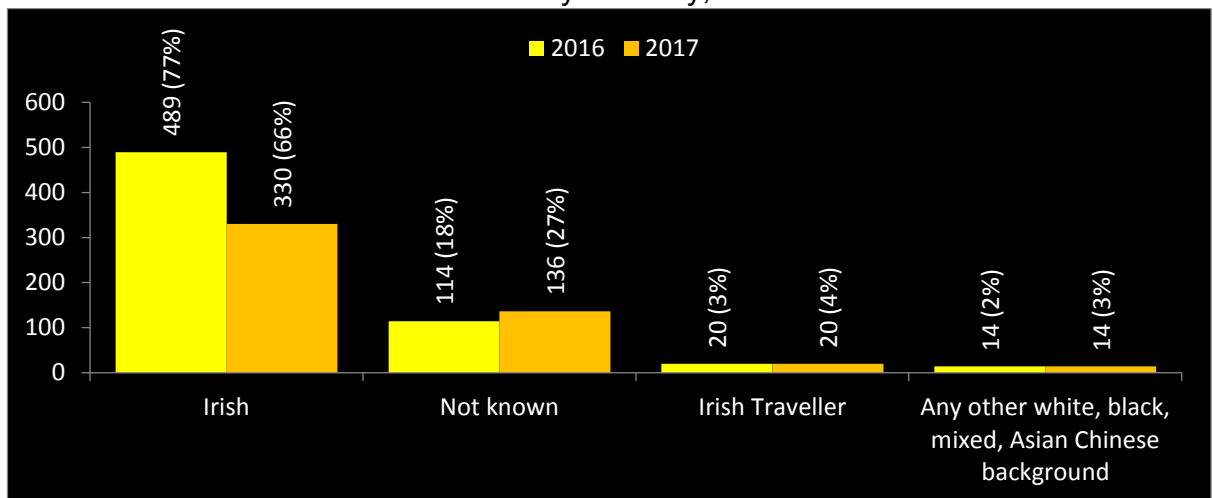
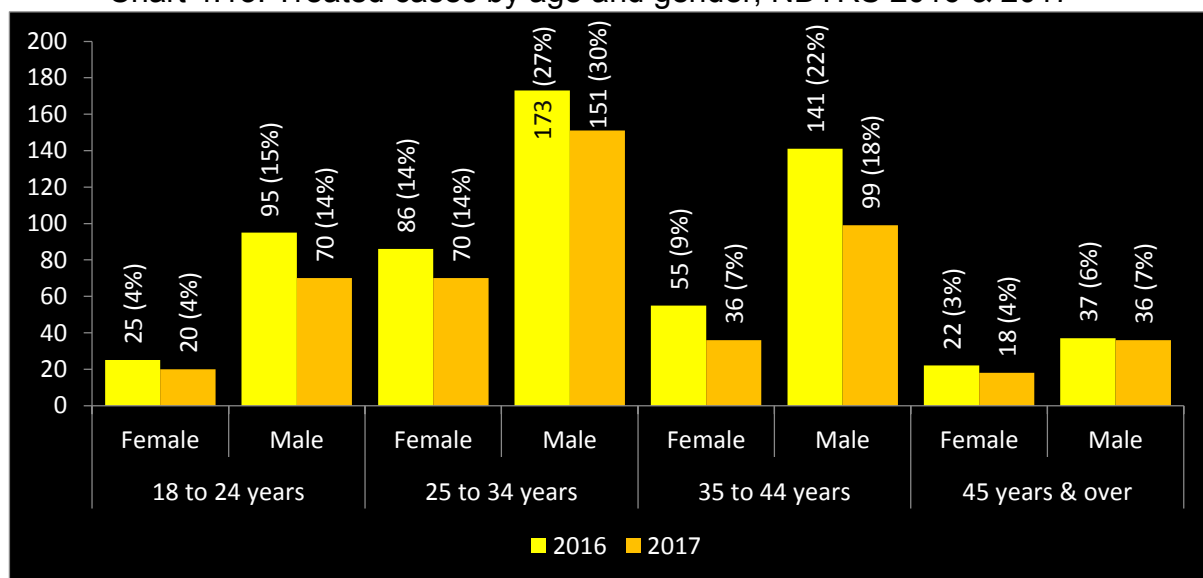


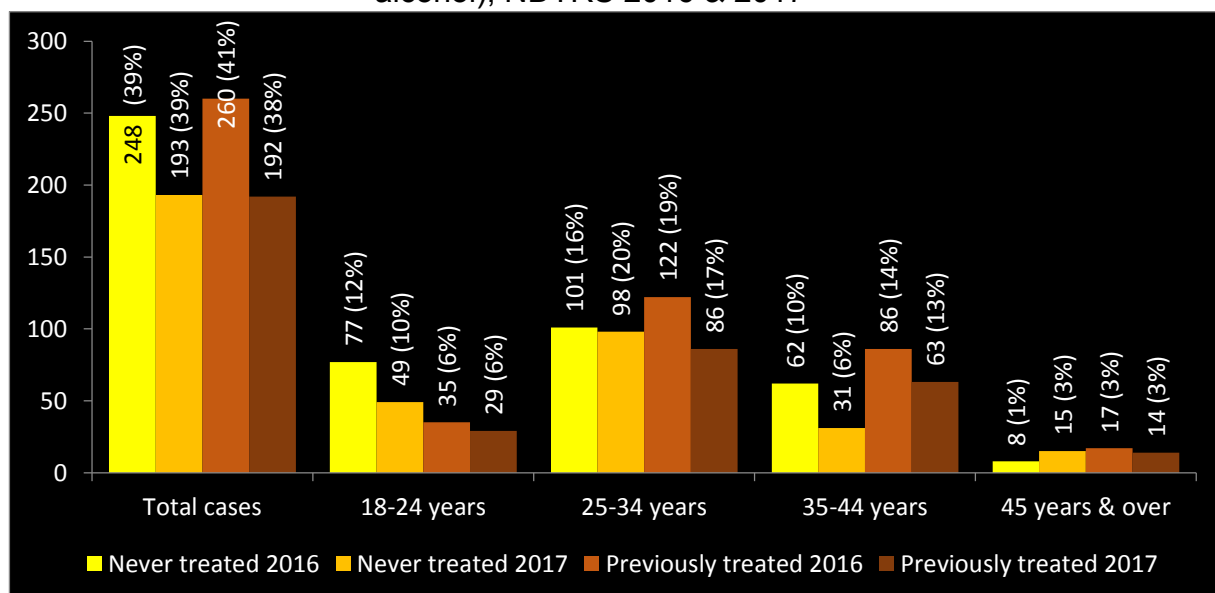
Chart 4.13: Treated cases by age and gender, NDTRS 2016 & 2017



Category totals less than 100% as category 'unknown' removed

In 2016 and 2017, 37% of cases were in treatment for the first time for drugs (Chart 4.14). Chart 4.15 reports the history of treatment for alcohol cases though comparison between reporting periods is challenging due to the high number of cases with unknown history of treatment.

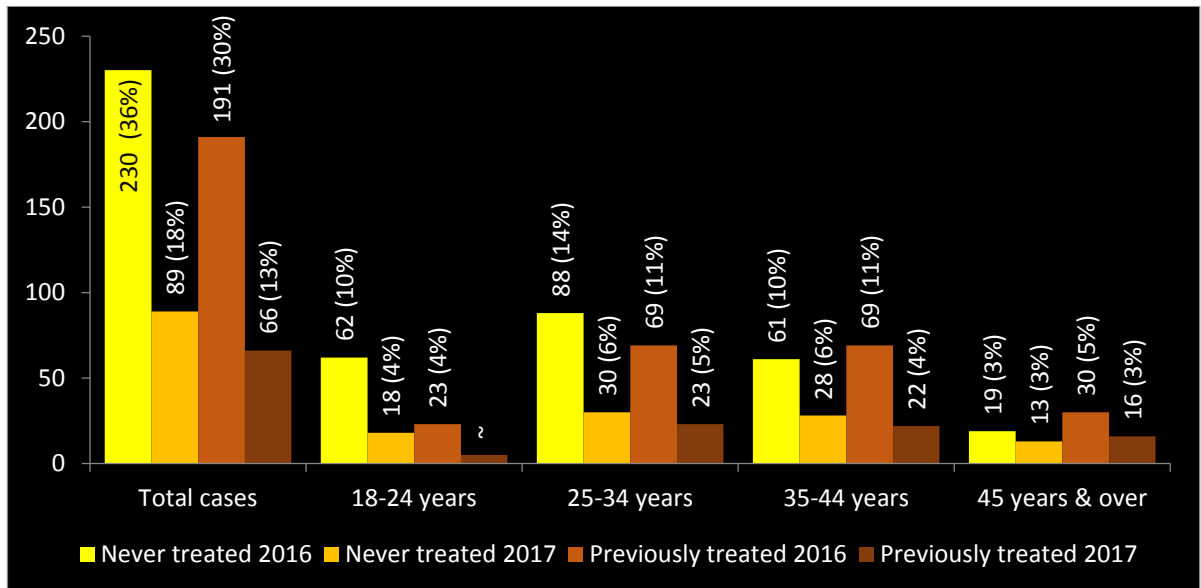
Chart 4.14: Treated cases by history of treatment for drug use (excluding alcohol), NDTRS 2016 & 2017



Category totals less than 100% as category 'not known' removed

TREATED DRUG AND ALCOHOL USE

Chart 4.15: Treated cases by history of treatment for alcohol use, NDTRS 2016 & 2017

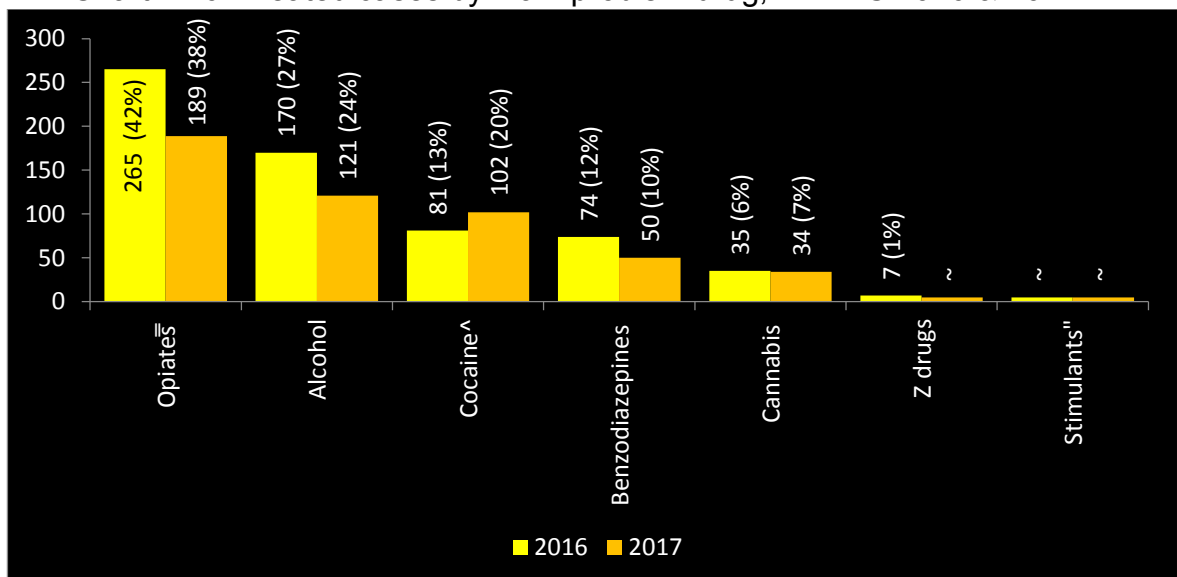


Category totals less than 100% as category 'not known' removed
 ~Number of cases too small to be reported (5 or less)

PROFILE OF DRUG USE

Over the reporting period, the main problem drug for the majority of cases was Opiates (mainly Heroin), followed by Alcohol and Cocaine (Chart 4.16).

Chart 4.16: Treated cases by main problem drug, NDTRS 2016 & 2017



~Number of cases too small to be reported (5 or less)

⁼ Includes Heroin, Methadone, Codeine, Tramadol

[^]Includes Powder Cocaine, Crack Cocaine

^{''}Includes MDMA, Amphetamines, Methamphetamine, New Psychoactive Stimulants

DRUG AND ALCOHOL TRENDS
MONITORING SYSTEM YEAR 3

The following charts provide a breakdown of main problem drugs by age range (Charts 4.17 to 4.20). The data reports a reduction in the use of Opiates among treated cases except those aged from 45 years.

Chart 4.17: Treated cases aged 18 to 24 years by main problem drug, NDTRS 2016 & 2017

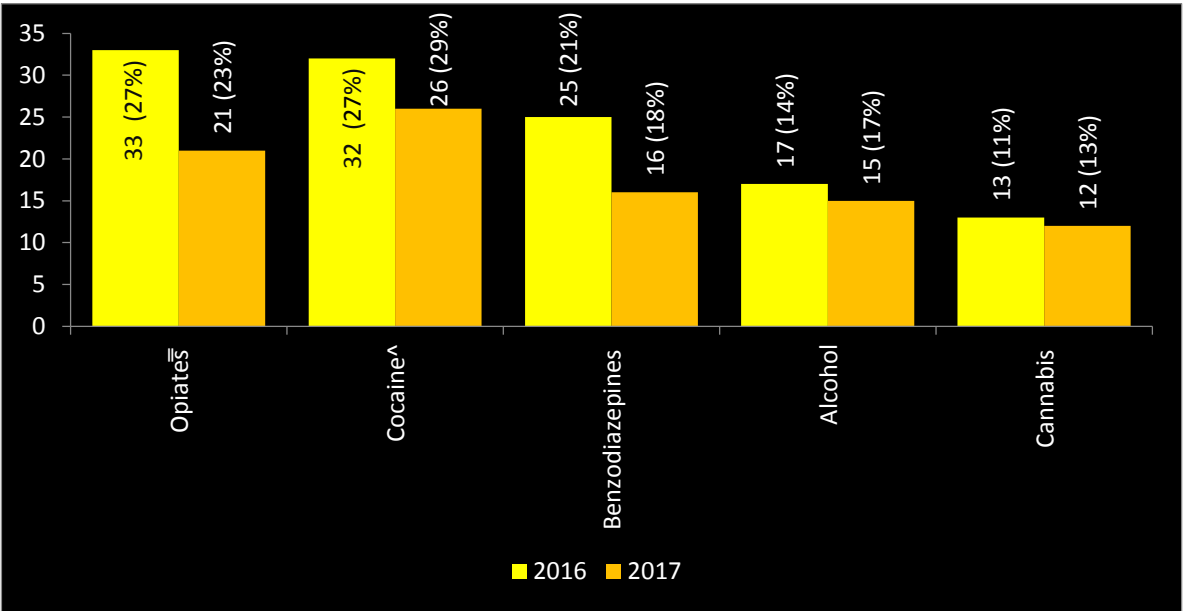
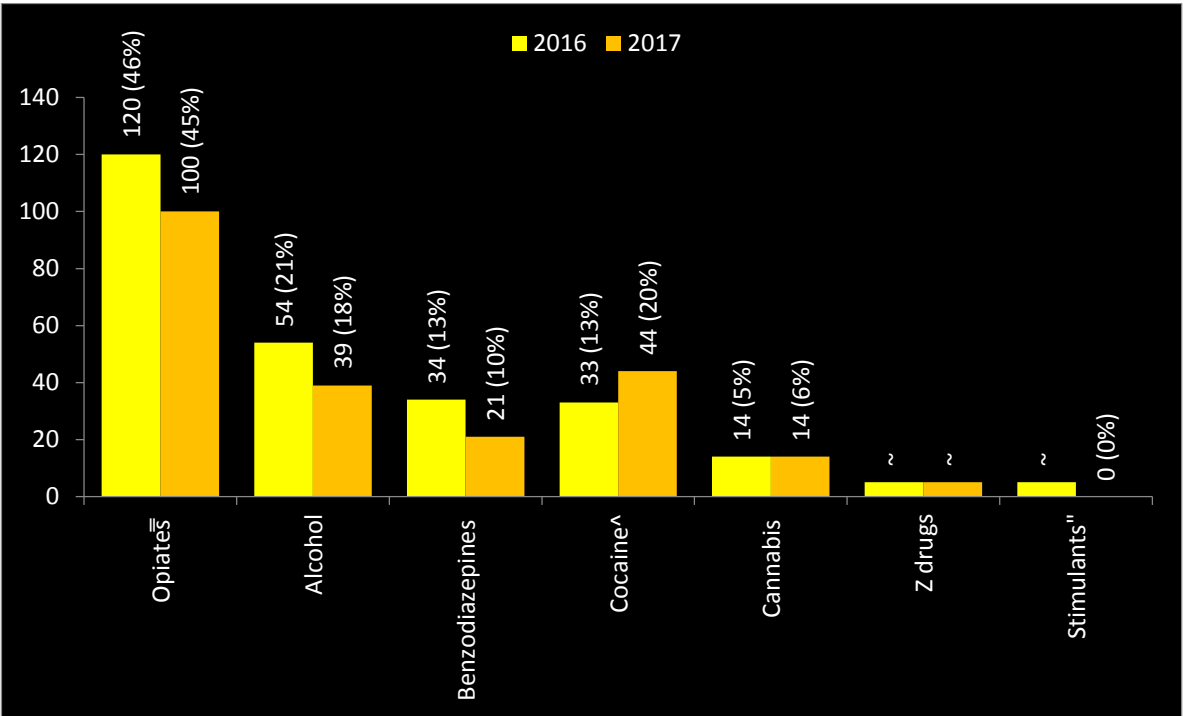


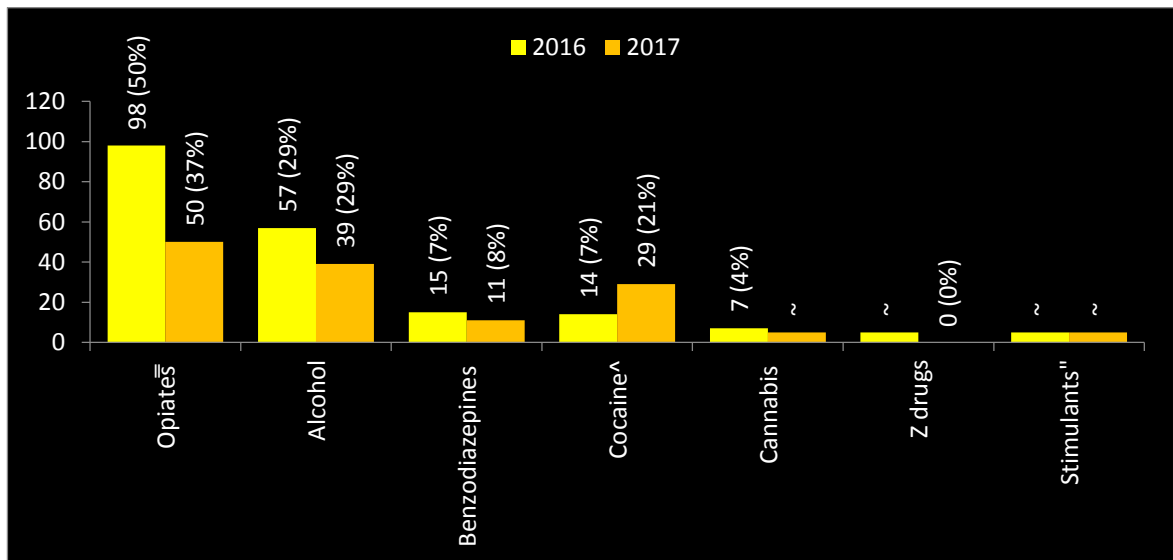
Chart 4.18: Treated cases aged 25 to 34 years by main problem drug, NDTRS 2016 & 2017



~Number of cases too small to be reported (5 or less)

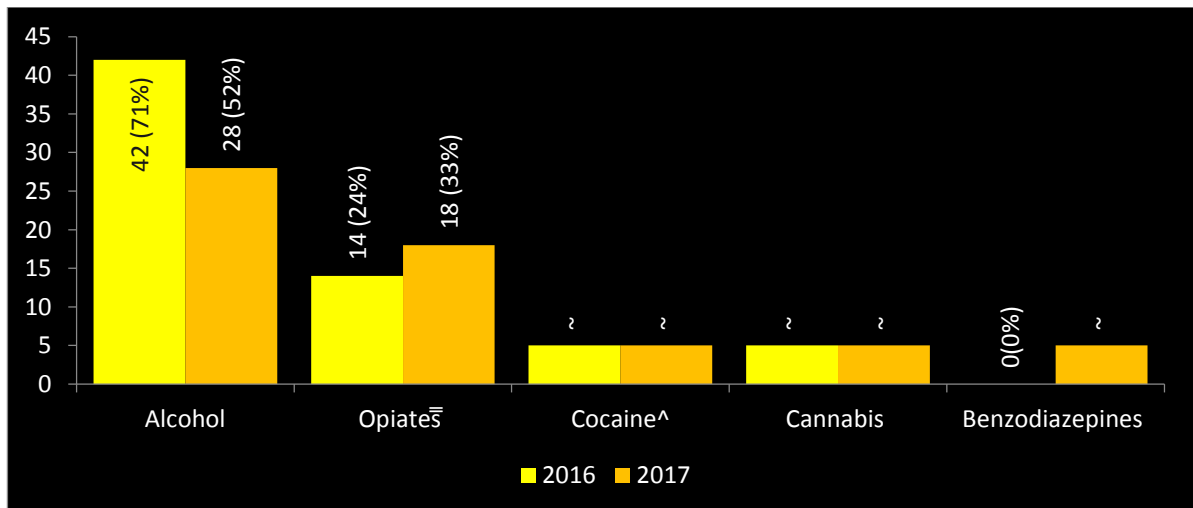
TREATED DRUG AND ALCOHOL USE

Chart 4.19: Treated cases aged 35 to 44 years by main problem drug, NDTRS 2016 & 2017



~Number of cases too small to be reported (5 or less)

Chart 4.20: Treated cases aged 45 years and over by main problem drug, NDTRS 2016 & 2017



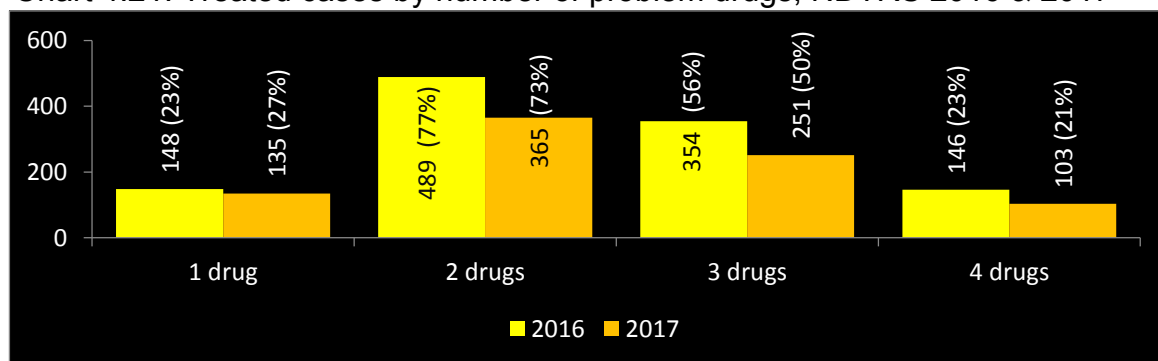
~Number of cases too small to be reported (5 or less)

NDTRS data reports the use of New Psychoactive Stimulants, though the number of cases treated for these drugs was too small to be reported. Synthetic drug types also include Cannabis, Opioids and Sedatives/Hypnotics. As drugs are generally used without completing an analysis of their composition it is probable that synthetic types are used with or without users' knowledge. Thus, the use of these drugs is likely to be under-reported in treatment data.

DRUG AND ALCOHOL TRENDS MONITORING SYSTEM YEAR 3

In 2016 and 2017, the majority of cases were treated for polydrug use (Chart 4.21).

Chart 4.21: Treated cases by number of problem drugs, NDTRS 2016 & 2017



The following charts report polydrug use by age range (Charts 4.22 to 4.25). The analysis identifies that treated cases aged 18 to 24 years have the highest proportion of polydrug cases; as the age of treated cases increases the proportion of polydrug cases decreases.

Chart 4.22: Treated cases aged 18 to 24 years by number of problem drugs, NDTRS 2016 & 2017

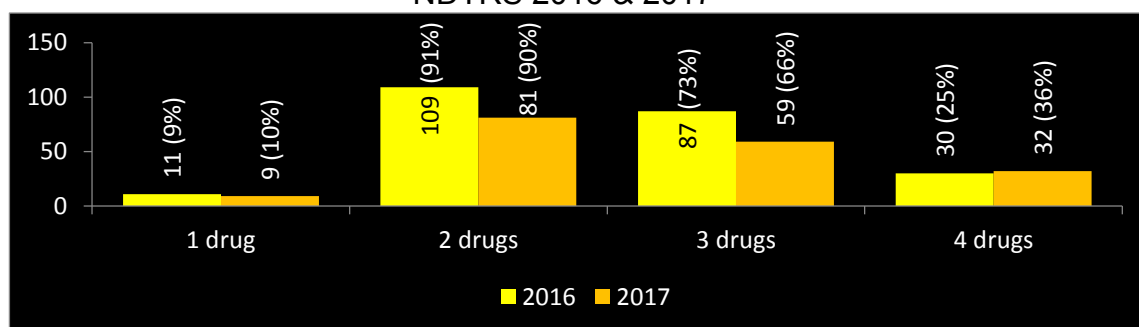


Chart 4.23: Treated cases aged 25 to 34 years by number of problem drugs, NDTRS 2016 & 2017

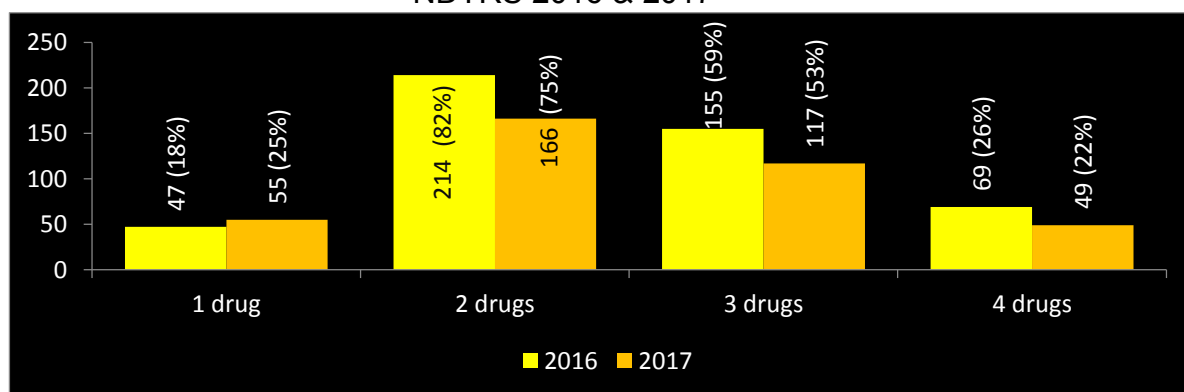


Chart 4.24: Treated cases aged 35 to 44 years by number of problem drugs, NDTRS 2016 & 2017

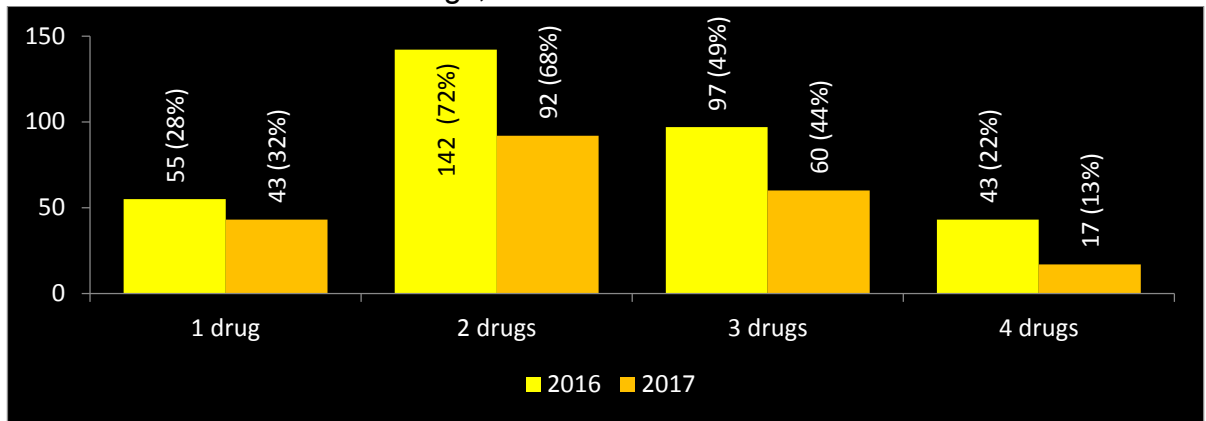
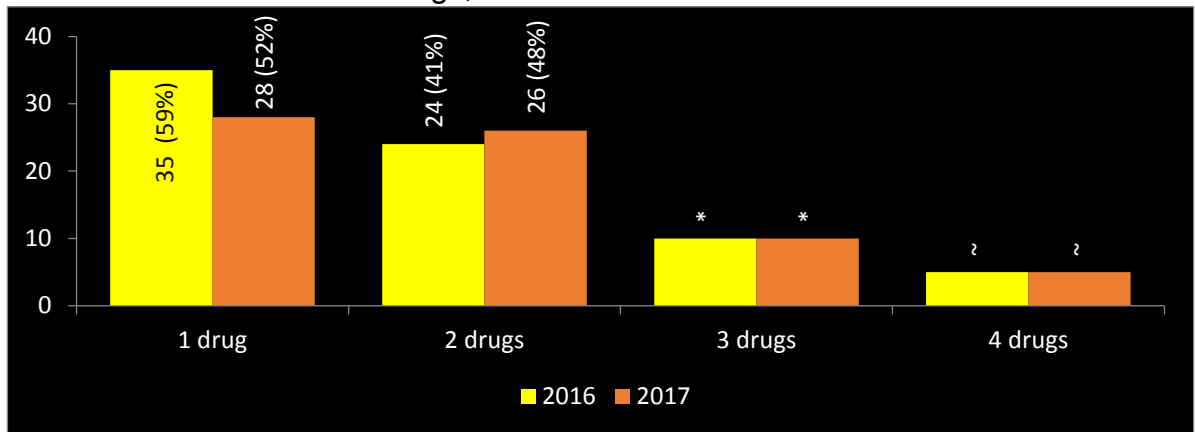


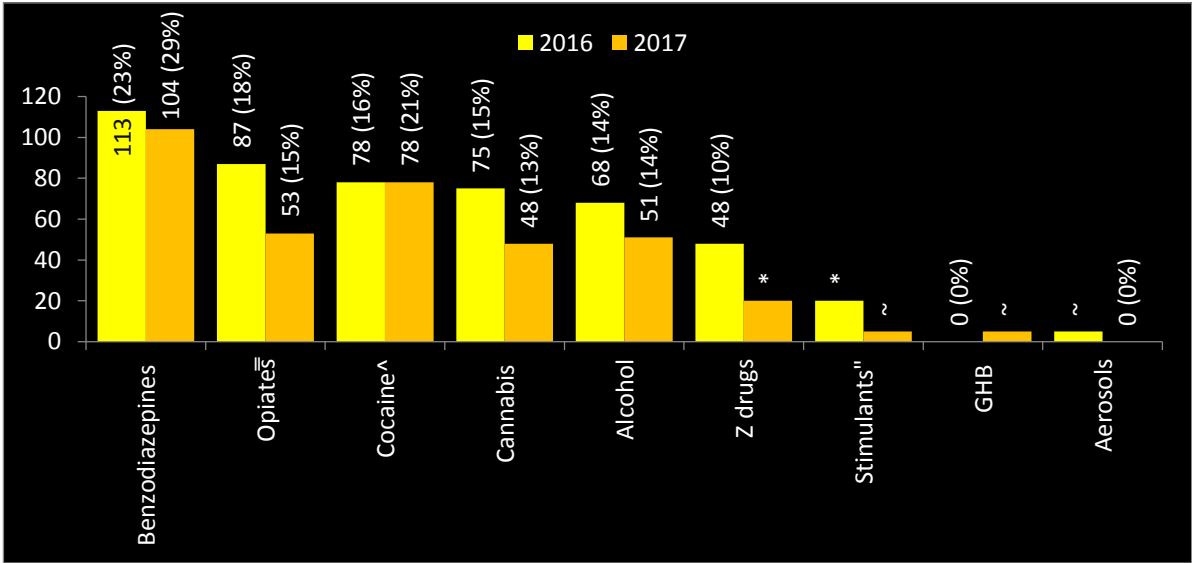
Chart 4.25: Treated cases aged 45 years and over by number of problem drugs, NDTRS 2016 & 2017



*Number of cases greater than 5 not reported to ensure cases with 5 or less are not disclosed
 ~Number of cases too small to be reported (5 or less)

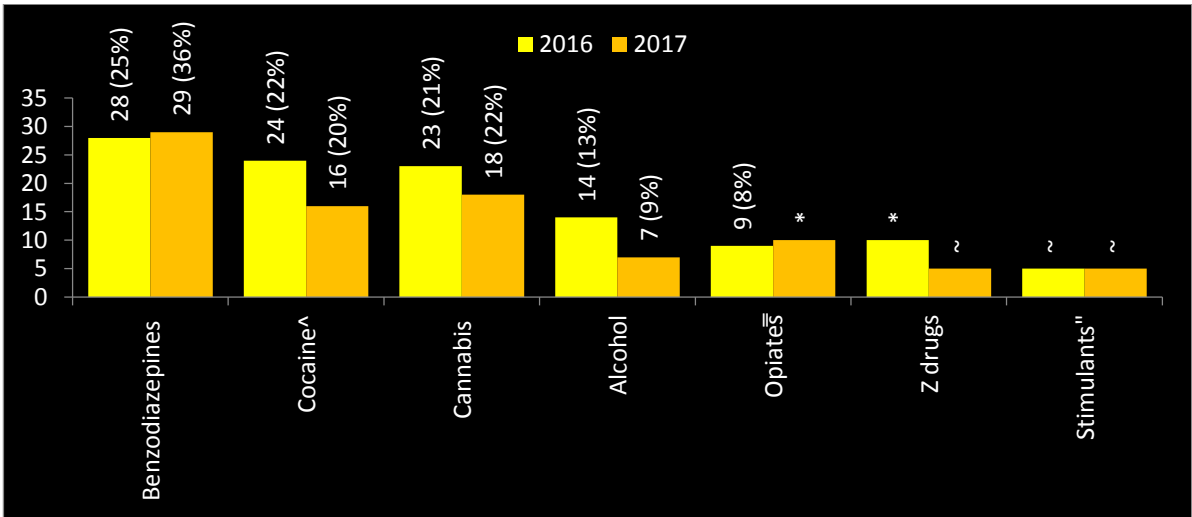
Analysis of polydrug cases reports Benzodiazepines as the most common additional or second problem drug (Chart 4.26). A breakdown of this analysis by age range is reported (Charts 4.27 to 4.30).

Chart 4.26: Treated cases by second problem drug, NDTRS 2016 & 2017



*Number of cases greater than 5 not reported to ensure cases with 5 or less are not disclosed
 ~Number of cases too small to be reported (5 or less)
 = Includes Heroin, Methadone, Codeine, Tramadol
 ^Includes Powder Cocaine, Crack Cocaine
 ~Includes MDMA, Amphetamines, Methamphetamine, New Psychoactive Stimulants

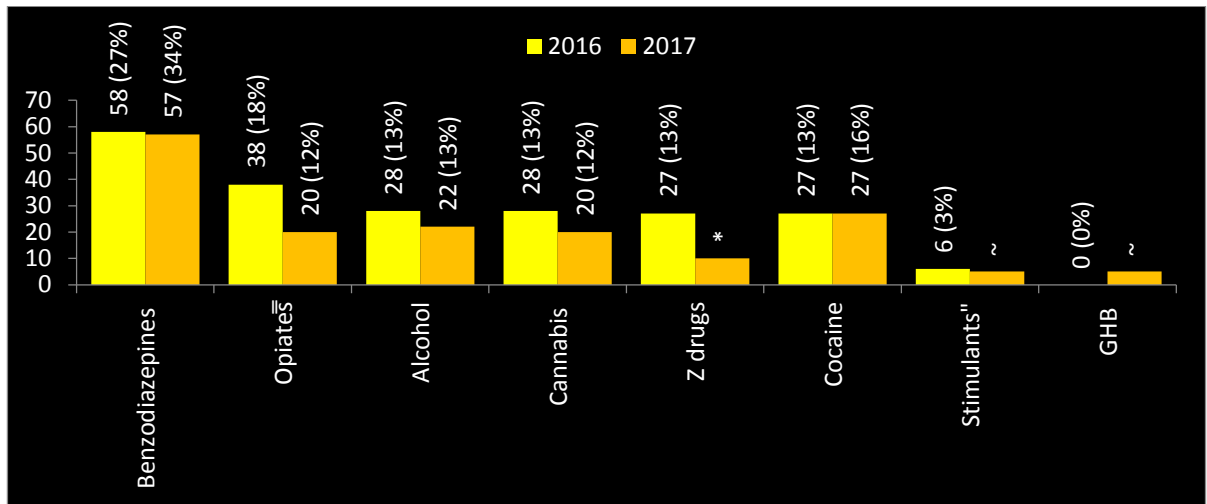
Chart 4.27: Treated cases aged 18 to 24 years by second problem drug, NDTRS 2016 & 2017



*Number of cases greater than 5 not reported to ensure cases with 5 or less are not disclosed
 ~Number of cases too small to be reported (5 or less)

TREATED DRUG AND ALCOHOL USE

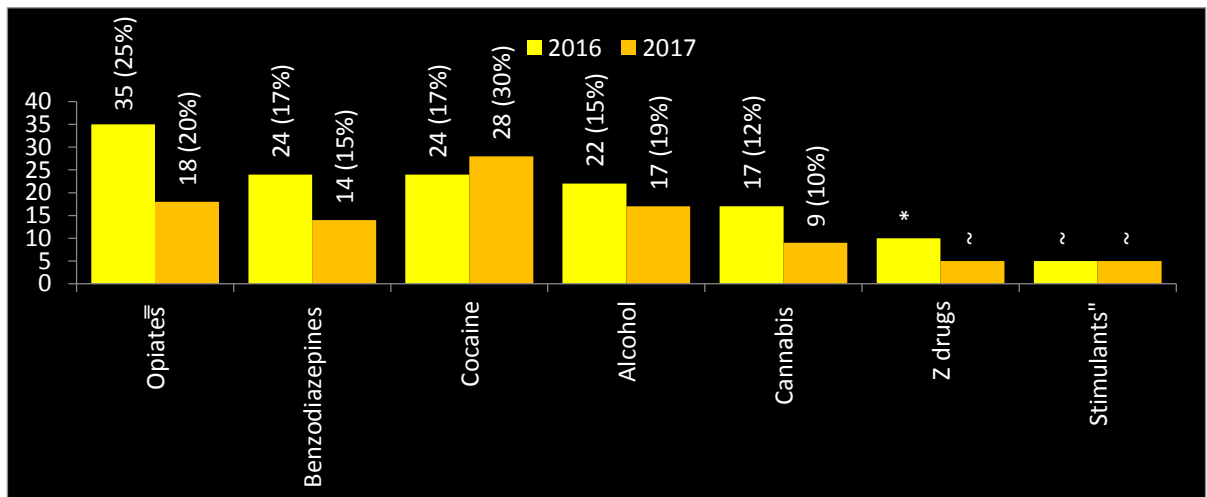
Chart 4.28: Treated cases aged 25 to 34 years by second problem drug, NDTRS 2016 & 2017



*Number of cases greater than 5 not reported to ensure cases with 5 or less are not disclosed

~Number of cases too small to be reported (5 or less)

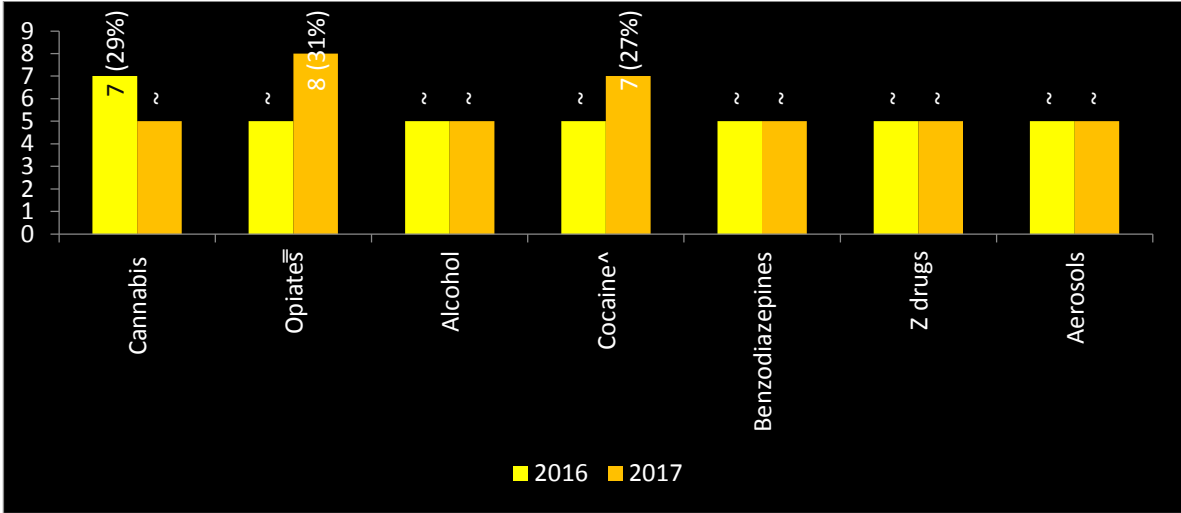
Chart 4.29: Treated cases aged 35 to 44 years by second problem drug, NDTRS 2016 & 2017



*Number of cases greater than 5 not reported to ensure cases with 5 or less are not disclosed

~Number of cases too small to be reported (5 or less)

Chart 4.30: Treated cases aged 45 years and over by second problem drug, NDTRS 2016 & 2017



~Number of cases too small to be reported (5 or less)

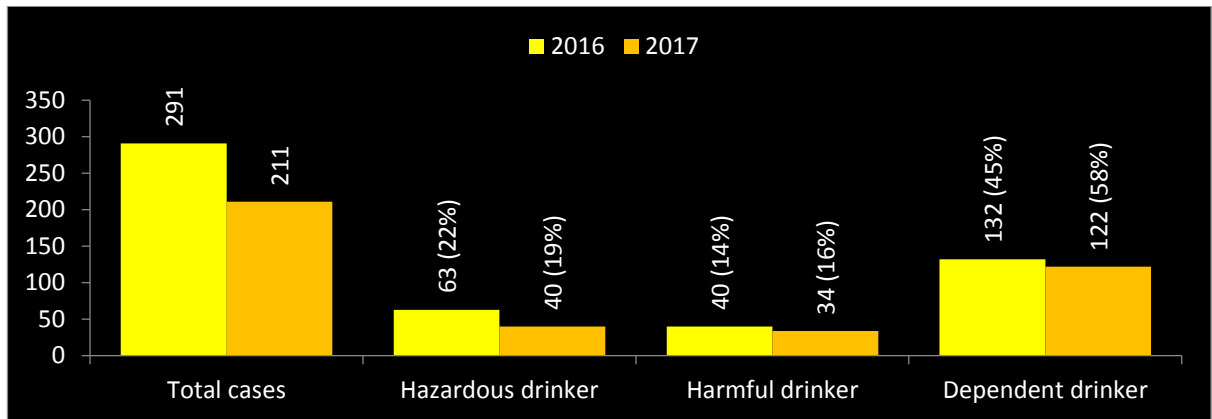
NDTRS cases treated for Alcohol are categorised by the extent of the problem, ranging from hazardous to harmful or dependent drinking. The Health Research Board's definition of these categories is as follows (Health Research Board, 2016):

- **Hazardous drinking** increases the risk of harmful consequences for the user. It describes drinking over the recommended limits by a person who has no apparent alcohol-related health problems.
- **Harmful drinking** is a pattern of use that results in damage to physical or mental health. Some would also consider social consequences among the harms caused by alcohol.
- **Dependent drinking:** includes a strong desire to consume alcohol, impaired control over its use, persistent drinking despite harmful consequences, a higher priority given to drinking than to other activities and obligations, increased alcohol tolerance. Also notably a physical withdrawal reaction when alcohol use is discontinued.

Out of all cases treated for Alcohol, the extent of the problem for the majority was categorised at the highest level as dependent drinking (Charts 4.31 & 4.32).

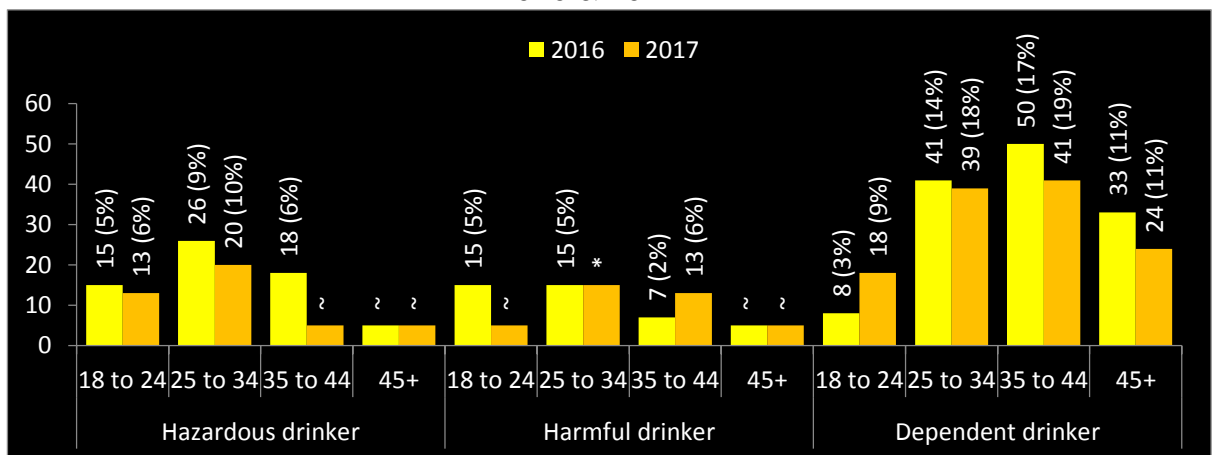
TREATED DRUG AND ALCOHOL USE

Chart 4.31: Treated cases by extent of Alcohol problem, NDTRS 2016 & 2017



Category totals less than 100% as category 'unknown' removed

Chart 4.32: Treated cases by extent of Alcohol problem by age, NDTRS 2016 & 2017

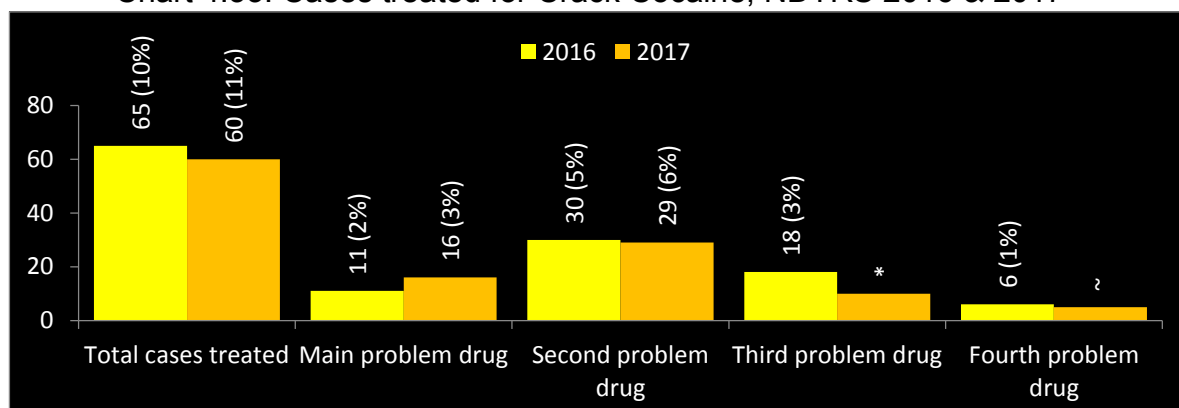


Category totals less than 100% as category 'unknown' removed

An analysis of cases treated for Crack Cocaine is provided as DATMS data has continued to identify an increase in the use of this drug. From 2016 and 2017, there has been a slight reduction in the number of cases treated for this drug (Chart 4.33). The majority of cases were aged 35 to 44 years (Chart 4.34). An explanation for the discrepancy between NDTRS and DATMS data may include under-reporting to the NDTRS.

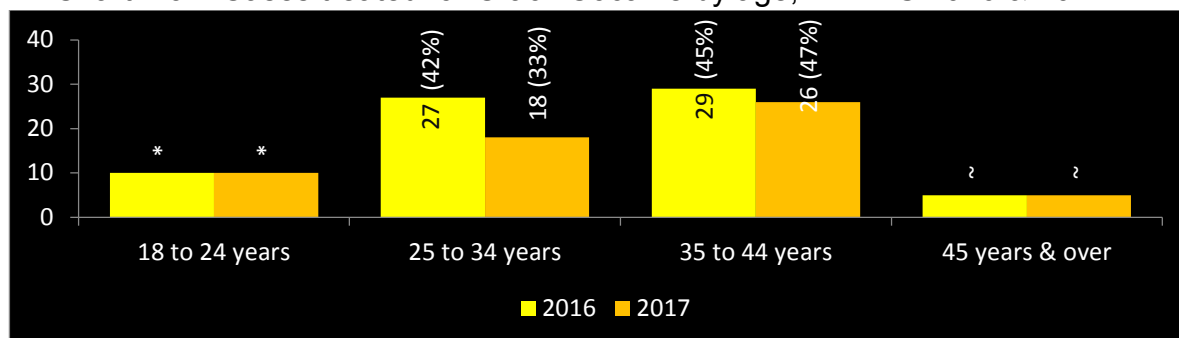
DRUG AND ALCOHOL TRENDS MONITORING SYSTEM YEAR 3

Chart 4.33: Cases treated for Crack Cocaine, NDTRS 2016 & 2017



*Number of cases greater than 5 not reported to ensure cases with 5 or less are not disclosed
~Number of cases too small to be reported (5 or less)

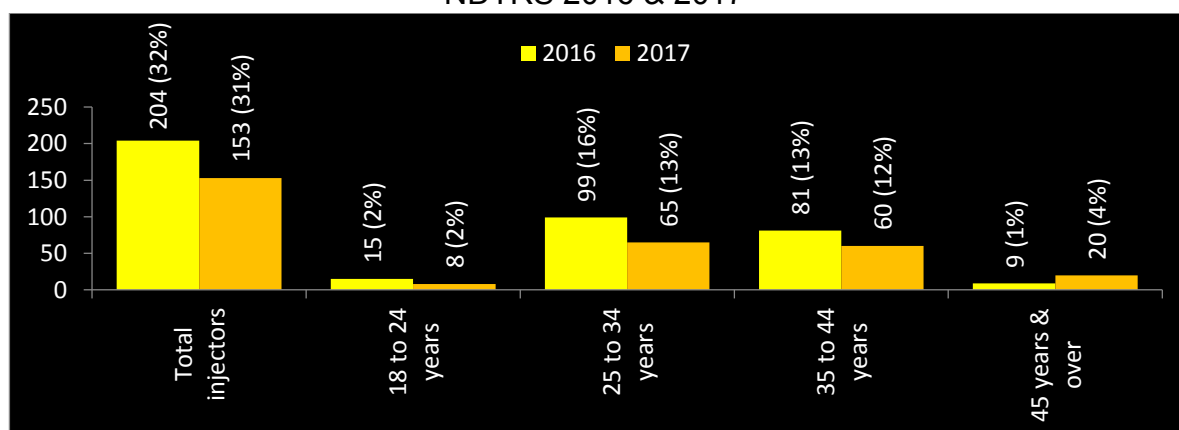
Chart 4.34: Cases treated for Crack Cocaine by age, NDTRS 2016 & 2017



*Number of cases greater than 5 not reported to ensure cases with 5 or less are not disclosed
~Number of cases too small to be reported (5 or less)

High risk drug use includes injecting drug use. In 2016 and 2017, almost a third of treated cases reported injecting drugs in their lifetime (Chart 4.35). The most common drug injected was Heroin (Chart 4.36).

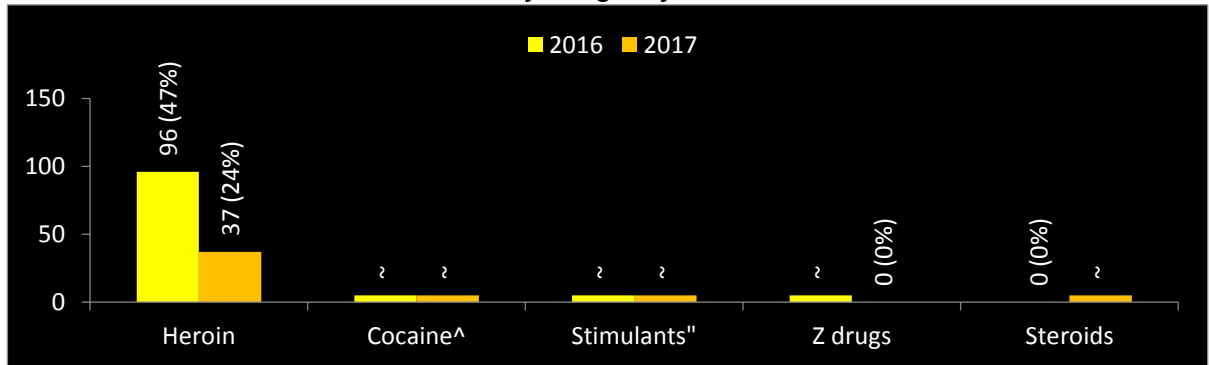
Chart 4.35: Treated cases by lifetime injecting drug use by age, NDTRS 2016 & 2017



Category totals less than 100% as category 'not known' removed

TREATED DRUG AND ALCOHOL USE

Chart 4.36: Treated cases by drugs injected, NDTRS 2016 & 2017



Category totals less than 100% as category 'not known' removed

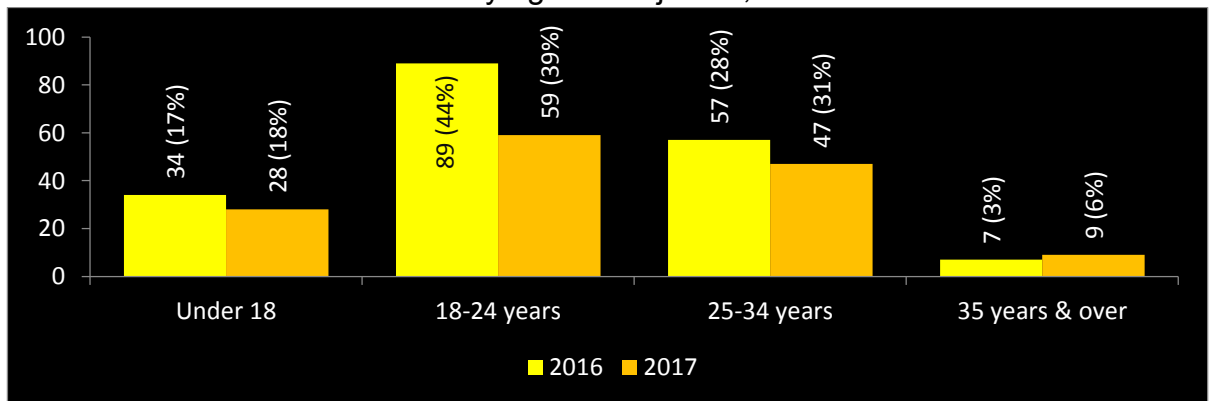
^Includes Powder & Crack Cocaine

''Includes Mephedrone, Methamphetamine

Year 3 DATMS participants also reported the use of injected skin tanning drugs. The use of non-psychoactive drugs (Anabolic Steroids and Injected Skin Tan) was also reported in Year 1 and 2. In addition, there was no evidence of treated drug users aged under 18 injecting drugs in Year 3 or in either of the previous reporting periods.

The majority of treated cases reporting injecting drug use were aged between 18 and 24 years when they started injecting (Chart 4.37).

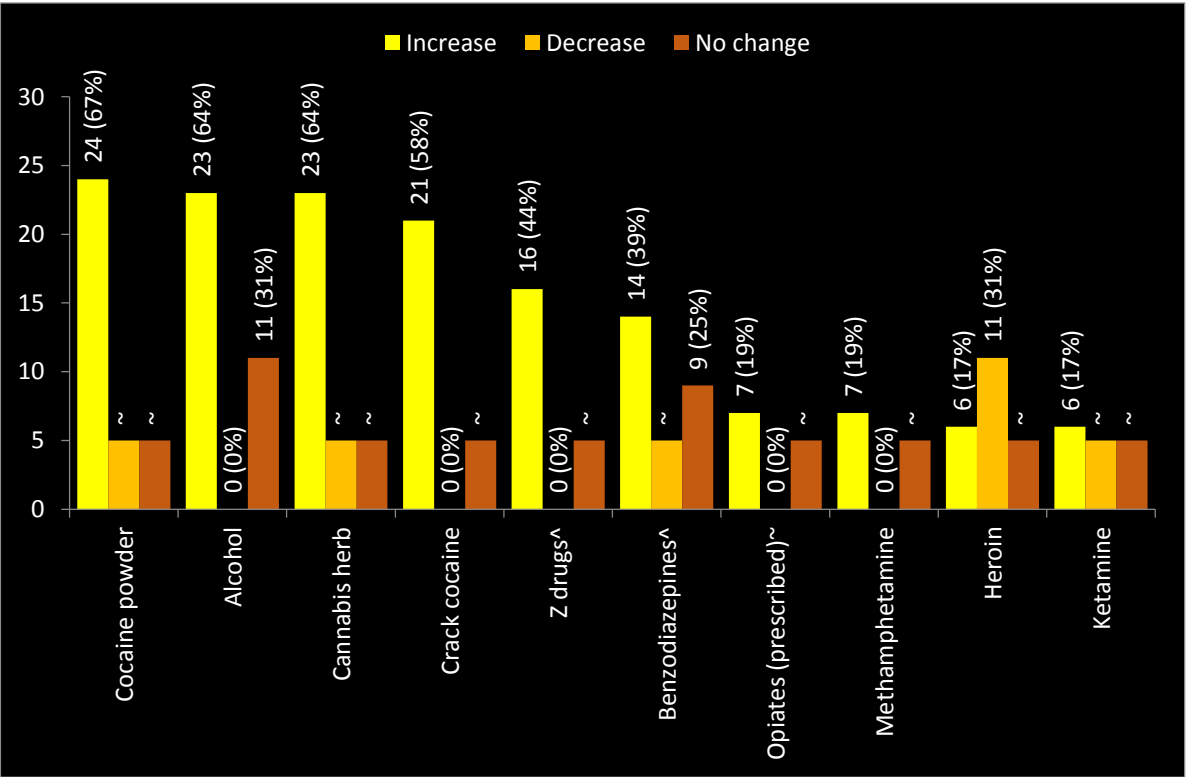
Chart 4.37: Treated cases by age first injected, NDTRS 2016 & 2017



CHANGES IN DRUG USE

DATMS participants reported perceptions concerning changes in drug use among treated drug users from Year 2 to 3 in Dublin 15 (Chart 4.38)³. All of these changes relate to treated adult drug users; changes among those aged under 18 relate only to increases in the use of Alcohol, Cannabis and Cocaine powder.

Chart 4.38: Changes in drug use among treated drug users from DATMS Year 2 to 3



Category totals do not add up to 100% as category 'unknown' not included

~Number too small to be reported (5 or less)

^Includes counterfeit

~Tramadol, Oxycodone, Tylex, Kapake

Some treated drug users reported an increase in the use of Pregabalin (Lyrica), MDMA, Methadone and OTC Codeine based drugs (Solpadeine, Nurofen Plus); the number of participants reporting increases was too small to be meaningful.

³ Analysis based on 36 participants (Treated drug users and service providers)

METHADONE MAINTENANCE SERVICES IN DUBLIN 15

Year 3 examined the distribution of methadone maintenance prescribing and dispensing services in Dublin 15. It identified that Ongar, Tyrrelstown and Carpenterstown are severely lacking in these services despite the fact that we have found through our drug litter and treatment demand maps that there is demand for these services in these areas.

In 2015, the Central Treatment List (CTL) reported that 270 patients in Dublin 15 were prescribed methadone and 95% were aged over 30. In 2016, the CTL reported a slight increase in the number of patients prescribed this drug, though the actual number was not provided.

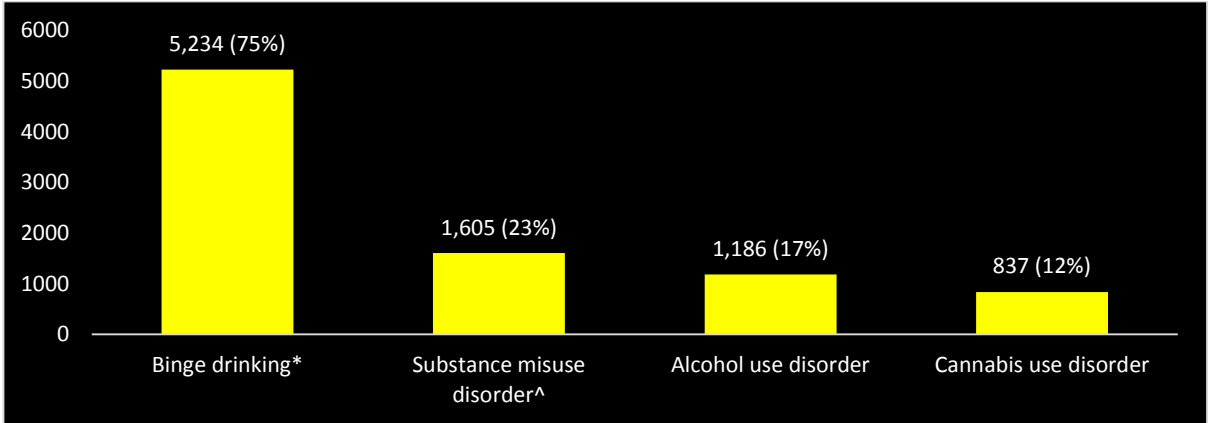
PREVALENCE RATES OF SUBSTANCE MISUSE IDENTIFY LARGE PERCENTAGE OF PROBLEM DRUG USERS IN DUBLIN 15 NOT IN TREATMENT

Estimated prevalence rates of problem drug and alcohol use identify a large proportion of problem drug users in Dublin 15 not seeking treatment. The following analyses estimate that between 1% and 3% of problem drug and alcohol users in Dublin 15 attend treatment services.

Research completed by the Royal College of Surgeons in Ireland (RCSI) reported lifetime prevalence rates of substance misuse among Irish people aged 19 to 24 years (Cannon *et al.*, 2013). The data is contextualised by CSO data to estimate the number of young people in Dublin 15 with substance use disorders (Chart 4.39)⁴. By the age of 24, 23% (1,605) young people living in Dublin 15 are likely to have a substance misuse disorder.

⁴ CSO 2016 data reported 6,979 19 to 24 year olds were living in Dublin 15

Chart 4.39: Lifetime prevalence rates of substance misuse among 19 to 24 year olds living in Dublin 15, RCSI & CSO data



*Binge drinking: Consumption of 6 or more standard drinks during one drinking episode

^Substance misuse disorder: Polydrug use of alcohol & other drugs

NDTRS 2017 data reported 19 treated cases aged 19 to 24 years living in the BLDATF area. When this is compared with the estimated prevalence of substance use disorders, just 1% of young people living in Dublin 15 with a substance misuse disorder attended treatment services.

As part of the 2018 strategic review of the BLDATF, estimated prevalence rates of problematic drug and alcohol use in the BLDTAF area were produced (Murtagh & Partners, 2018). The review reported an estimate of 11,865 people living in the BLDATF area with problem drug and alcohol use.

To produce this estimate, Murtagh and Partners used the NDTRS data and estimated prevalence rates of problem Opiate and Benzodiazepine use among 15 to 64 year olds in Scotland (Information Service Division Scotland & National Service Scotland, 2014). The Scottish research estimated the inner city prevalence rate for problem Opiate and Benzodiazepine use was 3.23%. The population of Dublin 15 aged 15 to 64 years was 73,481 and 3.23% of this population produces the estimate of 2,373 problem Opiate and Benzodiazepine users in Dublin 15. A number of assumptions from the NDTRS data were utilised to estimate the prevalence of the problematic use of all drugs and alcohol in Dublin 15. Firstly, that Opiates and Benzo-diazepines account for approximately 40% (2,373) of inner city drug use. Thus, producing the estimate of 5,932 people treated for all other drugs. Secondly, that 50% of cases were treated for alcohol use (5,932 cases). Therefore, estimating the prevalence of problematic drug and alcohol use at 11,865 people in Dublin 15. In 2017, 352 treated cases aged 15 to 64 years

were living in the BLDATF area (NDTRS 2017 data reported 247 treated cases aged 18 years and over, DATMS data reported 105 treated cases aged 15 to 17 years). When this data is compared with the Scottish estimated prevalence rate, just 3% of people living in Dublin 15 with a substance misuse disorder attended treatment services.

Murtagh and Partners reported that their analysis identified significant gaps in the availability and delivery of treatment services. They acknowledged that not all people with problematic drug and alcohol use will access services and especially not at the same time. They concluded that the challenge for local services is to identify and engage this target group.

In addition, all three years of the DATMS reported that some peer and family groups perceived drugs to be widely used, risk free and socially acceptable. This perception was reported to be a factor that contributed to drug use. Perhaps this normalisation of drug use may partly explain the potential lack of help seeking in Dublin 15⁵.

⁵ See chapter 'Factors contributing to drug and alcohol use' for more data concerning the normalisation of drug use

5. UNTREATED DRUG & ALCOHOL USE

All three years of the DATMS reported untreated drug use among all socio-economic groups, ethnicities and in all areas of Dublin 15. The following reports the drugs used by untreated young drug users in Dublin 15 in 2017:

UNTREATED YOUNG DRUG USERS						
(aged up to 24 years)						
	Drug type	Irish	Irish Traveller	Irish African	Irish Eastern European	Irish Asian
Most common	Alcohol	√	√		√	√
	Cannabis herb	√	√	√	√	√
	MDMA	√	√	√	√	
	Cocaine powder	√	√	√	√	
	Ketamine	√				
Least common	Alcohol			√		
	Cannabis resin	√	√			
	Cannabis oil	√				
	Ketamine		√	√	√	
	Amphetamines	√	√			
	Methamphetamine	√				
	Crack cocaine	√				
	Magic mushrooms	√				
	LSD	√				
	Benzodiazepines, Z drugs^	√	√	√		
	Opiates (prescribed)~		√			
	Pregabalin (Lyrica)	√	√			
	OTC Codeine*		√			
	OTC Cough syrup (Lean)		√	√	√	
Other drugs used	Anabolic steroids	√	√	√	√	
	Injected skin tan	√	√			
	Slimming drugs	√	√			

^Includes counterfeit

~Tramadol, Oxycodone, Fentanyl, Tylex, Kapake

*Solpadeine, Nurofen Plus, Feminax, Ibuprofen

- The most commonly used drugs by untreated young drug users reported in Year 3 were similar to those reported in Year 1 and 2
 - Alcohol was the most commonly used by all ethnicities except Irish Africans who reported Cannabis as the most commonly used drug
- A larger range of drug types were reported as least commonly used among untreated young drug users in Year 3 compared with Year 1 and 2
 - This may be due to an increase in data quality rather than an increase in drug use
- Irish and Irish Traveller ethnicities reported the use of most drug types
 - This may be due to larger numbers of people from these ethnicities participating in the research
- As drugs are generally used without completing an analysis of their composition it is probable that synthetic types (New Psychoactive Substances) are used with or without users' knowledge

The following reports the age that young people began using drugs. There were no changes from Year 1 to Year 3. The norm is reported for all drug types and for some the norm plus youngest age is reported.

DRUG TYPE BY AGE OF INITIATION	
Alcohol, cannabis, MDMA	• 14 years (12 years = youngest)
Cocaine powder, Benzodiazepines, Z drugs	• 15 years (14 years = youngest)
Ketamine, codeine OTC drugs	• 16 years (14 years = youngest)
Skin tanning injections	• 18 years (14 years = youngest)
Steroids	• 15 years

DRUG AND ALCOHOL TRENDS MONITORING SYSTEM YEAR 3

From to Year 1 to 3, untreated drug users aged 25 years and over were under-represented in the DATMS. Year 3 produced limited data concerning drug use among Irish and Irish Traveller ethnicities. The following reports the drugs used by untreated adult drug users in Dublin 15 in 2017; it was similar to the drug use profile provided in DATMS Year 1 and 2.

UNTREATED ADULT DRUG USERS						
(aged 25 years and over)						
	Drug type	Irish	Irish Traveller	Irish African	Irish Eastern European	Irish Asian
Most common	Alcohol	√	√	No data		
	Cannabis herb	√	√			
	MDMA	√				
	Cocaine powder	√	√			
	Benzodiazepines, Z drugs^		√			
	Opiates (prescribed)~		√			
	Pregabalin (Lyrica)		√			
	OTC Codeine*		√			
Least common	Cannabis resin	√	√			
	Cannabis oil		√			
	Ketamine	√	√			
	MDMA		√			
	Amphetamines		√			
	Crack cocaine	√				
	Magic mushrooms	√				
	Heroin	√				
Other drugs used	Anabolic steroids	√	√			
	Injected skin tan		√			
	Slimming drugs	√	√			

^Includes counterfeit

~Tramadol, Oxycodone, Fentanyl, Tylex, Kapake

*Solpadeine, Nurofen Plus, Feminax, Ibuprofen

Drugs used by untreated adult drug users were similar to those used by untreated young drug users, thus only the differences shall be discussed:

- Most commonly used drugs by Irish Travellers also included a range of prescribed and OTC drugs
- Least commonly used drugs by Irish untreated adult drug users also included Heroin
- Unlike untreated young drug users, untreated adult drug users did not report the use of Methamphetamine, LSD, OTC cough syrup (Lean)

UNTREATED POLYDRUG USE

The profile of untreated polydrug use is the same as reported in Year 1 and 2. Polydrug use was the norm and alcohol was an integral part of it. The most common forms of polydrug use were the same among untreated young and adult drug users.

UNTREATED YOUNG & ADULT DRUG USERS

Most common forms
of polydrug use

- 1st: Alcohol and Cannabis herb
- 2nd: Alcohol and Cocaine powder and/or MDMA

Young and adult untreated drug users reported that after the use of stimulant type drugs (Cocaine powder, MDMA) other drugs were used to aid the withdrawal; these drugs included Cannabis, Alcohol, Benzodiazepines and Z drugs.

PATTERN OF UNTREATED DRUG USE

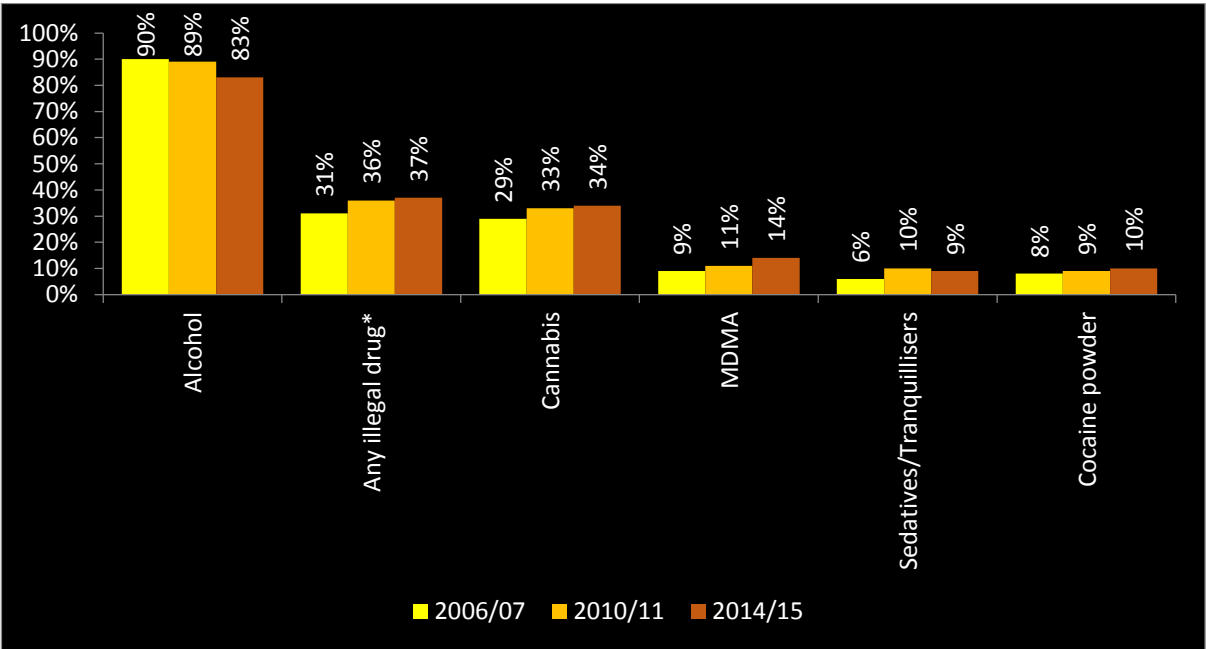
The pattern of untreated drug use was the same as reported in Year 1 and 2. Alcohol and Cannabis herb were used throughout the week, and other drugs were mainly used at the weekend. Cannabis herb was also used during school time⁶. The frequency of drug use varied from daily, weekly to less regular use. The frequency of drug use was age dependent, with those aged 18 and over reporting more regular use.

⁶ The use of drugs during school time is discussed further in the chapter 'Consequences of drug and alcohol use'

PREVALENCE RATES OF DRUG USE IN IRELAND AND DUBLIN 15

The NACDA National Drug Prevalence Survey (NACDA, 2016) provides a trend analysis of the prevalence of drug use in the general Irish population from 2006/07 to 2014/15. The charts below report lifetime, recent (last year) and current (last month) prevalence rates of drug use in Ireland (Charts 5.1 to 5.6). The findings suggest illegal drug use has increased and alcohol use has decreased. Though the proportion of population using alcohol remains high and it is the most commonly used drug (also reported by the DATMS).

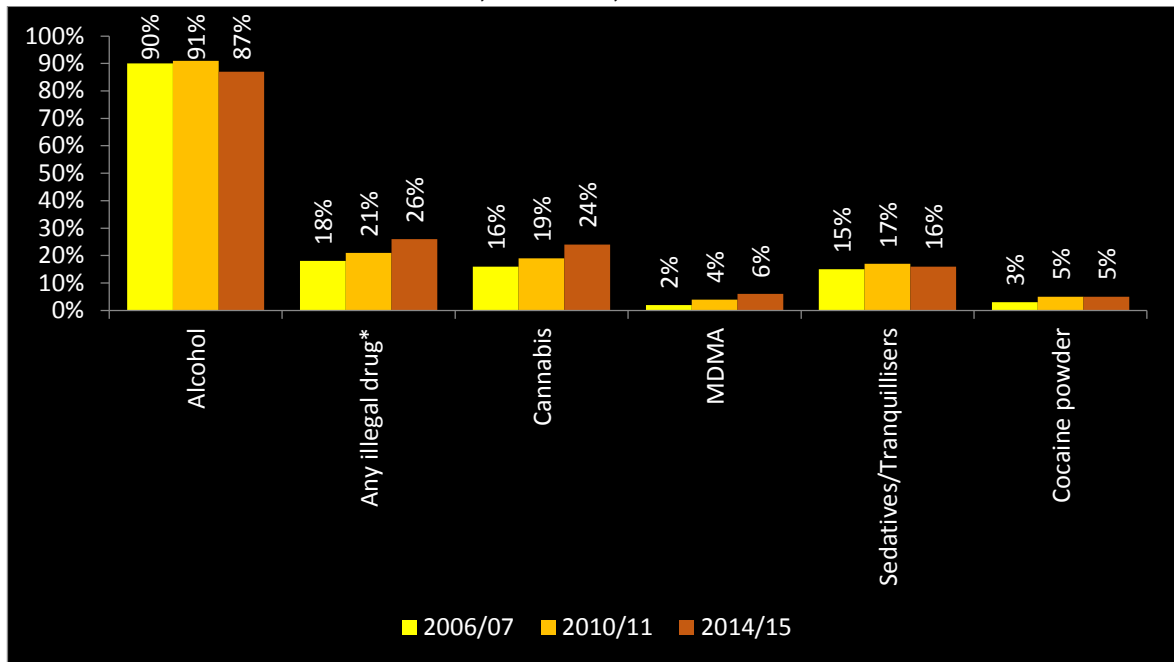
Chart 5.1: Lifetime prevalence rates of drug use among 15 to 34 year olds in Ireland, 2006/07, 2010/11 & 2014/15



*Any illegal drug refers to cannabis, MDMA, cocaine powder, magic mushrooms, amphetamines, poppers, LSD, new psychoactive substances, mephedrone, solvents, crack cocaine, heroin

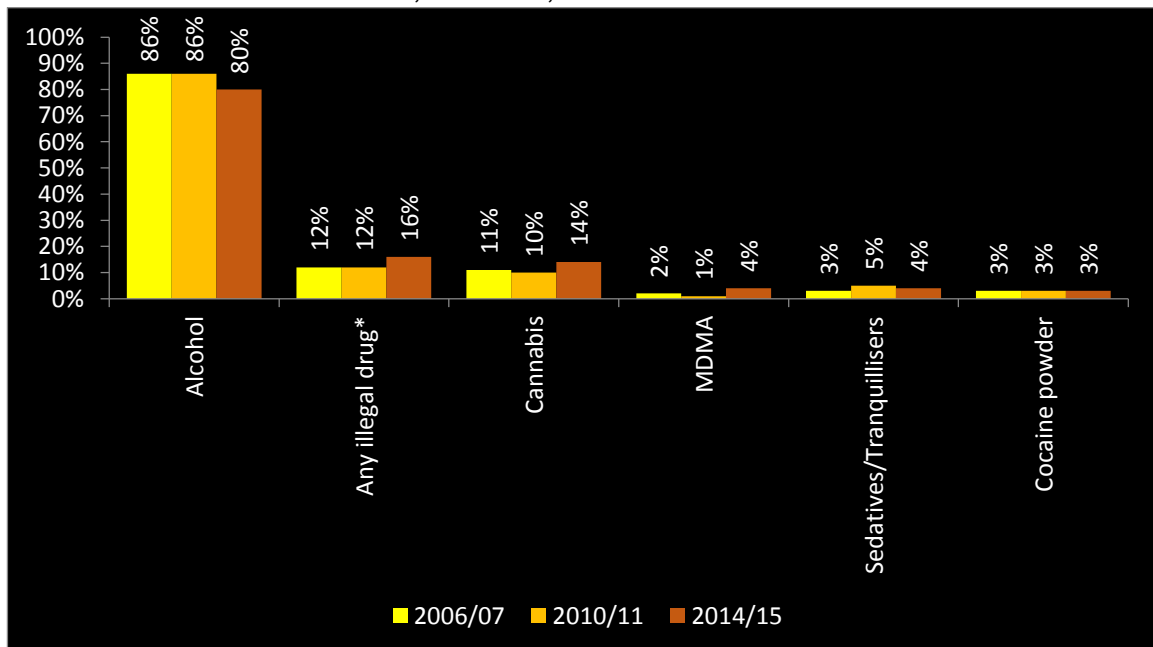
UNTREATED DRUG AND ALCOHOL USE

Chart 5.2: Lifetime prevalence rates of drug use among 35 year olds and over in Ireland, 2006/07, 2010/11 & 2014/15



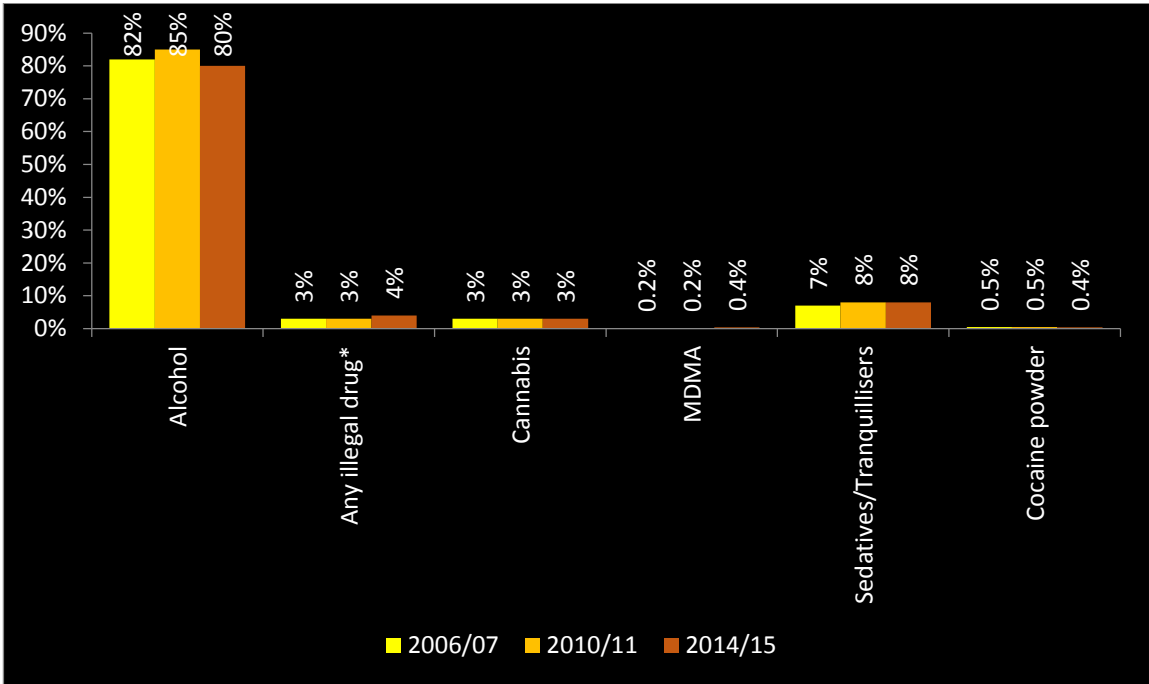
*Any illegal drug refers to cannabis, MDMA, cocaine powder, magic mushrooms, amphetamines, poppers, LSD, new psychoactive substances, mephedrone, solvents, crack cocaine, heroin

Chart 5.3: Last year prevalence of drug use among 15 to 34 year olds in Ireland, 2006/07, 2010/11 & 2014/15



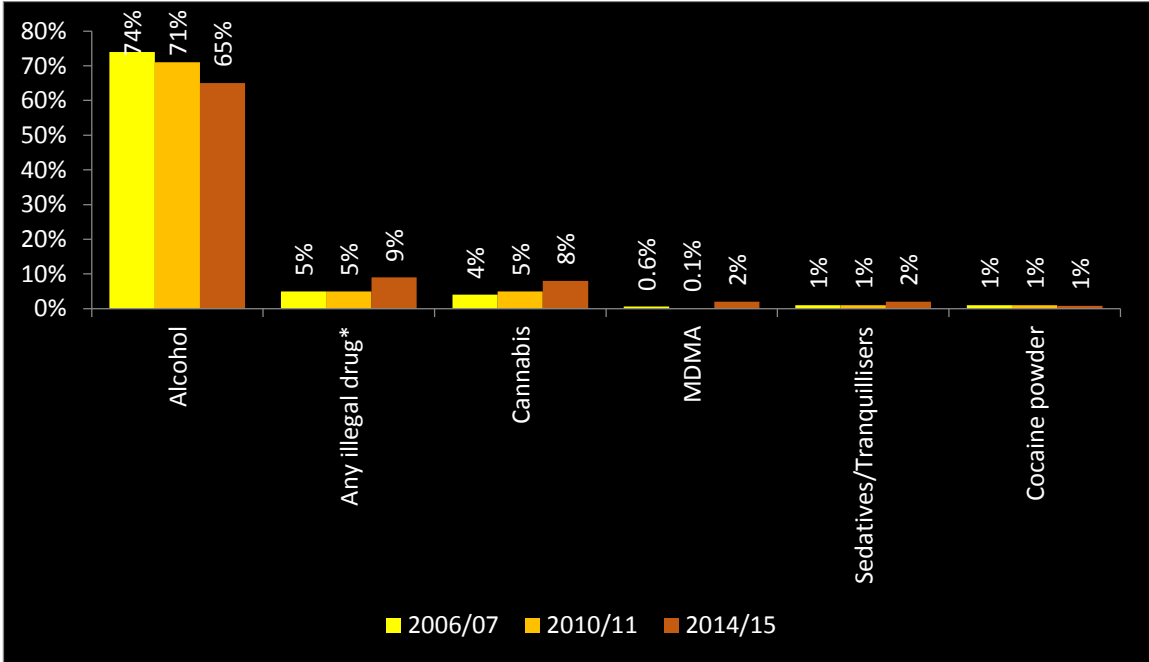
*Any illegal drug refers to cannabis, MDMA, cocaine powder, magic mushrooms, amphetamines, poppers, LSD, new psychoactive substances, mephedrone, solvents, crack cocaine, heroin

Chart 5.4: Last year prevalence of drug use among 35 year olds and over in Ireland, 2006/07, 2010/11 & 2014/15



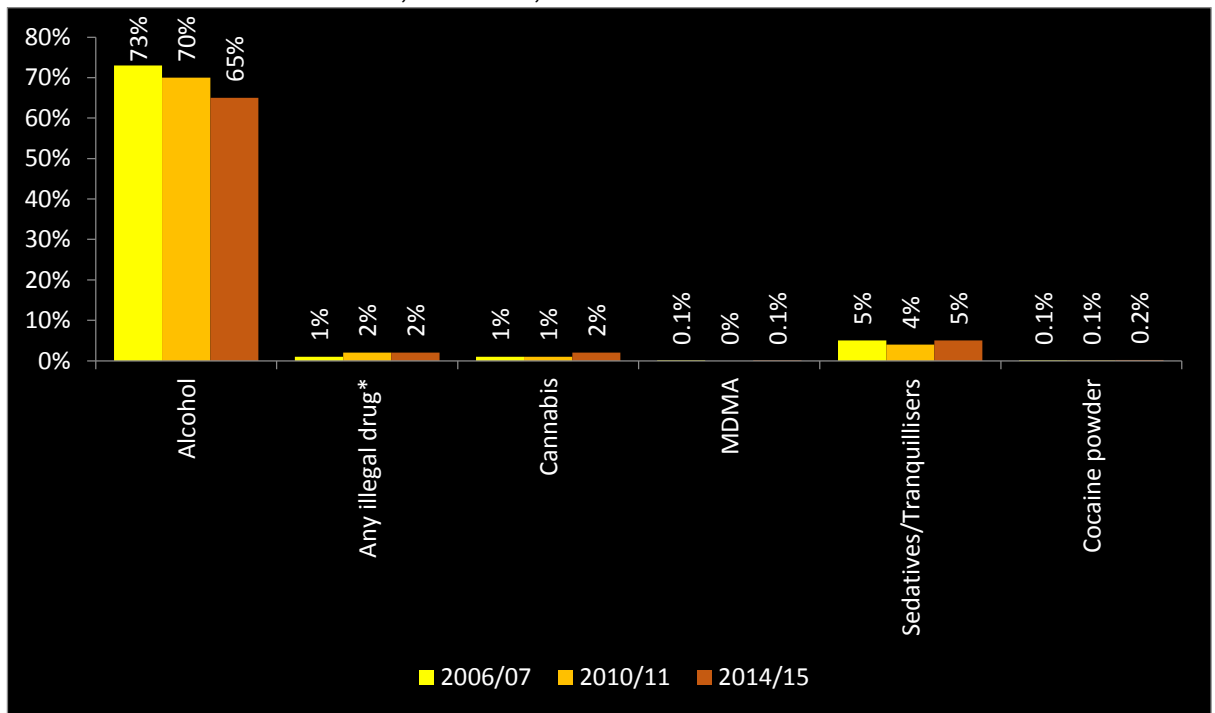
*Any illegal drug refers to cannabis, MDMA, cocaine powder, magic mushrooms, amphetamines, poppers, LSD, new psychoactive substances, mephedrone, solvents, crack cocaine, heroin

Chart 5.5: Last month prevalence of drug use among 15 to 34 year olds in Ireland, 2006/07, 2010/11 & 2014/15



*Any illegal drug refers to cannabis, MDMA, cocaine powder, magic mushrooms, amphetamines, poppers, LSD, new psychoactive substances, mephedrone, solvents, crack cocaine, heroin

Chart 5.6: Last month prevalence of drug use among 35 year olds and over in Ireland, 2006/07, 2010/11 & 2014/15

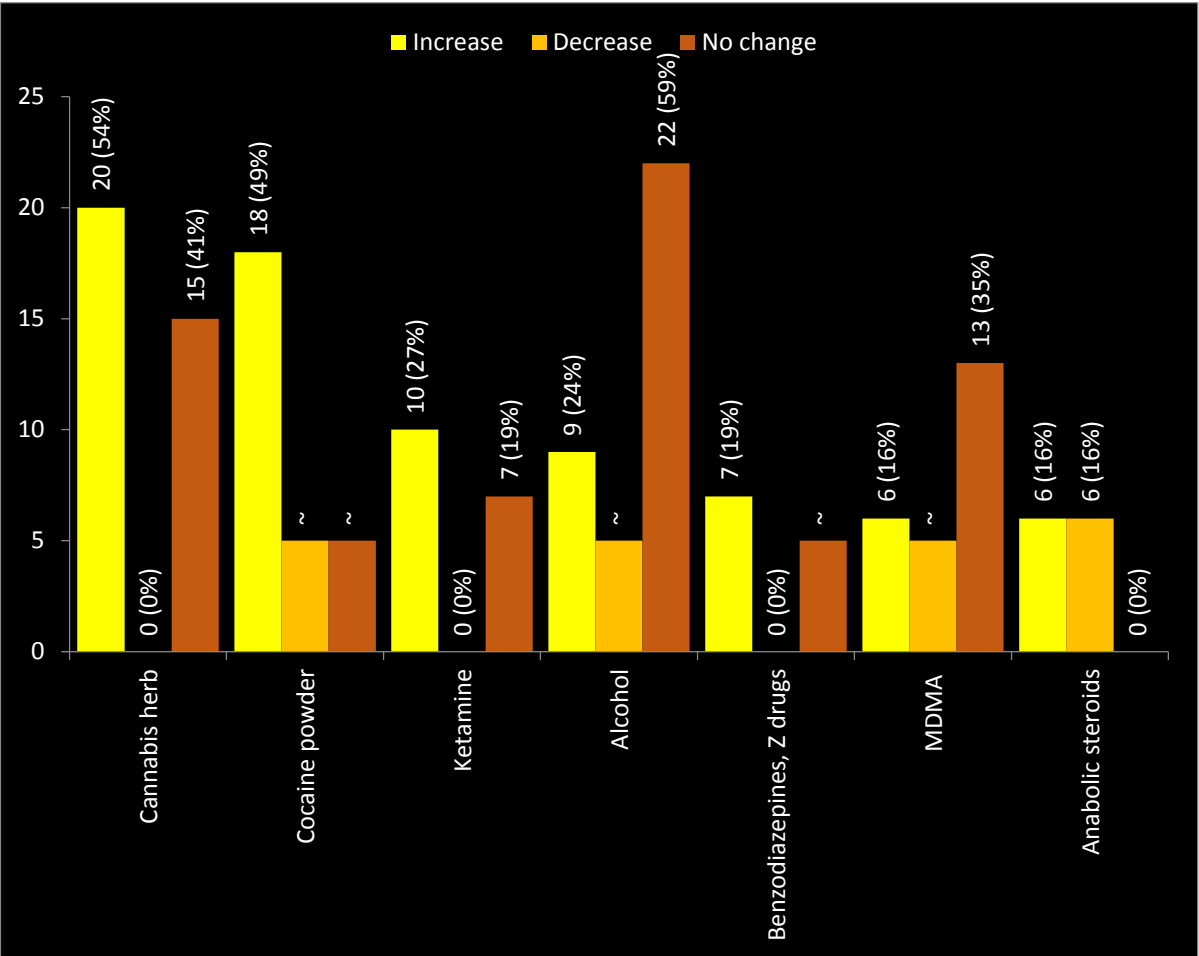


*Any illegal drug refers to cannabis, MDMA, cocaine powder, magic mushrooms, amphetamines, poppers, LSD, new psychoactive substances, mephedrone, solvents, crack cocaine, heroin

CHANGES IN DRUG USE

DATMS participants reported changes in untreated drug use in Dublin 15 in 2017 (Chart 5.7)⁷.

Chart 5.7: Changes in untreated drug use in 2017, DATMS Year 3



Category totals do not add up to 100% as category 'unknown' not included
~Number too small to be reported (5 or less)

There were similarities and differences between these perceptions and the findings of the NACDA drug prevalence survey (2014/15). As the majority of DATMS participants were aged under 35 years, this comparison relates to drug use among young people aged 15 to 34 years.

- Similarities included an increase in the use of Cannabis, Benzo-diazepines and Z drugs

⁷ Analysis based on 37 participants (Untreated drug users, young people and service providers)

- Differences included:
 - DATMS reported no change in alcohol use, whereas the NACDA reported a decrease
 - DATMS reported no change in MDMA use, whereas the NACDA reported an increase
 - DATMS reported an increase in cocaine powder use which was also reported by the NACDA, though only regarding lifetime use with no change in the recent or current use of this drug

In relation to these differences, while the NACDA sample is larger and representative of the general Irish population, the DATMS is the most comprehensive dataset regarding Dublin 15.

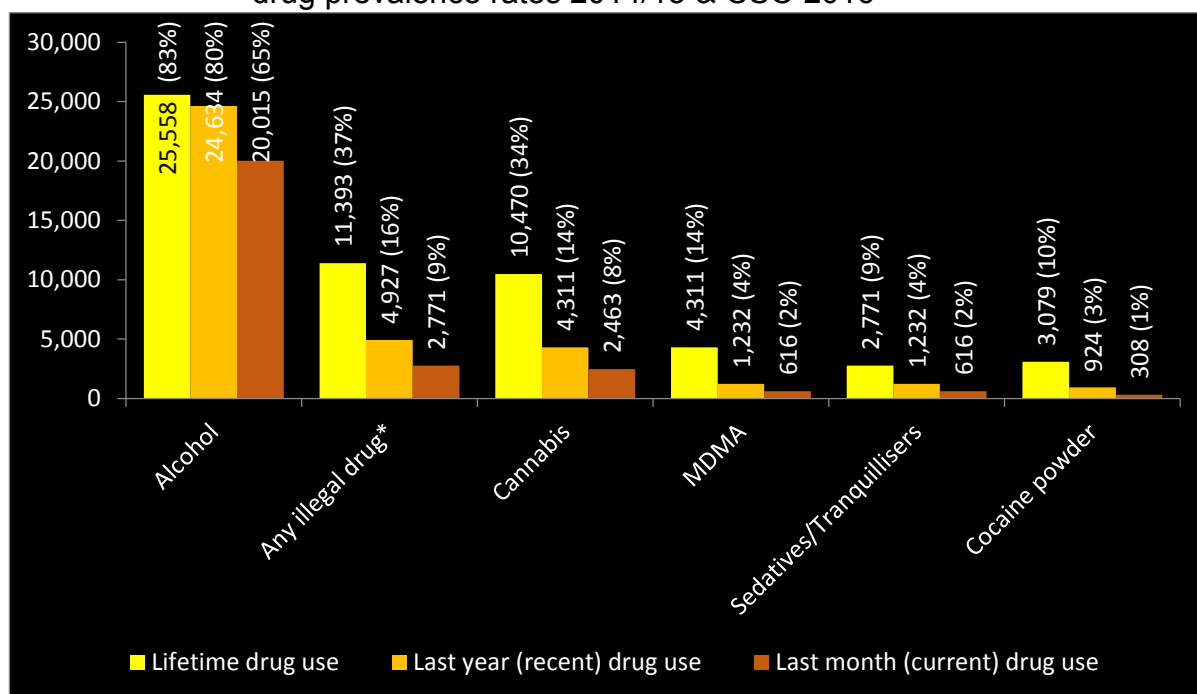
Similar to previous DATMS reports, the trend continues whereby Cannabis resin was not as commonly used as Cannabis herb and was harder to access. The use of Cannabis oil was reported for the first time, though it is not as commonly available as Cannabis herb.

2014/15 prevalence rates of drug use were used to estimate the number of drug users in Dublin 15; 2016 CSO population statistics were used for this analysis (Charts 5.8 to 5.9). The analysis reports:

- 20,015 Dublin 15 residents aged 15 to 34 years recently used alcohol compared with 32,873 aged from 35 years
- 2,771 Dublin 15 residents aged 15 to 34 years recently used illegal drugs compared with 1,011 aged from 35 years

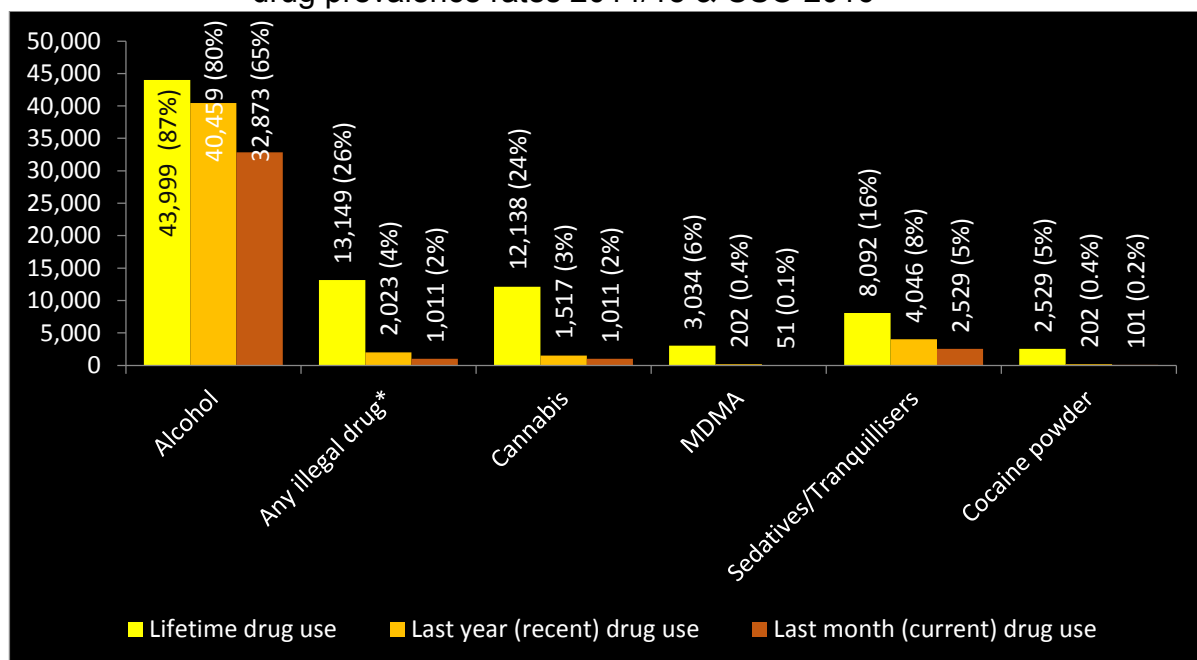
DRUG AND ALCOHOL TRENDS MONITORING SYSTEM YEAR 3

Chart 5.8: Number of drug users in Dublin 15 aged 15 to 34 years, NACDA drug prevalence rates 2014/15 & CSO 2016



*Any illegal drug refers to cannabis, MDMA, cocaine powder, magic mushrooms, amphetamines, poppers, LSD, new psychoactive substances, mephedrone, solvents, crack cocaine, heroin

Chart 5.9: Number of drug users in Dublin 15 aged from 35 years, NACDA drug prevalence rates 2014/15 & CSO 2016

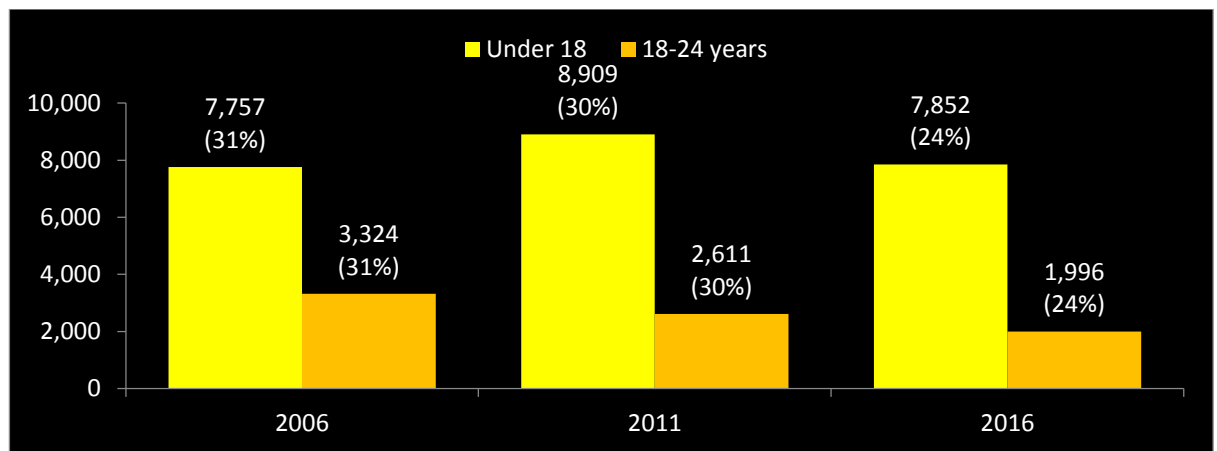


*Any illegal drug refers to cannabis, MDMA, cocaine powder, magic mushrooms, amphetamines, poppers, LSD, new psychoactive substances, mephedrone, solvents, crack cocaine, heroin

DUBLIN 15 AT RISK YOUTH POPULATION

It is important to quantify deprived youth populations as they have higher risk factors for drug use compared with non-deprived youths. This data can then be used for service planning. Year 2 mapped at risk under 18 year olds in Dublin 15 to identify where these young people lived. The map showed that the highest concentration of at risk youths live in areas traditionally associated with disadvantage (Mulhuddart, Corduff, Mountview, Blakestown, Tyrrelstown, Coolmine). This data was not provided for Year 3 and the Deprivation Index was used to calculate the at risk youth population of Dublin 15 (Chart 5.10)⁸. The areas within which these young people live were similar to the areas reported in Year 2.

Chart 5.10: Dublin 15 deprived populations aged under 18 and 18 to 24 years, CSO 2006 to 2016



⁸ Previously reported in chapter 'Socio-demographic profile of Dublin 15'

6. DRUG PREVENTION EDUCATION
EDUCATIONAL PSYCHOLOGICAL ASSESSMENTS

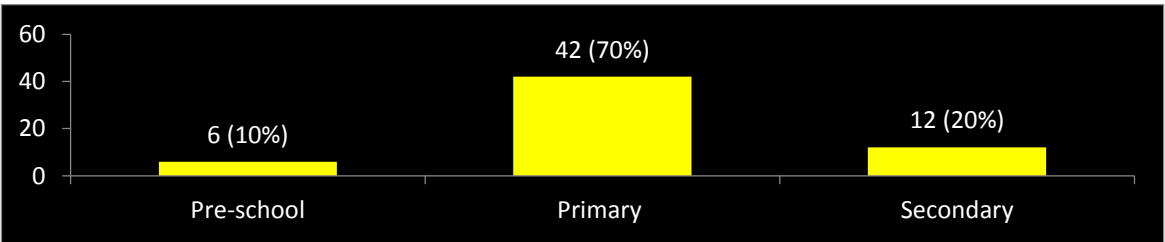
Educational psychological assessments evaluate learning, behaviour, social and emotional development, and identify specific needs and supports required. Year 2 reported limited access to educational psychological assessments for young people in Dublin 15. This resulted in a lack of support for those with suspected educational and behavioural issues. This issue particularly affected young people and families from disadvantaged backgrounds with no resources to fund private assessments. Young people from disadvantaged backgrounds are more 'at risk' of under achievement and early school leaving than peers from affluent backgrounds. Having an unidentified or unsupported learning difficulty on top of this is adding another level of disadvantage. Risk factors for drug use include poor educational attainment, early school leaving and being from a disadvantaged background. To assist academic development and foster protective factors, early intervention was reported to be necessary. In 2017, funding was provided to address this gap in service provision. This initiative was a long-term measure in a drug prevention capacity. Service providers in Year 3 reported the benefits of this provision:

- Identified needs that were unmet and impacting on education
- Facilitated an understanding of challenging behaviours
- Applications for educational resources could be sought
- Strengthened relationship between family and school

PROFILE OF CHILDREN AND YOUNG PEOPLE WHO RECEIVED ASSESSMENTS

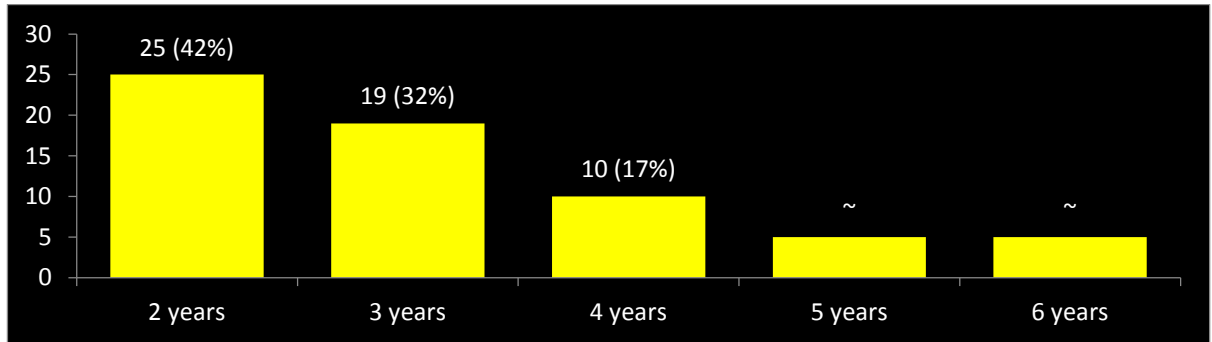
A total of 60 young people received educational psychological assessments in 2017 (Chart 6.1).

Chart 6.1: Number of educational psychological assessments by school level, DATMS Year 3



The need for our service provision is identified in the following chart which reports waiting lists of two or more years for these assessments (Chart 6.2).

Chart 6.2: Number of years waiting for educational psychological assessments, DATMS Year 3



~Number of cases too small to be reported (5 or less)

The following charts report the socio-demographic profile of the young people who received educational psychological assessments (Charts 6.3 to 6.6)

Chart 6.3: Gender of young people, DATMS Year 3

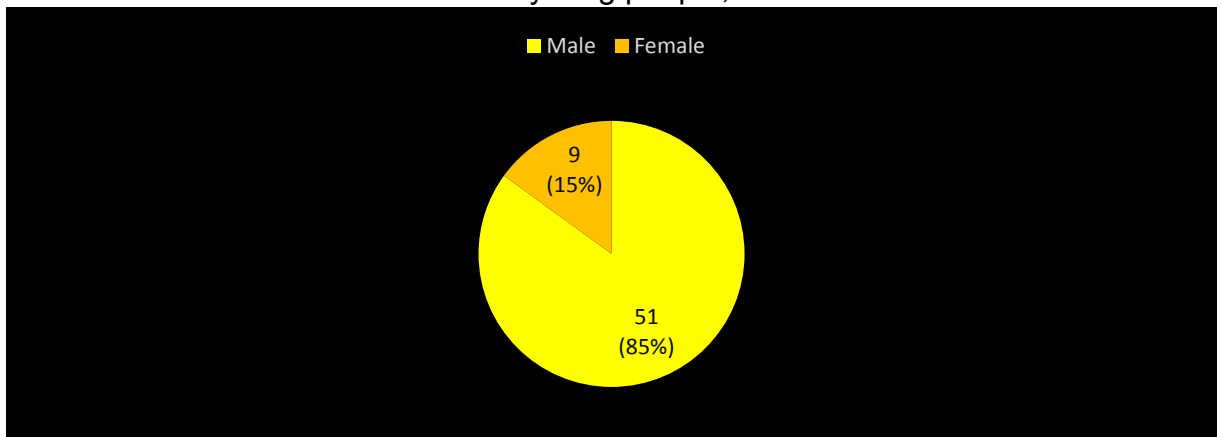


Chart 6.4: Age profile of young people, DATMS Year 3

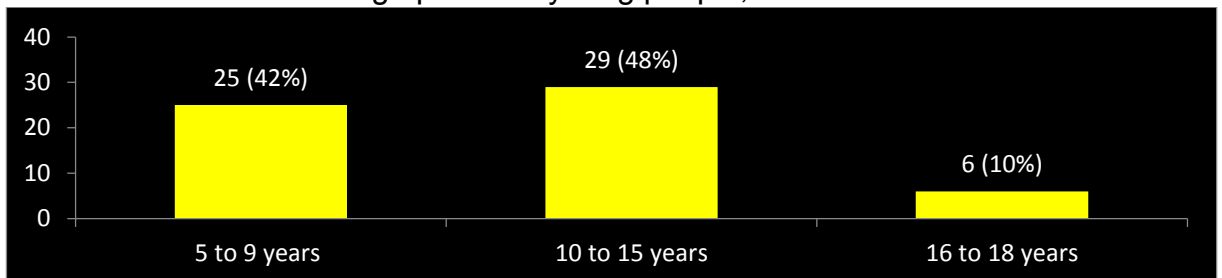


Chart 6.5: Ethnicity of young people, DATMS Year 3

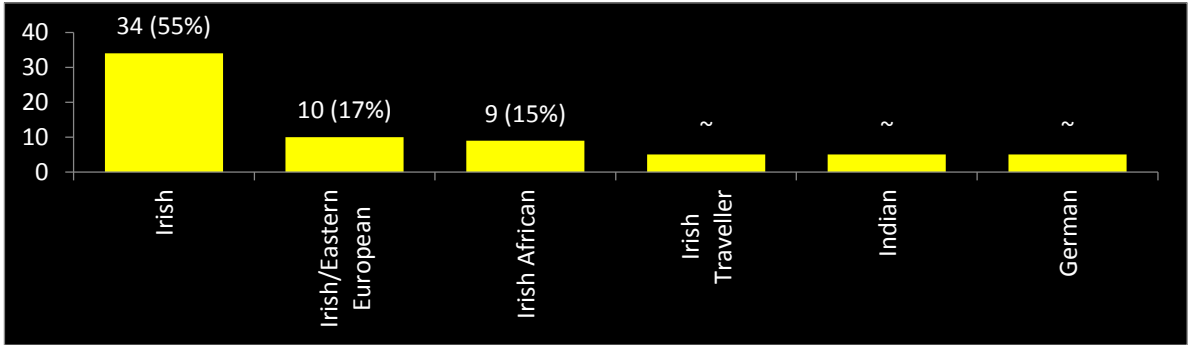
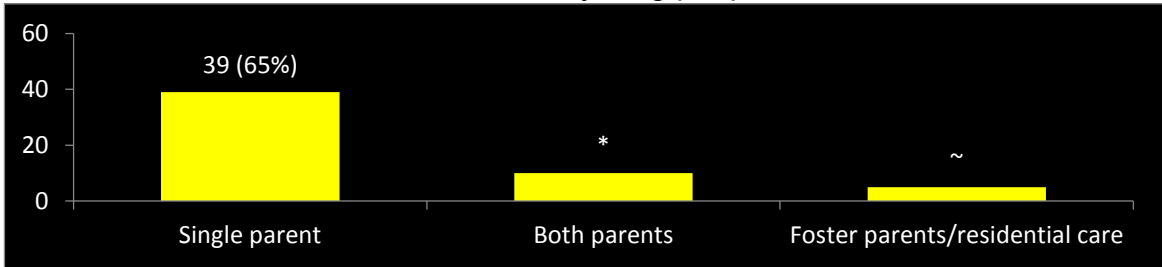


Chart 6.6: Parental status of young people, DATMS Year 3

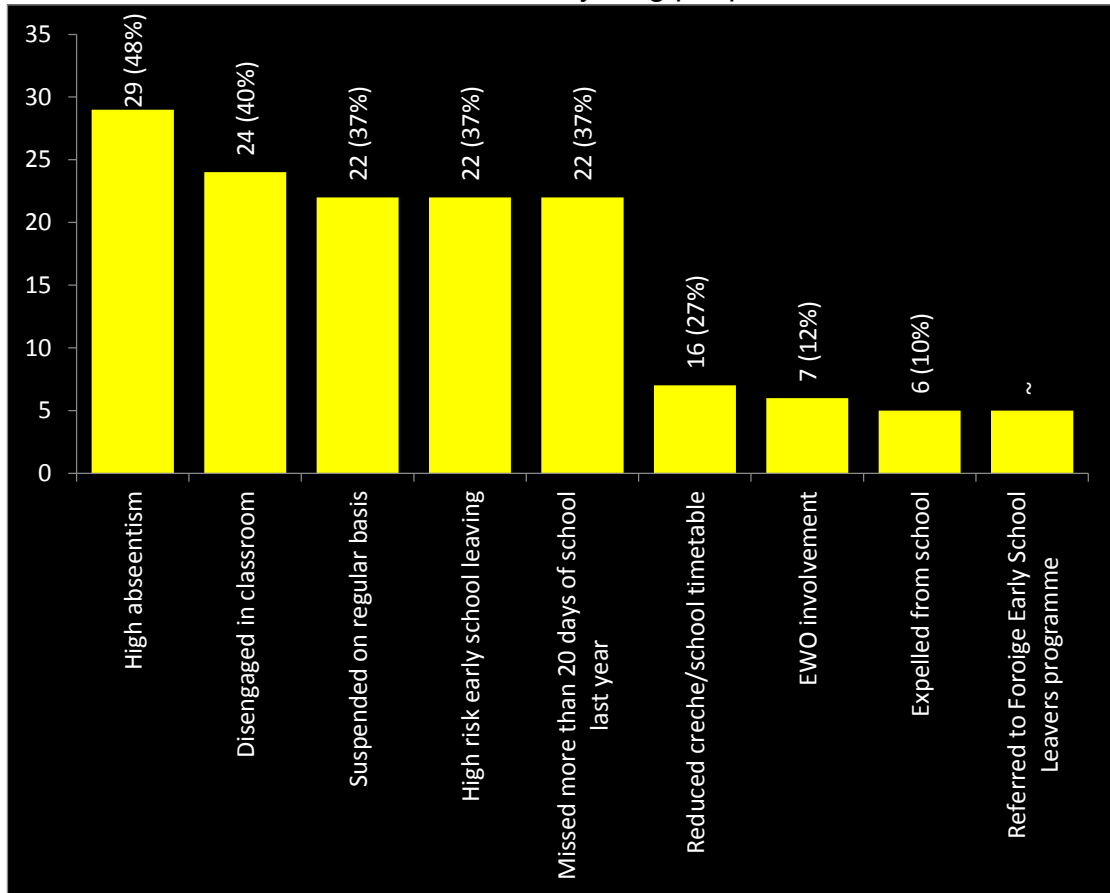


~Number of cases too small to be reported (5 or less)

*Number of cases greater than 5 not reported to ensure cases with 5 or less are not disclosed

The need to provide these assessments was further evidenced by the levels of disruption to young people’s education prior to assessment (Chart 6.7). Low educational attainment is a risk factor for drug use. In addition, a significant amount of young people had family circumstances that were risk factors for drug use (Charts 6.8 & 6.9), and almost a third were already engaged in high risk behaviours (Chart 6.10)

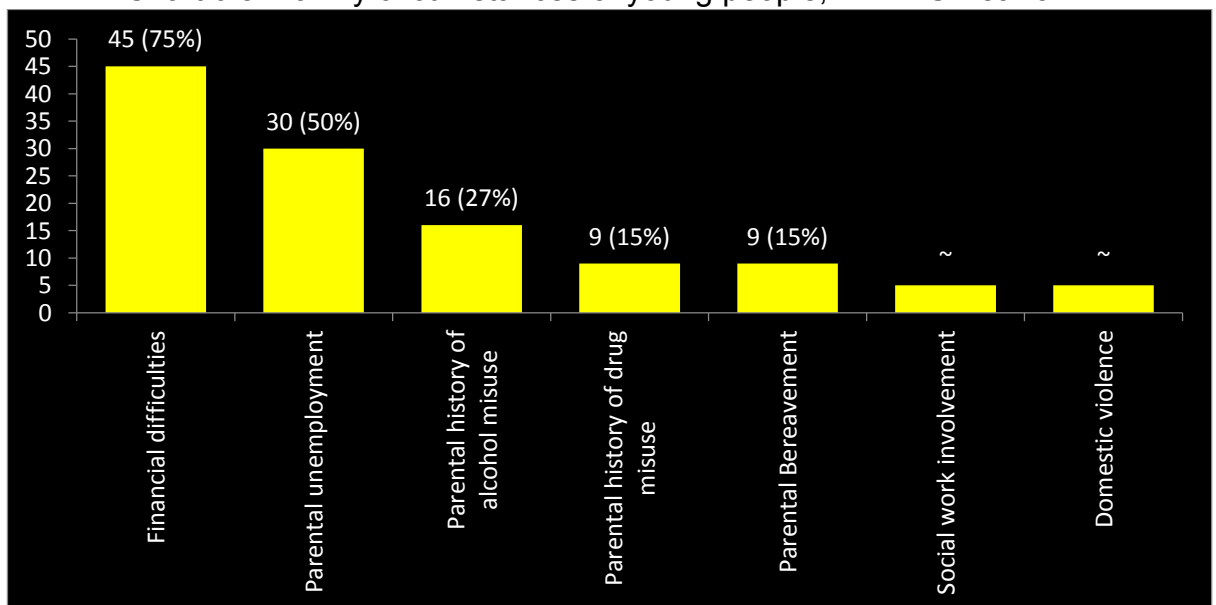
Chart 6.7: Educational record of young people, DATMS Year 3



~Number of cases too small to be reported (5 or less)

Totals exceed 100% as most young people experienced more than one educational disruption

Chart 6.8: Family circumstances of young people, DATMS Year 3



~Number of cases too small to be reported (5 or less)

Chart 6.9: Housing status of young people, DATMS Year 3

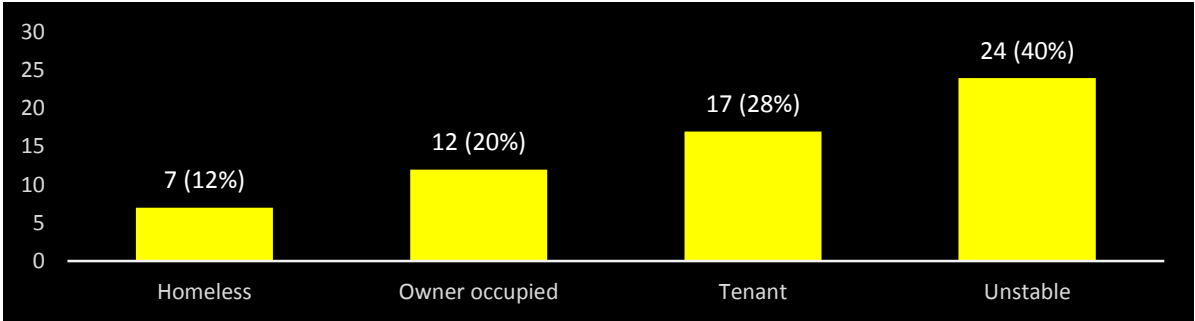
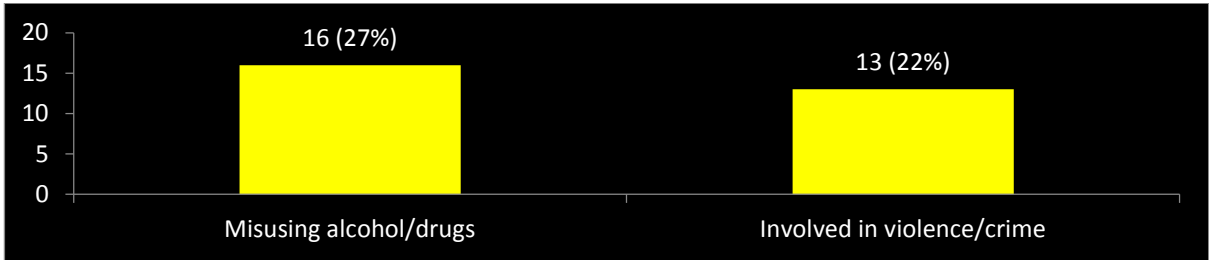


Chart 6.10: Number of young people engaged in high risk behaviours, DATMS Year 3



EDUCATIONAL PSYCHOLOGICAL ASSESSMENT DIAGNOSES

Most young people were diagnosed with more than one difficulty or disorder. The types of diagnoses identified included low IQ scores, learning, speech and language difficulties, mental health, emotional and behavioural disorders. These diagnoses are reported in the following charts (Charts 6.11 to 6.15).

Chart 6.11: Full scale IQ scores, DATMS Year 3

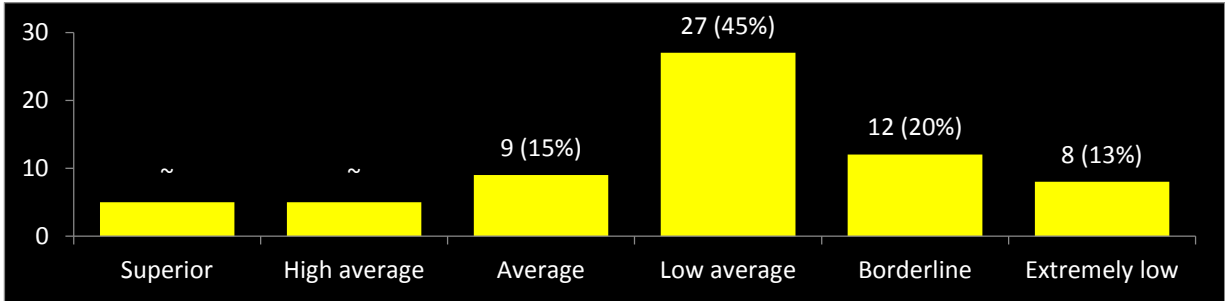
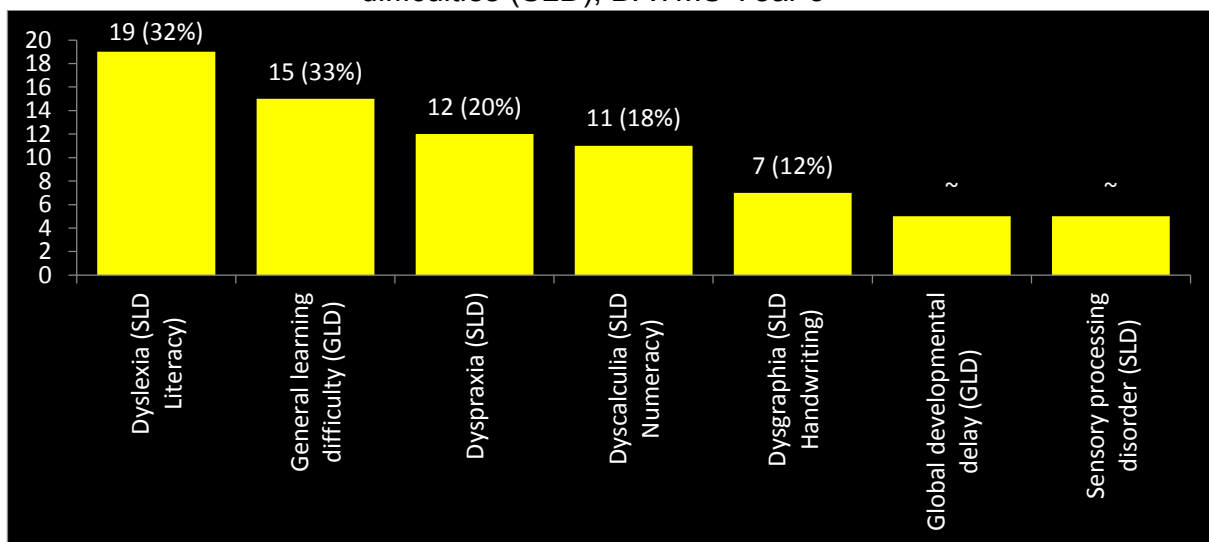
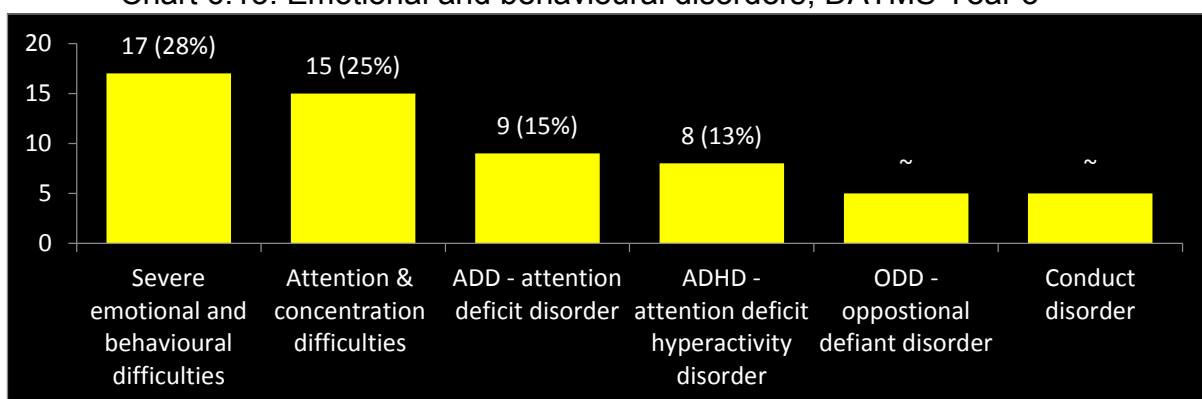


Chart 6.12: General learning difficulties (GLD) and Specific learning difficulties (SLD), DATMS Year 3



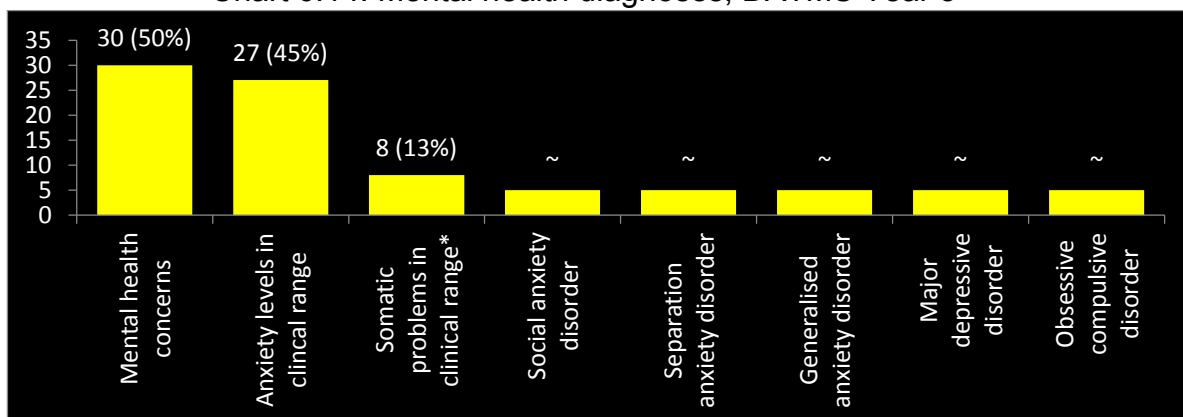
~Number of cases too small to be reported (5 or less)

Chart 6.13: Emotional and behavioural disorders, DATMS Year 3



~Number of cases too small to be reported (5 or less)

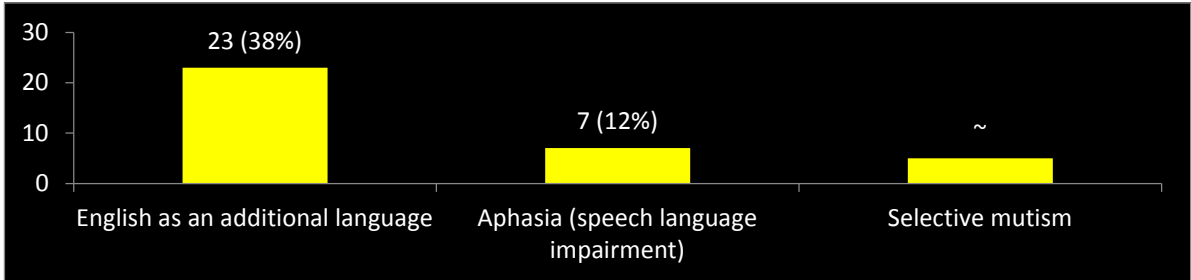
Chart 6.14: Mental health diagnoses, DATMS Year 3



~Number of cases too small to be reported (5 or less)

*Daily functioning affected by lack of sleep

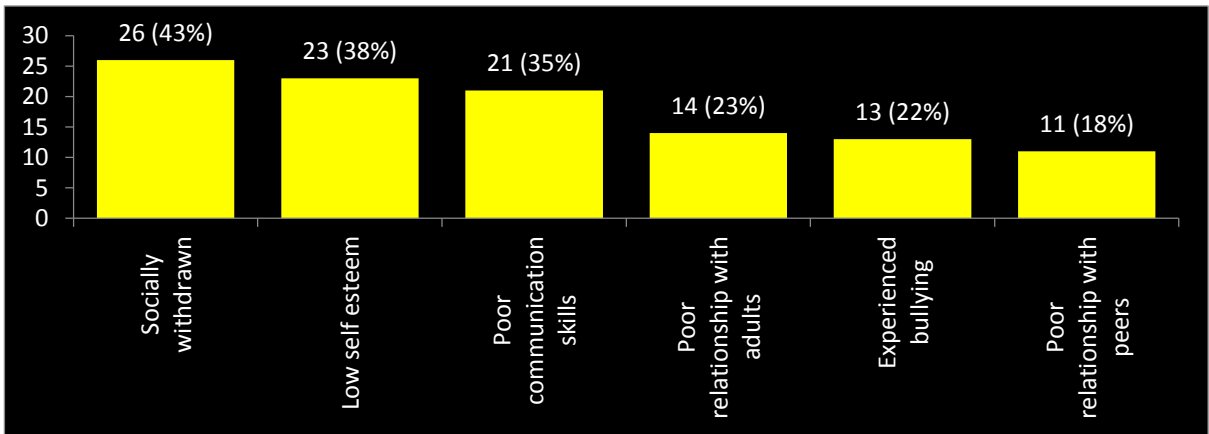
Chart 6.15: Speech and language difficulties, DATMS Year 3



In addition to these diagnoses, a few young people were diagnosed with autistic spectrum disorder and a few were referred for further assessment for the same diagnoses (numbers too small to be reported). A total of fifteen (25%) were diagnosed with medical issues such as epilepsy, hearing and vision difficulties.

The chart below identifies social and emotional issues experienced by the young people (Chart 6.16).

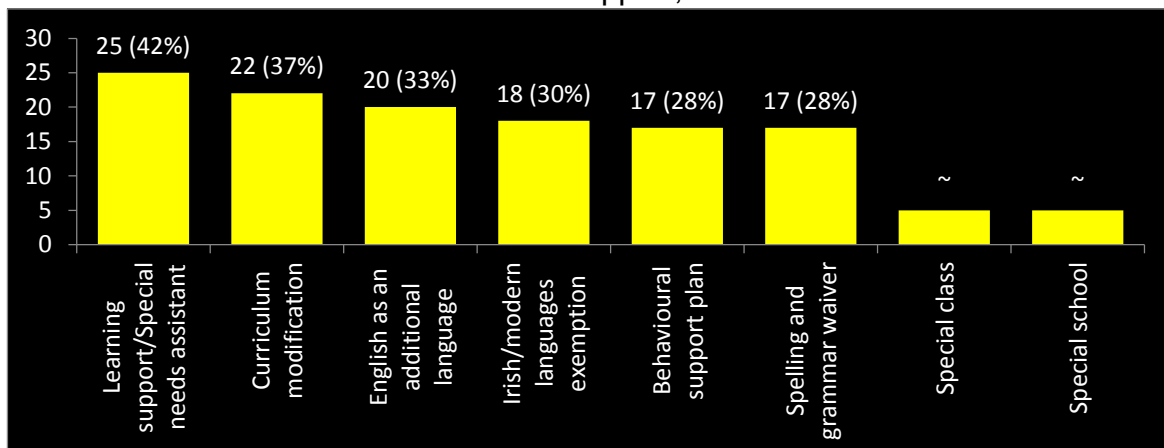
Chart 6.16: Social/emotional issues experienced by young people, DATMS Year 3



PSYCHOLOGIST’S RECOMMENDATIONS

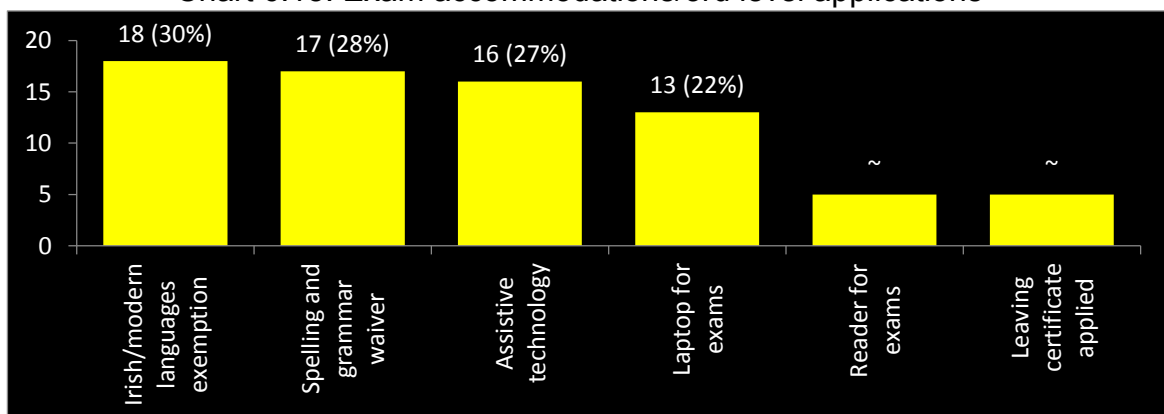
The types of recommendations suggested included learning supports, curriculum modifications or exemptions, and referrals to mental and physical health services. These recommendations are reported in the following charts (Charts 6.17 to 6.20).

Chart 6.17: In-school support, DATMS Year 3



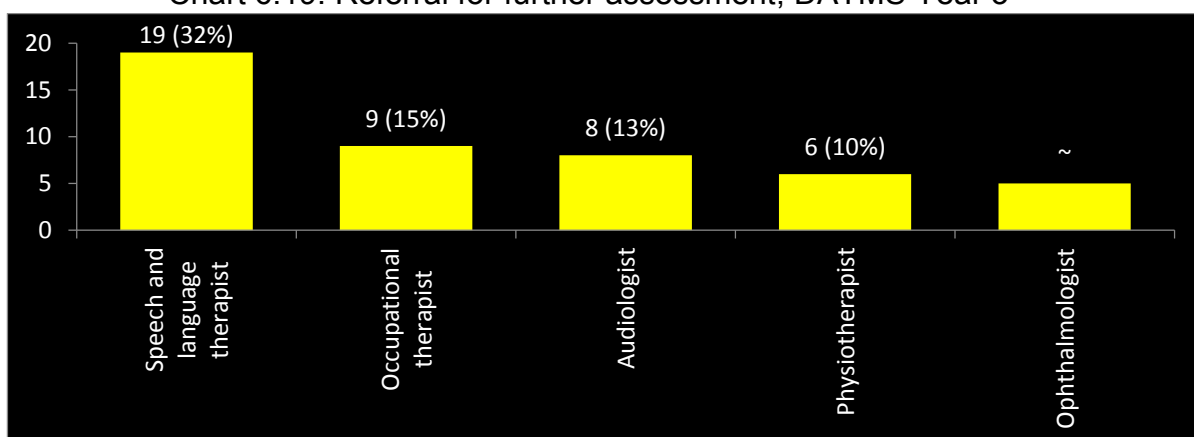
~Number of cases too small to be reported (5 or less)

Chart 6.18: Exam accommodations/3rd level applications



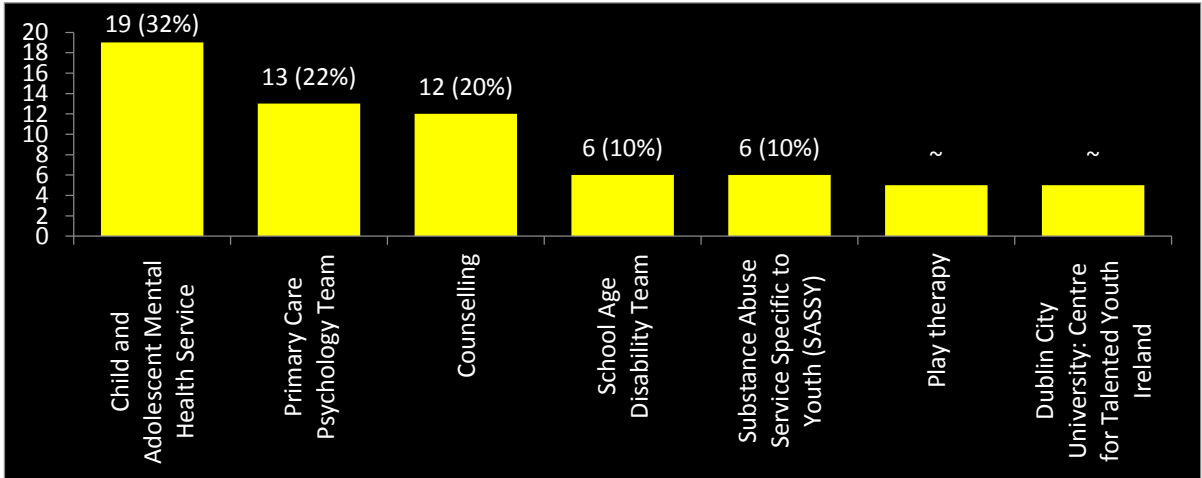
~Number of cases too small to be reported (5 or less)

Chart 6.19: Referral for further assessment, DATMS Year 3



~Number of cases too small to be reported (5 or less)

Chart 6.20: Referral to services, DATMS Year 3



~Number of cases too small to be reported (5 or less)

These personal profiles and diagnoses, along with the family profiles, identify that these young people possessed many risk factors for the development of drug and/or alcohol dependence. This identifies the need for early intervention at a personal, familial and environmental level.

7. FACTORS CONTRIBUTING TO DRUG AND ALCOHOL USE

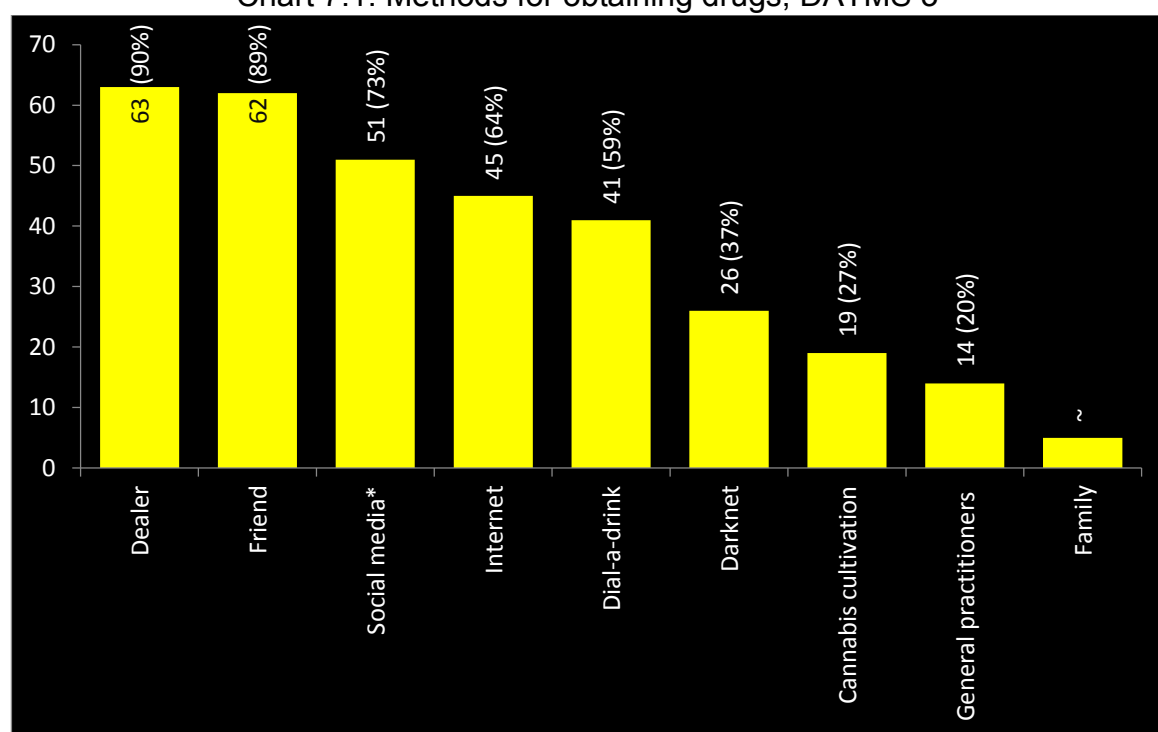
The factors contributing to drug and alcohol use in Dublin 15 included the ease of access to drugs and alcohol, the normalisation of drug and alcohol use and the family context.

1) ACCESSIBILITY OF DRUGS

METHODS FOR OBTAINING DRUGS

From DATMS Year 1 to Year 3, the main method for obtaining drugs was through local dealers. Year 1 and 2 reported the internet was the second most commonly used method to obtain drugs, while Year 3 reported it was friends. Chart 7.1 reports the methods used to obtain drugs in DATMS Year 3⁹; all of these methods were also reported in Year 1 and 2.

Chart 7.1: Methods for obtaining drugs, DATMS 3



~Number too small to be reported (5 or less)

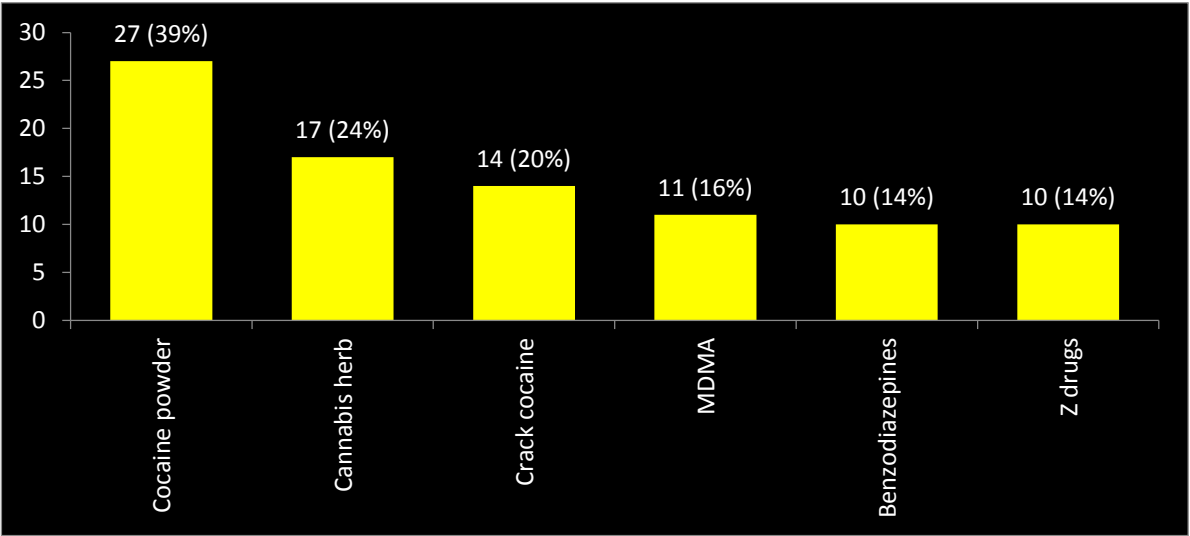
*Includes Facebook, Snapchat, Instagram

⁹ Analysis based on 70 participants (Treated and untreated drug users, young people and service providers)

CHANGES IN DRUG AVAILABILITY

Year 3 reported an increase in the availability of some drug types in Dublin 15 (Chart 7.2).

Chart 7.2: Increase in drug availability in Dublin 15, DATMS Year 3



- All three years reported an increase in the availability of Benzodiazepines and Z drugs
- An increase in the availability of Crack Cocaine and Cannabis herb was reported in Year 1 and 3
- Year 3 reported no change in the availability of Alcohol, Steroids, Opiates (Oxycodone) and Pregabalin (Lyrica) while Year 1 and/or 2 reported increases in the availability of these drugs
- Year 1 and 3 reported a decrease in the availability of Cannabis Resin, and Year 2 reported an increase

Reasons for increase in drug availability

1) Increase in drug use

In Year 3, 44% of participants reported that an increase in drug use was a reason for the increase in drug availability.

2) Easy access to drugs

In Year 3, 37% of participants reported that easy access to drugs was the main reason for increase in drug availability. In all three DATMS years, participants reported easy access to drugs in Dublin 15, with 86% of Year 3 participants reporting that access to drugs was 'very easy'. The following factors have contributed to the ease of access to drugs:

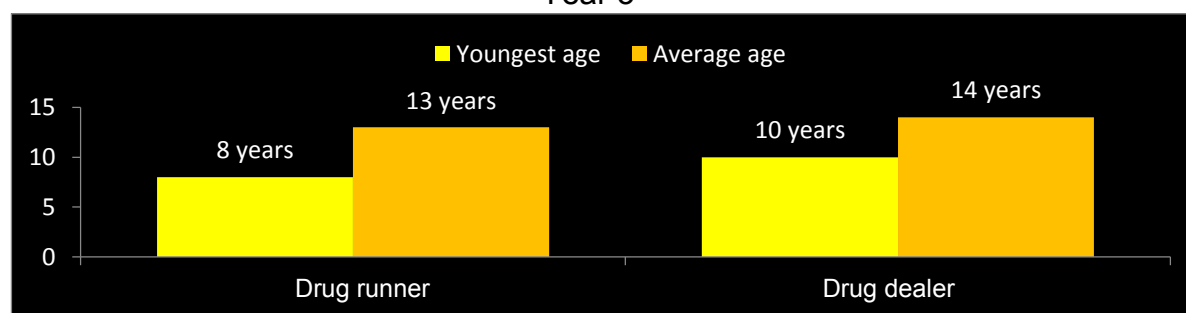
Table 7.1: Factors contributing to ease of access to drugs, DATMS Year 1 to 3

Factors contributing to ease of access to drugs	Year 1	Year 2	Year 3
Increase in number of dealers			√
Increase in number of under 18s dealing*		√	√
Dealers making home deliveries to customers	√	√	√
Obtaining drugs from the internet	√	√	√
Obtaining drugs from local General Practitioners	√	√	√

- ***Under 18 drug runners and dealers**

Year 2 and 3 reported an increase in the number of under 18s dealing drugs. This perceived increase may be related to levels of drug debt intimidation in Dublin 15, whereby young people are forced to hold and sell drugs to pay off debts¹⁰. Year 3 reported the age of drug runners and dealers in Dublin 15 (Chart 7.3).

Chart 7.3: Drug runners and dealers in Dublin 15 aged under 18, DATMS Year 3



¹⁰ See chapter 'Consequences of drug and alcohol use' for more data concerning drug debt intimidation

Under 18 drug runners and dealers were predominately male though females aged from 12 years also engaged in these activities. An explanation for the youngest ages was reported to be that older family members were drug dealers. Participants reported the perception that young people were attracted to drug dealing as a way to make ‘easy money’ and to increase their social status. The use of minors for drug distribution has been a long standing method used by older, larger scale dealers, as due to their age there are less criminal consequences.

- **Dealing in local secondary schools**

Year 1 to 3 reported that drug dealing has occurred in local secondary schools. In Year 3, 60% of participants reported that drug dealing occurred in secondary schools; there was evidence of drug dealing in 6 out of the 10 local secondary schools.

DRUGS MANUFACTURED IN DUBLIN 15

Year 1 to 3 reported that drugs were manufactured in Dublin 15. Table 7.2 reports the types of drugs manufactured from DATMS Year 1 to 3. In Year 3, 27% of participants reported that drugs were manufactured in Dublin 15.

Table 7.2: Types of drugs manufactured in Dublin 15, DATMS Year 1 to 3

Drug type	Year 1	Year 2	Year 3
Cannabis Herb	√	√	√
Crack Cocaine			√
Cannabis Oil			√
Benzodiazepines	√	√	√
Z drugs			√
MDMA			√

DRUGS SOURCED FROM OUTSIDE DUBLIN 15

In Year 3, 67% of participants reported that people also travelled outside the area to obtain drugs, though this was not the norm. Areas travelled to included Dublin City Centre, Finglas, Ballymun and Ballyfermot. Reasons for travelling outside Dublin 15 included drugs not being available in the area and to get larger quantities, better quality and price.

2) NORMALISATION OF DRUG AND ALCOHOL USE

In all three years of the DATMS the normalisation of drug use featured prominently as a factor contributing to drug use. The common perception was that drugs were widely used, risk free and socially acceptable. This normalisation was reported among peer groups and family units. The following drugs were normalised:

- Alcohol
- Cannabis
- Cocaine powder
- Prescription drugs such as Benzodiazepines, Z drugs, Lyrica, Opiates
- Steroids

In all three years, when participants were asked to report the five most frequently used drugs they had to be prompted to include alcohol in their answer. Thus identifying that alcohol was the most normalised of all drugs in Dublin 15.

Participants also reported that drugs such as Heroin or Methadone were not normalised and the use of these drugs was not socially acceptable. Thus identifying a skewed perception among drug users which does not take into account the harm associated with the use of all drugs.

3) DRUG USE WITHIN FAMILIES

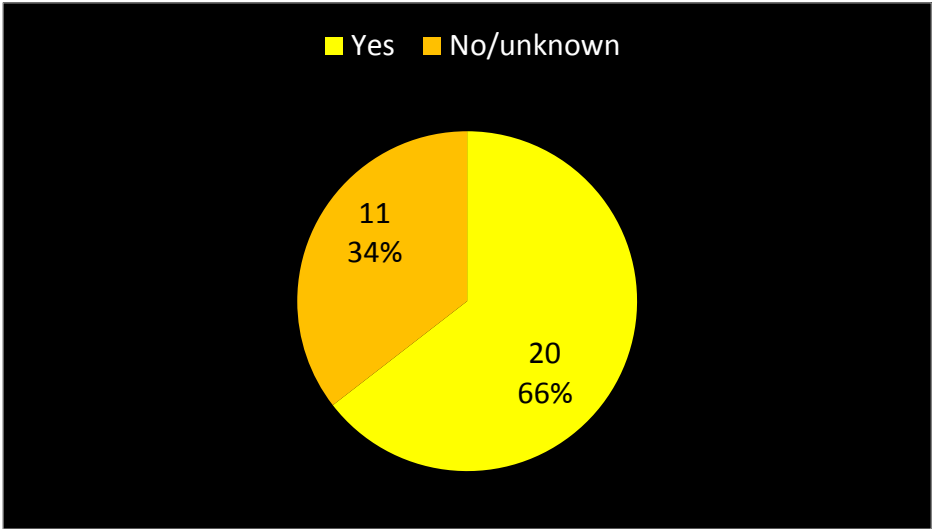
All three years of the DATMS reported the negative impact of drug and alcohol dependence within the family. The data reported the family context as a risk factor for the normalisation of drug and alcohol use, the development of inter-generational drug and alcohol dependence, and mental health issues¹¹.

The majority of treated drug users who participated in Year 3 reporting having family members who also had problems with drugs and/or alcohol (Chart 7.4)¹².

¹¹ Further data concerning the impact of drug dependence within the family is reported in the chapter 'Consequences of drug and alcohol use'

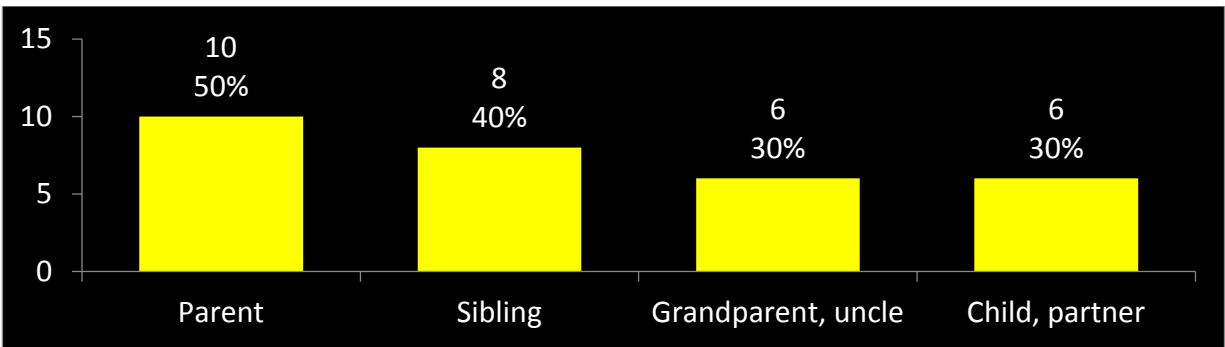
¹² Analysis based on 31 participants (Treated drug users)

Chart 7.4: Drug and/or alcohol issues among families, DATMS Year 3



Inter-generational drug and alcohol use spanning two to three generations was reported by 48% of treated drug users. Chart 7.5 reports the type of treated drug users’ family members with drug and/or alcohol issues.

Chart 7.5: Type of family members with drug and/or alcohol issues, DATMS Year 3



Category totals exceed total number of participants as some treated drug users reported having more than one drug and/or alcohol dependent family member

Service providers and treated drug users also reported that some young people used alcohol and drugs to cope with living with a drug dependent parent.

FAMILY SUPPORT SERVICES IN DUBLIN 15

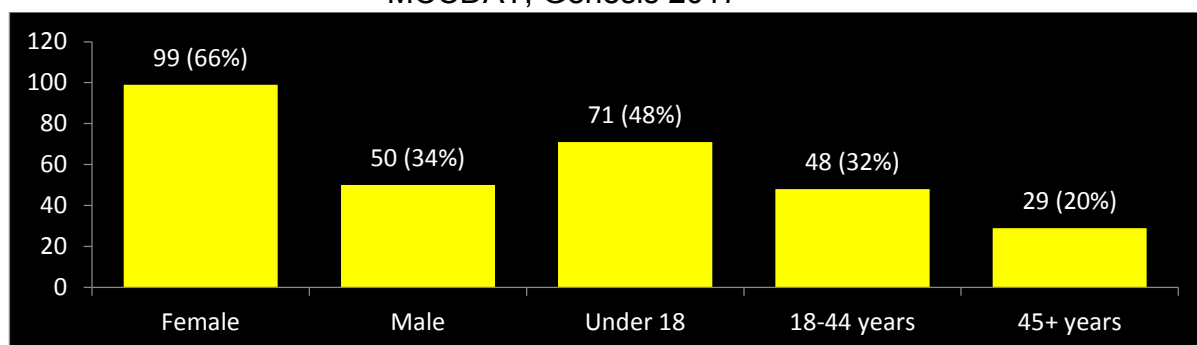
The provision of family support in Dublin 15 is a combination of statutory and voluntary organisations and peer led groups. They operate various models of

FACTORS CONTRIBUTING TO DRUG AND ALCOHOL USE

family support which are generally provided to families in their own community.

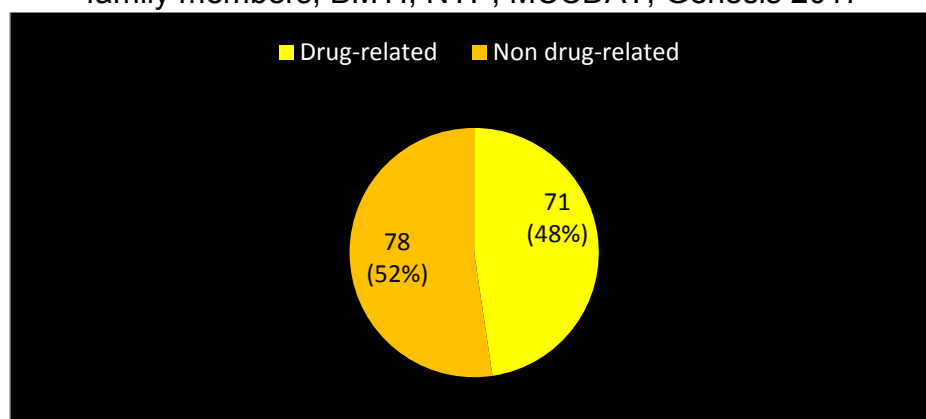
The following data reports a profile of family members who received support from local voluntary services in 2017. These services are Blakestown Mountview Youth Initiative (BMYI), Neighbour Youth Project (NYP), Mulhuddart/Corduff Community Drug and Alcohol Team (MCCDAT) and Genesis Psychotherapy and Family Therapy Service (Genesis). A total of 149 young people and adults received family support services in 2017 (Chart 7.6).

Chart 7.6: Gender and age range of family support clients, BMYI, NYP, MCCDAT, Genesis 2017



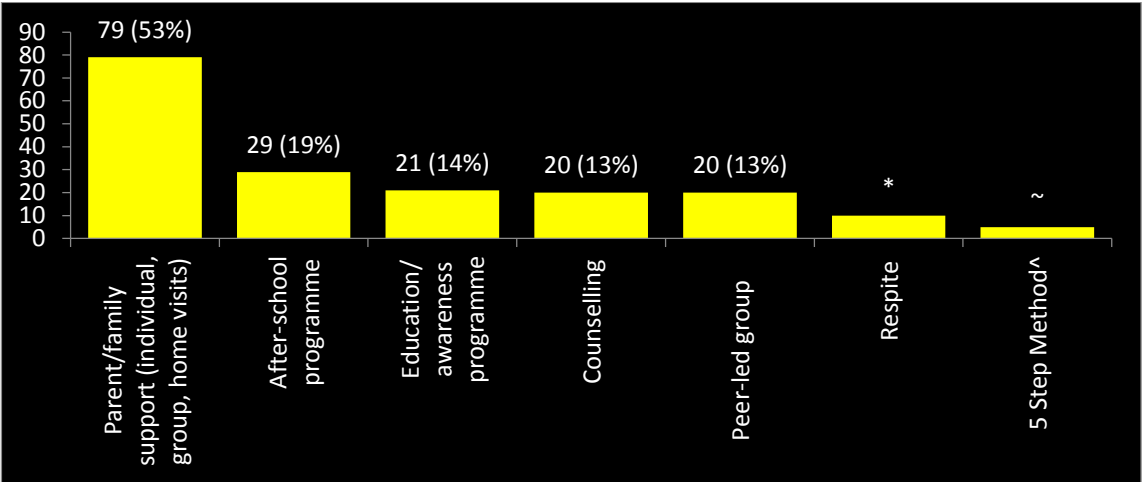
A total of 71 clients (48%) experienced active or chaotic drug use by another family member (Chart 7.7). The actual number of family members receiving support is higher than 71 as some family support services and peer led groups did not provide data. While some family members will not look for support, if we take this data into account it is evident that demand for local services could be much higher.

Chart 7.7: Number of clients by drug-related and non drug-related status of family members, BMYI, NYP, MCCDAT, Genesis 2017



The services received by family members and the length of time attending services are reported in the charts below (Chart 7.8 & 7.9).

Chart 7.8: Number of clients by type of service, BMYI, NYP, MCCDAT, Genesis 2017



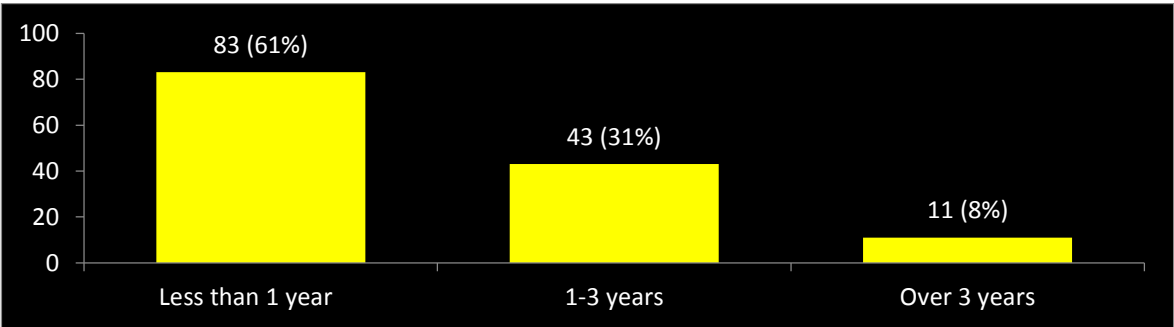
Category totals exceed total number of participants as some clients received more than one intervention

~Number of clients too small to be reported (5 or less)

*Number of cases greater than 5 not reported to ensure cases with 5 or less are not disclosed

^Evidence based brief counselling intervention

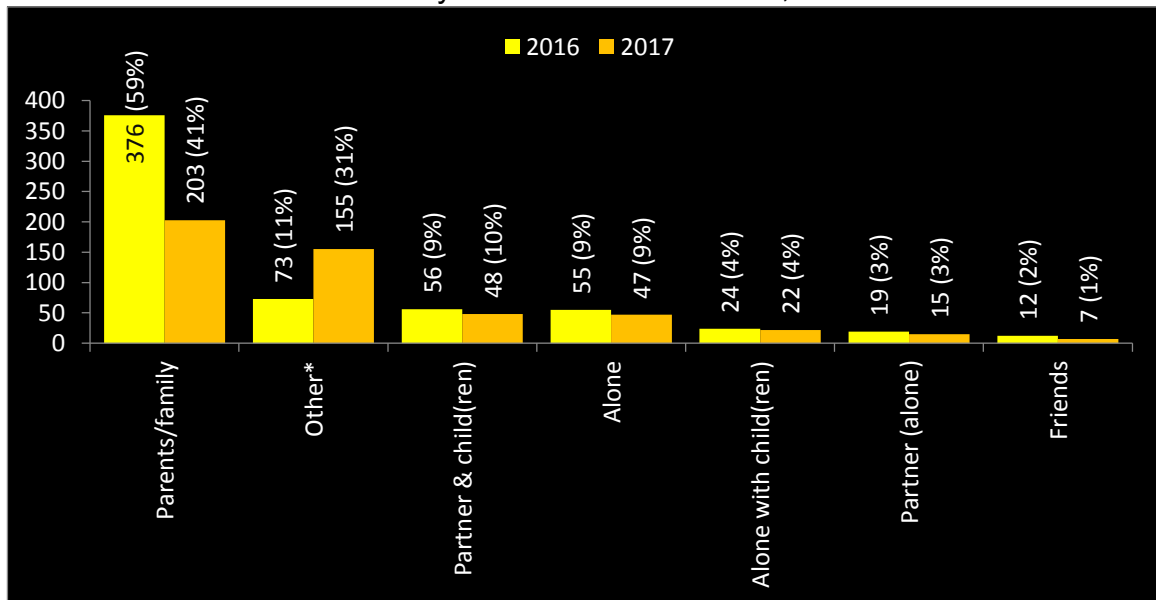
Chart 7.9: Length of time attending family support services, BMYI, NYP, MCCDAT, Genesis 2017



NDTRS data reports the accommodation status of treated cases (Chart 7.10). It identifies that in 2016 and 2017 the majority of treated cases were living with family.

FACTORS CONTRIBUTING TO DRUG AND ALCOHOL USE

Chart 7.10: Treated cases by accommodation status, NDTRS 2016 & 2017

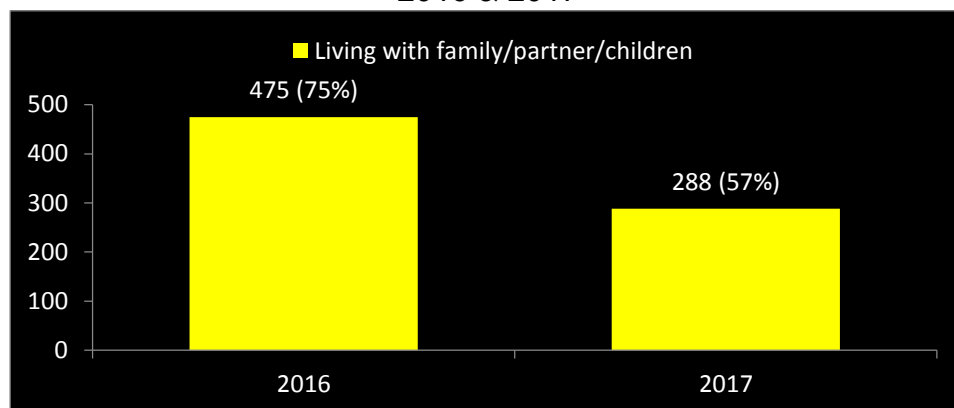


Category totals less than 100% as category 'unknown' removed

*Includes cases living in institutions, halfway houses or prisons

Further analysis identifies that in 2017 the majority (288, 57%) of treated cases were living with family, a partner and/or children (Chart 7.11). This means that there are at least 288 cases of family members that may be in need of local support services. This is considerably higher than the number of cases supported by local services. Indeed, it is probable that the need for support is even higher as the data does not include family members not living with treated drug users.

Chart 7.11: Treated cases living with family, partner and/or children, NDTRS 2016 & 2017



YOUTH MENTAL HEALTH

From Year 1 to Year 3, service providers reported an increase in the incidence of mental health issues (anxiety related issues) among children and young people. Poor mental health is a risk factor for drug use which identifies the importance of early intervention. Service providers reported the following personal, familial and environmental factors that compromised youth mental health:

- Lack of mental health protective factors such as resilience skills
- Parental mental health and/or drug and alcohol issues
- Poor parenting skills/parental support
- Child neglect
- Poverty
- Homelessness

These factors affected children's educational attendance and attainment. For some young people their education was further hampered by their parent's poor educational attainment. The negative impact of inter-generational drug use and deprivation on young people was apparent¹³.

DUBLIN 15 MENTAL HEALTH TREATMENT DEMAND

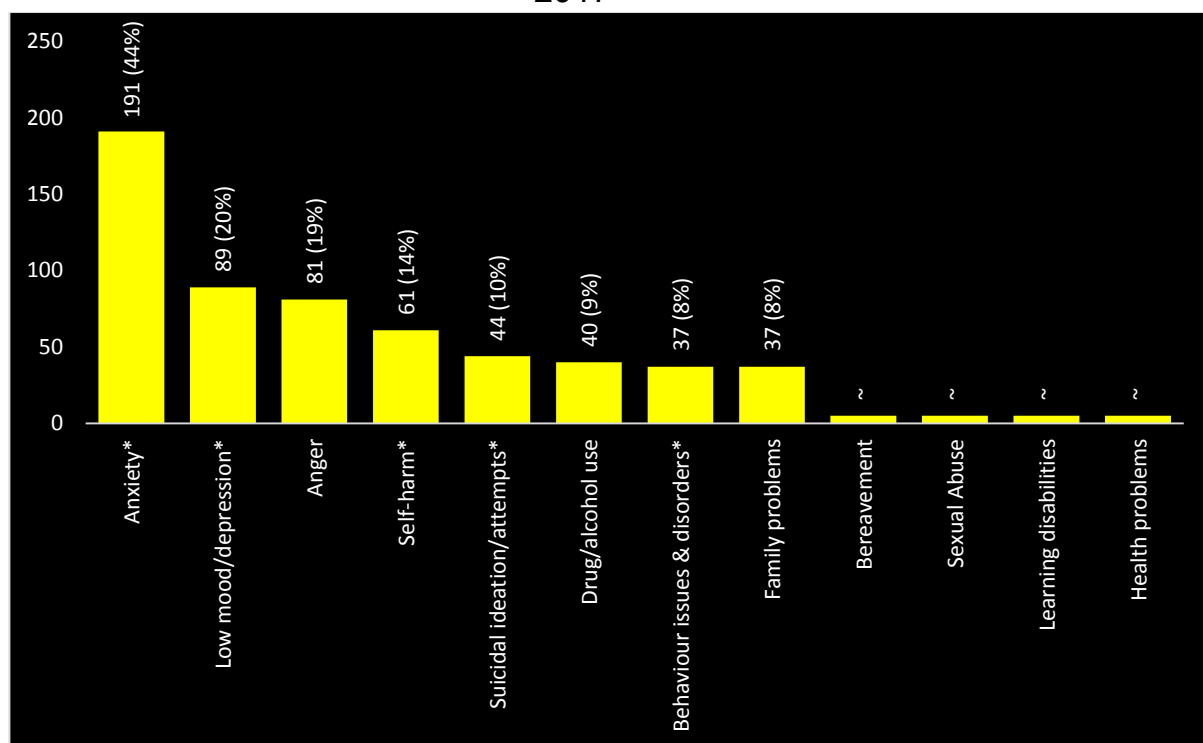
Three local mental health services provided treatment demand statistics for 2017. These are counselling services for under 18s and young adults, with one also providing treatment for substance use¹⁴. As there are no unique identifiers the number of cases will be reported rather than the number of individuals treated; thus individuals may be counted more than once. A total of 438 cases were treated for mental health issues or disorders in 2017 (Chart 7.12). The cases ranged in age from under 12 to 27 years; some cases were treated for more than one mental health issue or disorder.

¹³ Data concerning the impact drug use has on education is reported in chapter 'Consequences of drug use'

¹⁴ The services are Jigsaw Dublin 15, Substance Abuse Service Specific to Youth (SASSY) and Genesis Psychotherapy and Family Therapy Services

FACTORS CONTRIBUTING TO DRUG AND ALCOHOL USE

Chart 7.12: Number of cases by type of mental health issue or disorder among young people aged 12 to 27 years, SASSY, Jigsaw, Genesis 2017



Category totals exceed total number of cases as some cases experienced more than one mental health issue or disorder

~ Number of cases too small to be reported (5 or less)

* Mental health issues or disorders experienced by treated drug users aged under 18

A number of local primary and secondary schools operate resilience skills programmes and a local youth mental health service operates mental health prevention focused programmes. A peer mental health mentoring programme operating locally was reported to have a positive influence on young people. A range of other mental health services are available in Dublin 15, however, service providers reported the need to improve access to mental health services¹⁵. Service providers reported that in 2017 waiting lists for counselling varied from a few weeks to 16 weeks and were up to 18 months for clinical assessments and treatment.

¹⁵ The type of mental health services required are reported in the chapter 'Gaps in service provision'

HIGH PREVALENCE RATES OF YOUTH MENTAL HEALTH DISORDERS

The World Health Organisation reports that mental health disorders are the largest health problem among 10-24 year olds around the world, with 10-20% experiencing mental health disorders (Gore *et al.*, 2011). A substantial concurrence of mental health and substance use disorders is also reported. Due to the lack of population based mental health morbidity data, the Royal College of Surgeons in Ireland (RCSI) conducted research to establish the prevalence rates of mental health disorders among Irish young people aged 11 to 24 years (Cannon *et al.*, 2013). The findings reported high lifetime prevalence rates of mental health disorders among young people. Chart 7.13 and 7.14 report the lifetime prevalence rates of a range of mental health disorders among young people aged 11 to 13 years and young adults aged 19 to 24 years. The data is contextualised by CSO data to estimate the number of young people in Dublin 15 experiencing mental health disorders¹⁶.

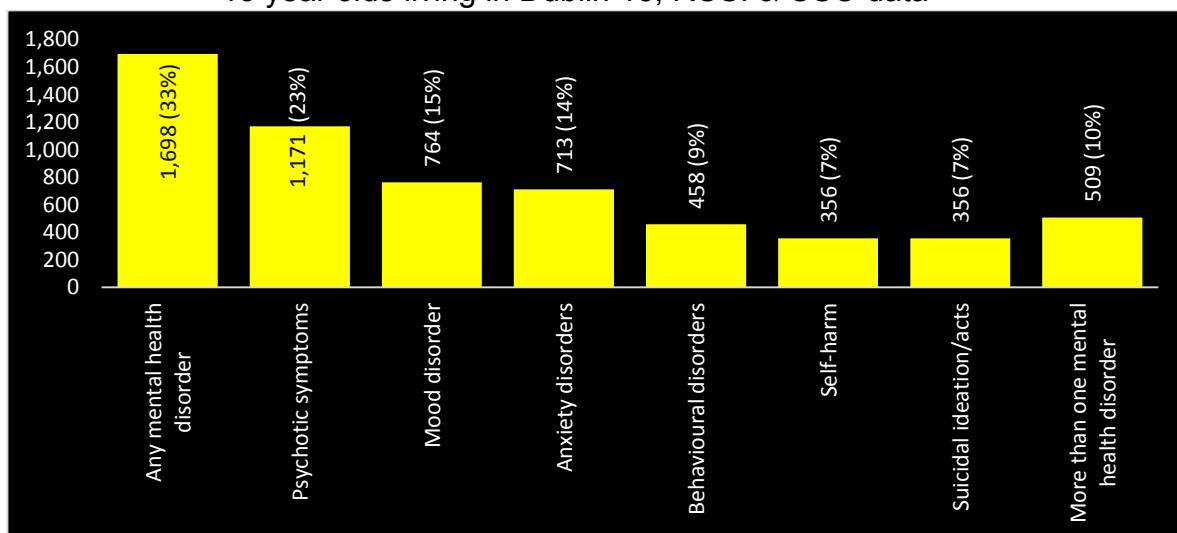
- By the age of 13, 33% (1,698) of young people living in Dublin 15 are likely to have experienced a mental health disorder, increasing to 56% (3,908) by the age of 24
- Mental ill-health during adolescence is a risk factor for future mental ill-health and substance misuse in young adulthood¹⁷

¹⁶ CSO 2016 data reported 5,095 11 to 13 year olds and 6,979 19 to 24 year olds living in Dublin 15

¹⁷ RCSI data reporting prevalence rates of substance misuse in young adulthood reported in chapter 'Treated Drug Use'

FACTORS CONTRIBUTING TO DRUG AND ALCOHOL USE

Chart 7.13: Lifetime prevalence rates of mental health disorders among 11 to 13 year olds living in Dublin 15, RCSI & CSO data



Mood disorder: Depression & manic disorders

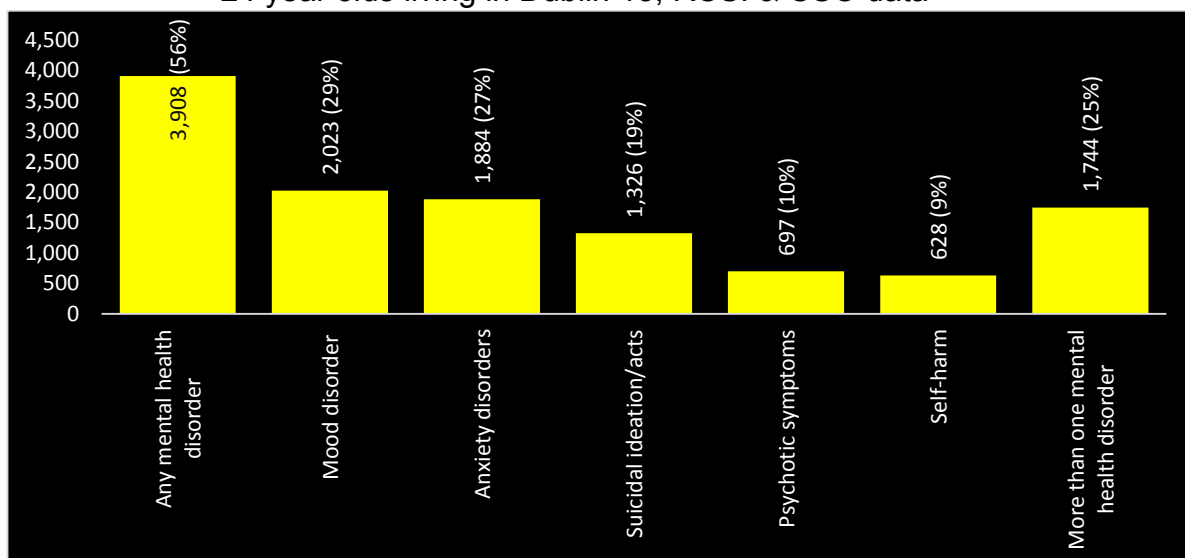
Anxiety disorders: Panic, obsessive compulsive & post-traumatic stress disorders, phobias & social phobia, generalised anxiety disorder

Psychotic symptoms: Hallucinations, delusions & behavioural changes

Behavioural disorders/issues: Attention-deficit/hyperactivity disorder, conduct & oppositional defiant disorder, autistic spectrum disorder

Self-harm: Intentional acts of harm to a person's own body without any associated suicidal intent

Chart 7.14: Lifetime prevalence rates of mental health disorders among 19 to 24 year olds living in Dublin 15, RCSI & CSO data



LARGE PROPORTION OF YOUNG PEOPLE WITH MENTAL HEALTH DISORDERS IN DUBLIN 15 NOT IN TREATMENT

Comparison between the RCSI prevalence rates and treatment demand for local services is challenging as the former relates to individuals and the latter to cases. Also, local data does not include service provision provided by private and some statutory services. Nevertheless, this comparison has been completed to inform service provision.

The number of cases attending local services for mental health issues is considerably lower than the prevalence rates estimated via the RCSI data. Service providers reported that explanations for this discrepancy may include young people's reluctance to seek professional help and limited access to youth mental health services.

8. CONSEQUENCES OF DRUG AND ALCOHOL USE

1) PHYSICAL AND MENTAL HEALTH CONSEQUENCES OF DRUG USE

There was limited data concerning the health related consequences of drug use for DATMS Year 1 to 3. Table 8.1 reports the main physical and mental health issues reported by treated adult drug users in Year 3; the same issues were reported in Year 1 and 2. Two local treatment services reported an increase in mental health disorders among treated adult drug users in Year 3.

Table 8.1: Main physical and mental health issues experienced by treated adult drug users, DATMS Year 3

Physical health	Respiratory diseases/issues associated with smoking drugs
	Problems associated with injecting drug use (blood borne viruses, vein damage)
	Liver diseases due to injecting drug use and alcohol use
Mental health	Mood disorders/issues (depression, manic disorders)
	Anxiety disorders/issues
	Psychotic symptoms (psychosis, schizophrenia)
	Personality disorders (borderline personality disorder)

A total of 458 adult clients were treated in Genesis Psychotherapy and Family Therapy Service in 2017. The chart below reports the gender and age range of these clients (Chart 8.1).

Chart 8.1: Gender and age range of clients, Genesis 2017

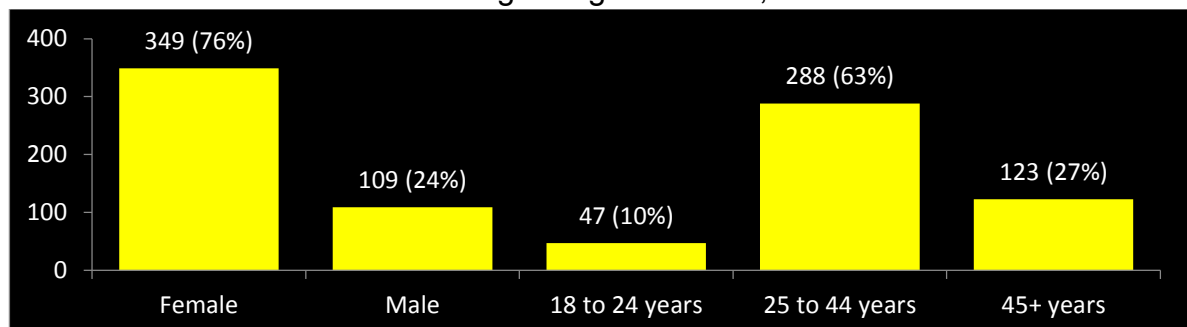
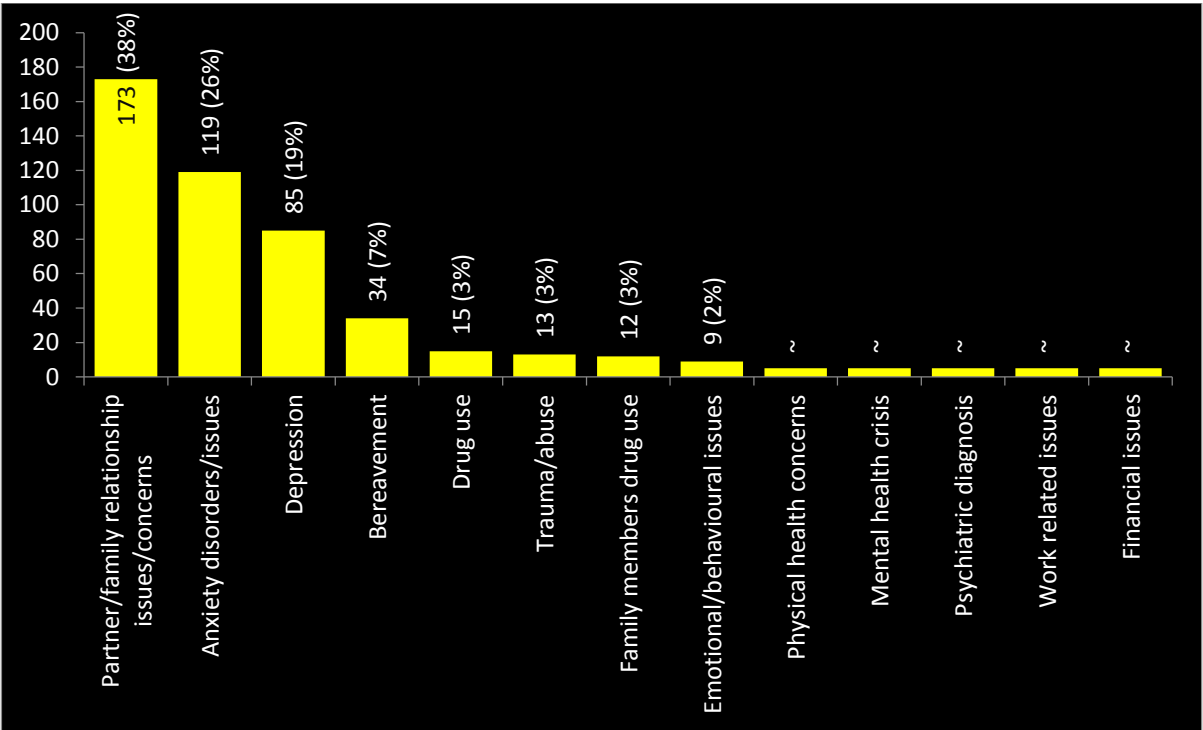


Chart 8.2 reports the reasons for counselling and for 27 (6%) of these clients the reason was drug-related.

Chart 8.2: Reasons for counselling, Genesis 2017



HOSPITAL IN-PATIENT ENQUIRY SCHEME (HIPE)

HIPE is a health information system that reports day and in-patient discharges from acute public hospitals. Each HIPE discharge record represents one episode of treatment rather than an individual patient; a patient may be admitted to hospital more than once in any given time period with the same or different diagnoses. From 2012 to 2017 there were 1,557 treatment episodes for mental health and behavioural disorders¹⁸ associated with drug use among Dublin 15 residents (Charts 8.3 & 8.4).

- The drugs implicated included Alcohol, Opioids, Cannabis, Benzo-diazepines, Z drugs, Cocaine, other Stimulants, Hallucinogens, Solvents and polydrug use

¹⁸ The HIPE classification ‘mental health and behavioural disorders’ includes the following diagnostic codes: acute intoxication; physical health consequences of drug use; drug dependence; drug withdrawal; psychotic disorder; other mental and behavioural disorders. The number of treatment episodes for some of the diagnostic categories was too small to be reported and therefore the data has been presented together.

CONSEQUENCES OF DRUG AND ALCOHOL USE

- Over the reporting period the number of treatment episodes increased, the majority of cases were male and aged over 30 years
- From 2012 and 2017, treatment episodes increased from 1% to 2% of national treatment episodes

Chart 8.3: Number of treatment episodes for mental health and behavioural disorders due to drug use among Dublin 15 residents by gender, HIPE 2012-2017

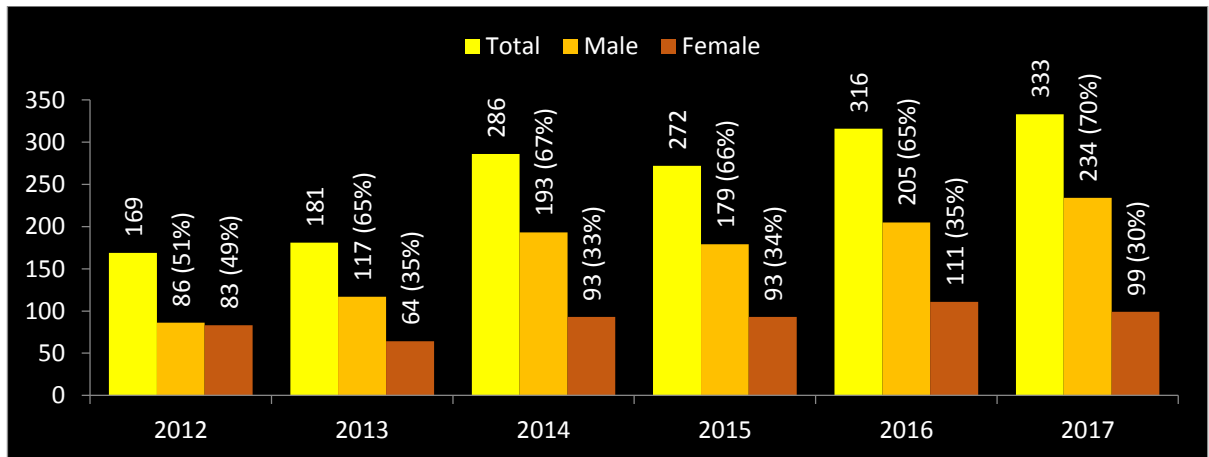
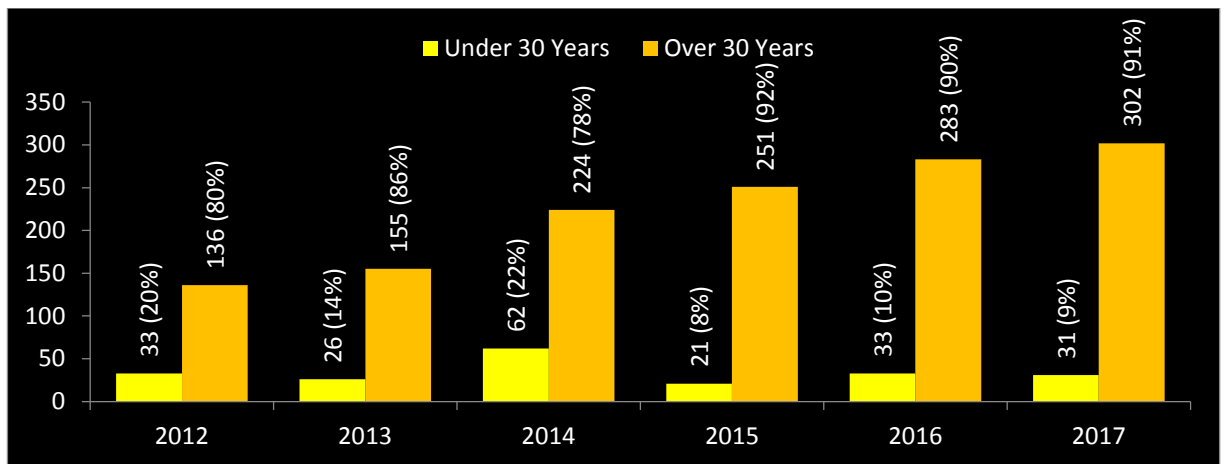


Chart 8.4: Number of treatment episodes for mental health and behavioural disorders due to drug use among Dublin 15 residents by age, HIPE 2012-2017

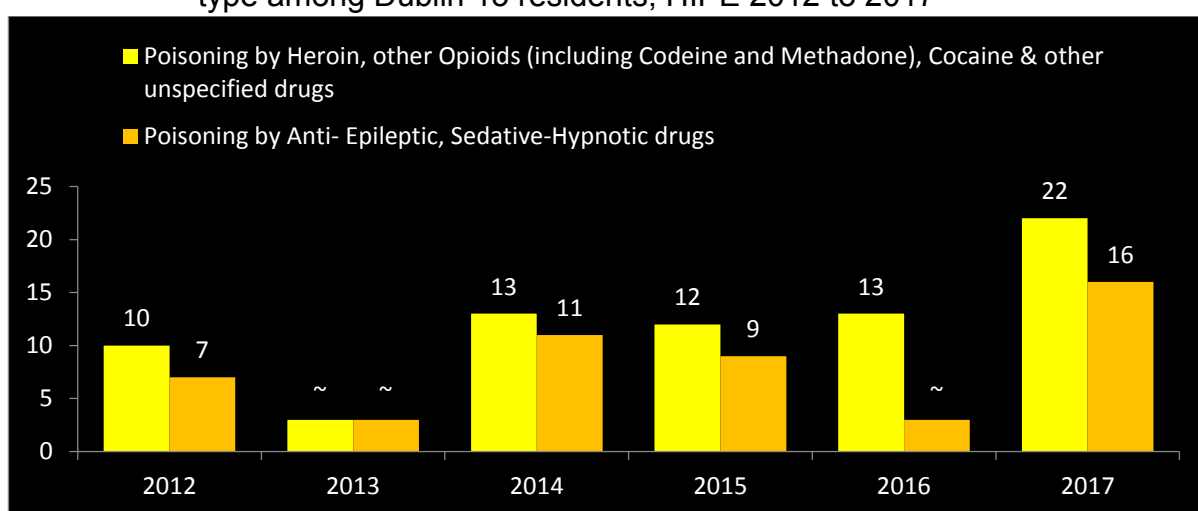


From 2012 to 2017 there were 113 treatment episodes for drug-related poisonings (overdoses) among Dublin 15 residents (Chart 8.5). The poisonings may not have resulted in death.

DRUG AND ALCOHOL TRENDS MONITORING SYSTEM YEAR 3

- Over the reporting period the number of treatment episodes increased
- From 2012 to 2017 the number of treatment episodes for poisonings associated with Opioids, Cocaine and other drugs increased from 2% to 3% of national treatment episodes
- From 2012 to 2017 the number of treatment episodes for poisonings associated with Anti-Epileptic and Sedative-Hypnotic drugs increased from 1% to 2% of national treatment episodes

Chart 8.5: Number of treatment episodes for drug-related poisonings by drug type among Dublin 15 residents, HIPE 2012 to 2017



~ Number of poisonings too small to be reported (5 or less)

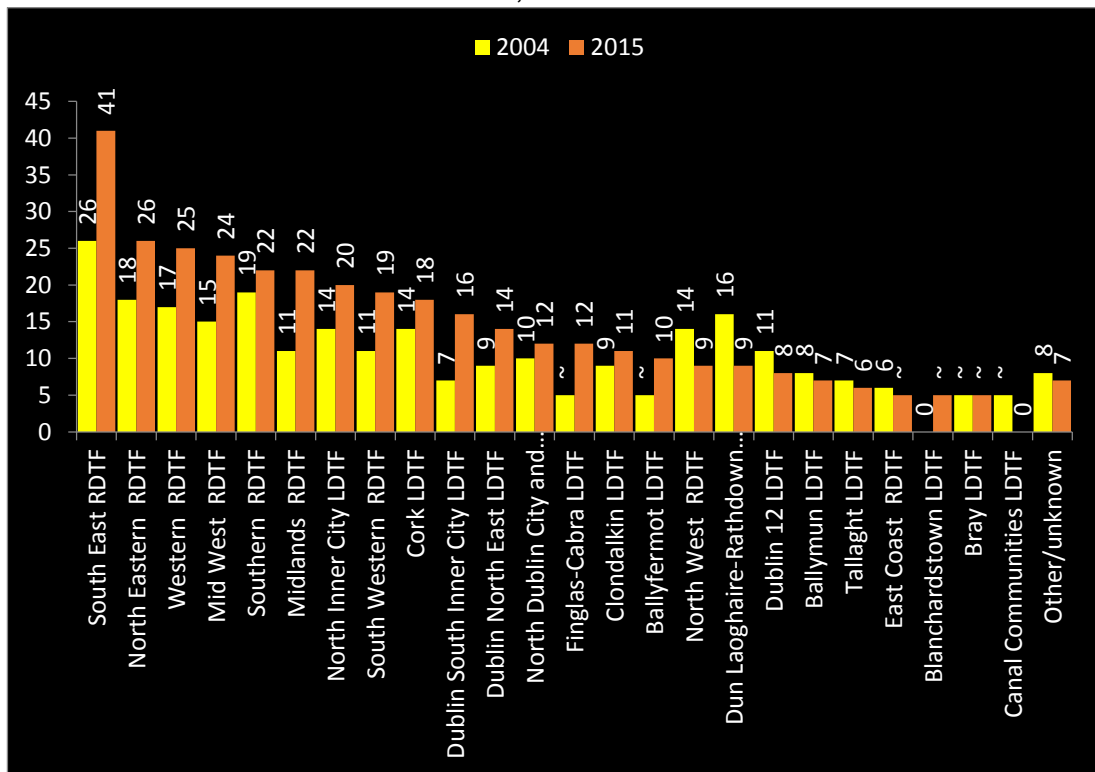
NATIONAL DRUG-RELATED DEATHS INDEX (NDRDI)

The NDRDI provides a census of drug-related deaths in Ireland. From 2004 to 2015 there were 7,422 drug-related deaths (Health Research Board, 2017):

- 4,222 (57%) were due to poisoning
- 3,200 (43%) were due to non-poisoning (trauma or medical causes)
- The number of deaths increased by 61% from 431 in 2004 to 695 in 2015 (Chart 8.6)

CONSEQUENCES OF DRUG AND ALCOHOL USE

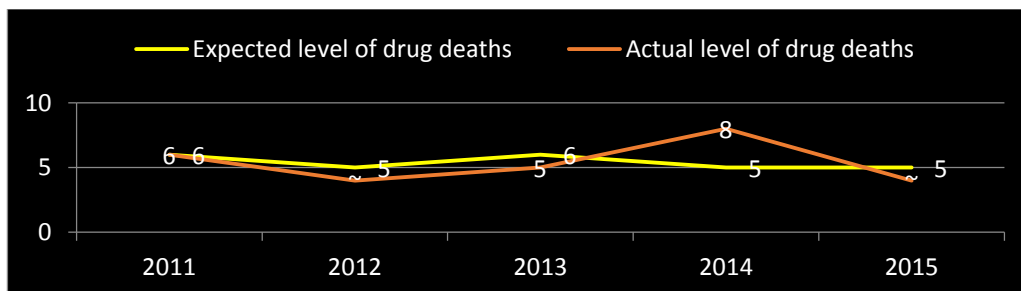
Chart 8.6: Number of poisoning deaths by Regional & Local Drug & Alcohol Task Force areas, NDRDI 2004 and 2015



~ Number of poisoning deaths too small to be reported (5 or less)

Analysis of the number of poisoning deaths in Ireland between 2011 and 2015, identifies that the actual levels of poisoning deaths in the BLDATF area were lower than expected in most years', except in 2014 when they were higher than expected levels (Chart 8.7). This may reflect the level of service provision in Dublin 15. Though the actual number of poisonings in Dublin 15 may be higher as NDRDI data is based on the BLDATF catchment area and does not include Tyrrelstown, Carpenterstown and Castleknock.

Chart 8.7: Expected and actual level of poisoning deaths in BLDATF area, NDRDI 2011 to 2015

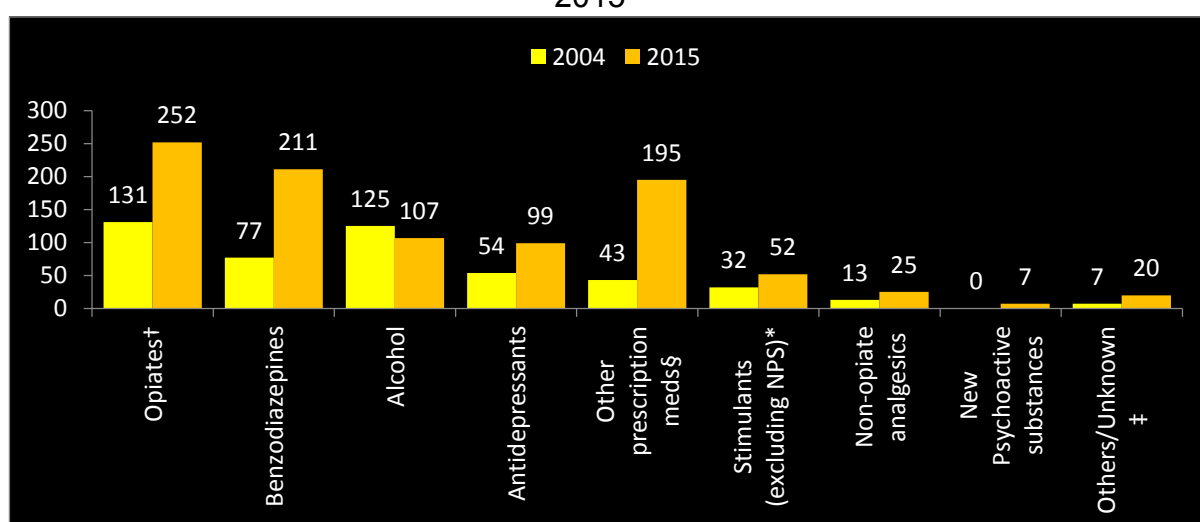


~ Number of drug-related deaths too small to be reported (less than 5)

DRUG AND ALCOHOL TRENDS MONITORING SYSTEM YEAR 3

- Nationally, over the reporting period, the majority of those who died were male (66% in 2015)
- Opiates were the most common drug associated with deaths, followed by Benzodiazepines and Alcohol (Chart 8.8 & 8.9); these drugs were often found together
- Deaths due to polydrug use increased from 118 (44%) in 2014 to 222 (64%) in 2015

Chart 8.8: Poisoning deaths categorised by drug group, NDRDI 2004 and 2015



Category totals exceed total number of poisoning deaths, as individual cases may have more than one drug implicated in their death

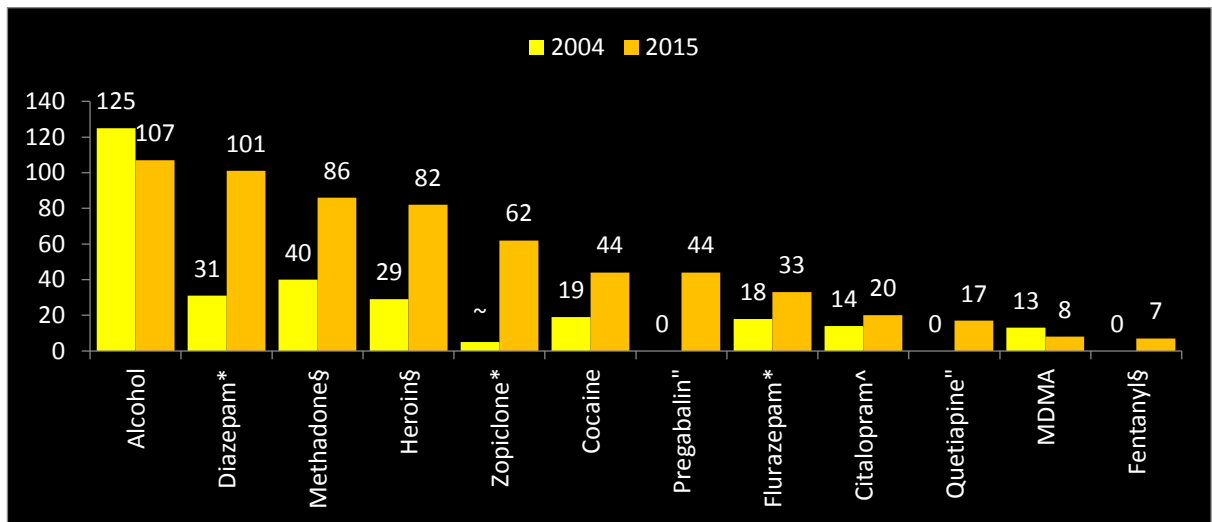
† Includes heroin, methadone, morphine, codeine, unspecified opiate-type drug, other opiate analgesic

§ Includes non-benzodiazepine sedatives (e.g. zopiclone), anti-psychotics, cardiac and all other types of prescription medication

* Includes cocaine and MDMA

‡ Includes solvents, insecticides, herbicides, other amphetamines, hallucinogens and other chemicals

Chart 8.9: Poisoning deaths categorised by individual drug, NDRDI 2004 and 2015



Category totals exceed total number of poisoning deaths, as individual cases may have more than one drug implicated in their death

~ Number of poisoning deaths too small to be reported (5 or less)

* Benzodiazepine/Z drug

\$ Opiates

" Anti-psychotic

^ Anti-depressant

CHEMSEX

Chemsex is a form of drug use that involves the use of specific drugs to facilitate or enhance sex. Chemsex refers to sex by men who have sex with men. The most commonly used drugs are Methamphetamine, Mephedrone and GHB/GBL, with one or more of these drugs used during a session. It can involve injecting drug use and thus can be a high risk activity.

Year 2 and 3 reported limited data concerning chemsex with less than five treated drug users engaging in this behaviour. Also, no untreated drug user reported engaging or knowing anyone who engaged in this behaviour. This may suggest that chemsex is hidden and/or is not prevalent. In addition, 2016 and 2017 NDTRS data reported very few cases treated for the use of drugs associated with chemsex; use of these drugs may be an indirect indicator of chemsex.

To try to access this hard-to-reach population, Year 3 used the location based social networking app Grindr to investigate chemsex. A Grindr profile was created which stated the preference for chemsex ('PnP', 'Party and Play', a

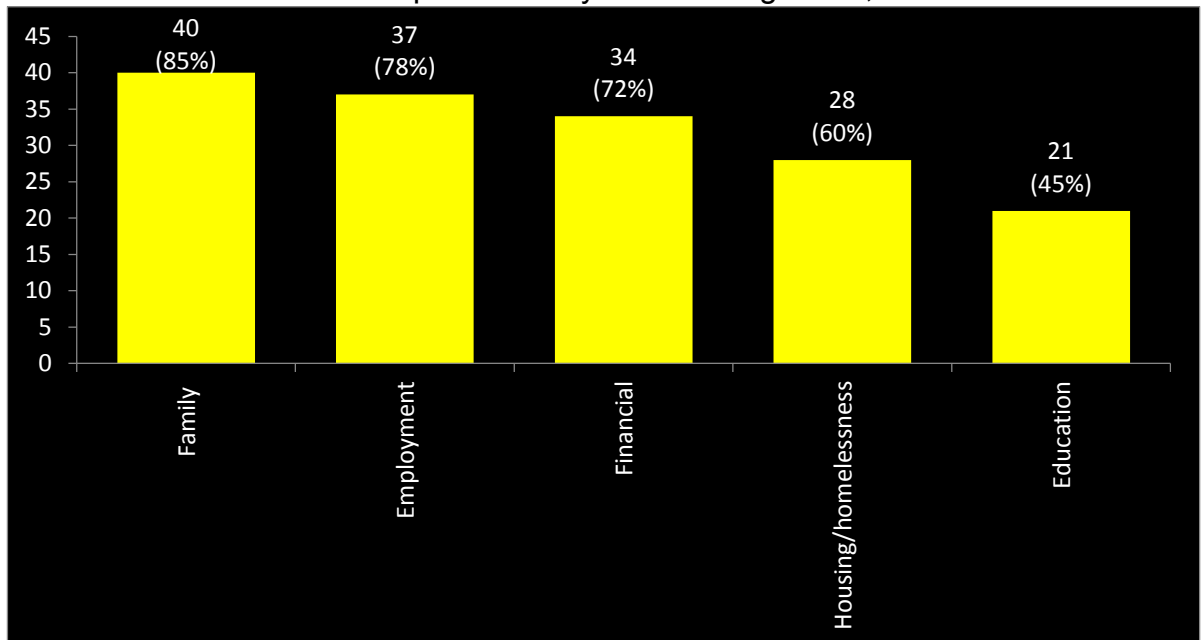
slang term for chemsex). This preference was removed by Grindr as the site censors content concerning risky behaviours.

Over the course of a week there were 66 responses to the profile and 13 (20%) were made from Dublin 15. Less than 5 of these contacts wanted to engage in chemsex. The data suggests that chemsex is not a significant issue in Dublin 15.

2) SOCIAL CONSEQUENCES OF DRUG AND ALCOHOL USE

The social consequences of drug and alcohol use were reported to be a barrier to rehabilitation for treated drug users. Year 3 reported that strained or fractured family relationships were the most common, followed by employment and financial issues (Chart 8.10)¹⁹.

Chart 8.10: Social issues experienced by treated drug users, DATMS Year 3



Category totals exceed total number of participants as some participants reported more than one social issue

These consequences have been reported in all three years of the DATMS, with many treated drug users and their family members experiencing more than one, as many are inextricably linked. Services support drug users and their families to address these issues. However, some of these issues such as homelessness require interventions beyond which local services have the capacity to provide.

• FAMILY

All three years of the DATMS reported the negative impact of drug and alcohol dependence within the family. Family members reported developing mental health issues and using drugs or alcohol to cope. The breakdown of

¹⁹ Analysis based on 47 participants (Treated drug users, family members of drug users, service providers)

relationships and family units was also reported. In some cases, children were in state care or being raised by other family members²⁰.

EDUCATION COMPROMISED DUE TO DRUG USE

In Year 1 to 3, service providers reported that drug use by parents and young people affected school attendance and educational attainment, and in some cases resulted in early school leaving or expulsions.

The Tulsa Education Welfare Service provided an analysis of cases referred to the Educational Welfare Officer (EWO) for poor school attendance during the academic years 2015/16 and 2016/17. The following charts report the number of cases and a profile of these young people (Charts 8.11 to 8.15).

Chart 8.11: Number of cases for poor school attendance, EWO 2015/16 & 2016/17

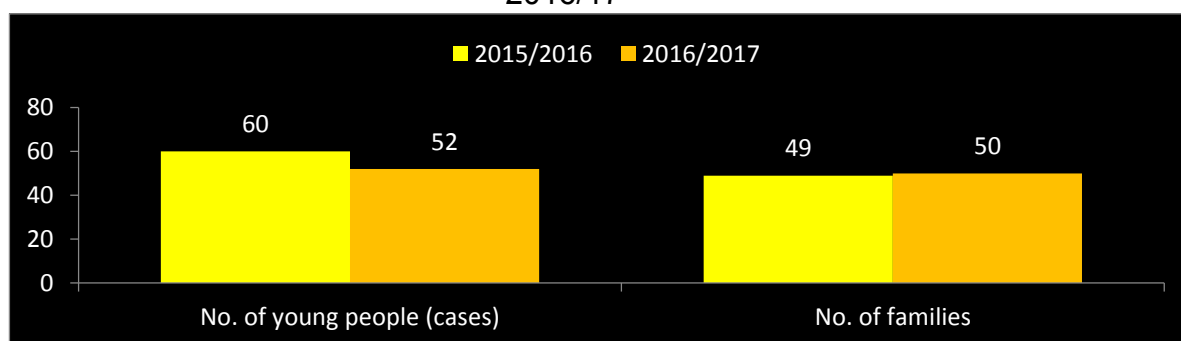
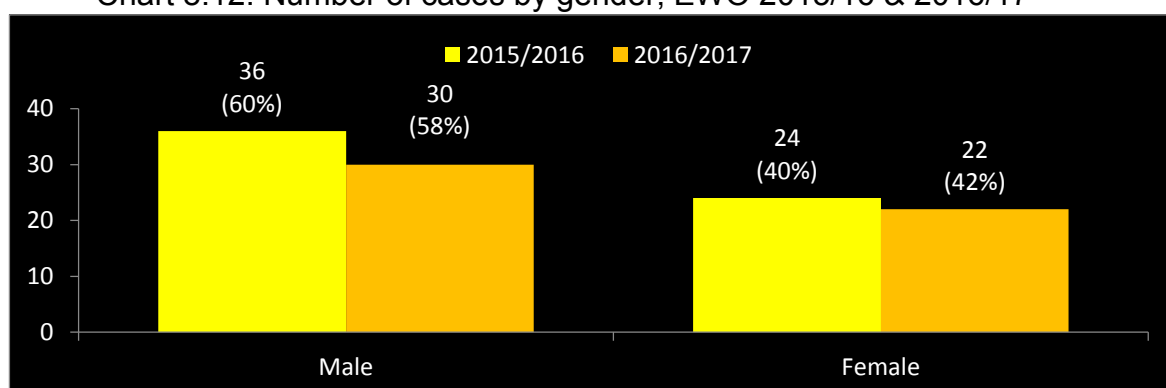


Chart 8.12: Number of cases by gender, EWO 2015/16 & 2016/17



²⁰ Data concerning the family context as a risk factor for the normalisation of drug use, the development of inter-generational drug dependence and mental health issues is reported in chapter 'Factors contributing to drug use'

CONSEQUENCES OF DRUG AND ALCOHOL USE

Chart 8.13: Number of cases by ethnicity, EWO 2015/16 & 2016/17

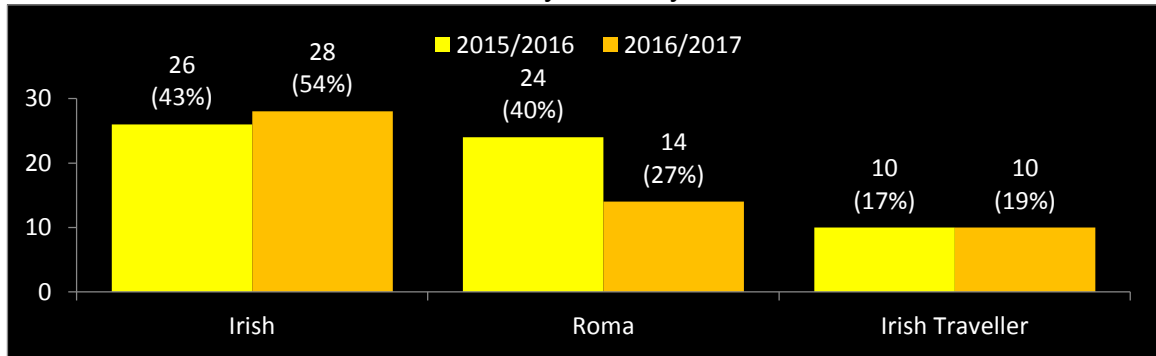


Chart 8.14: Number of cases by school level and age, EWO 2015/16 & 2016/17

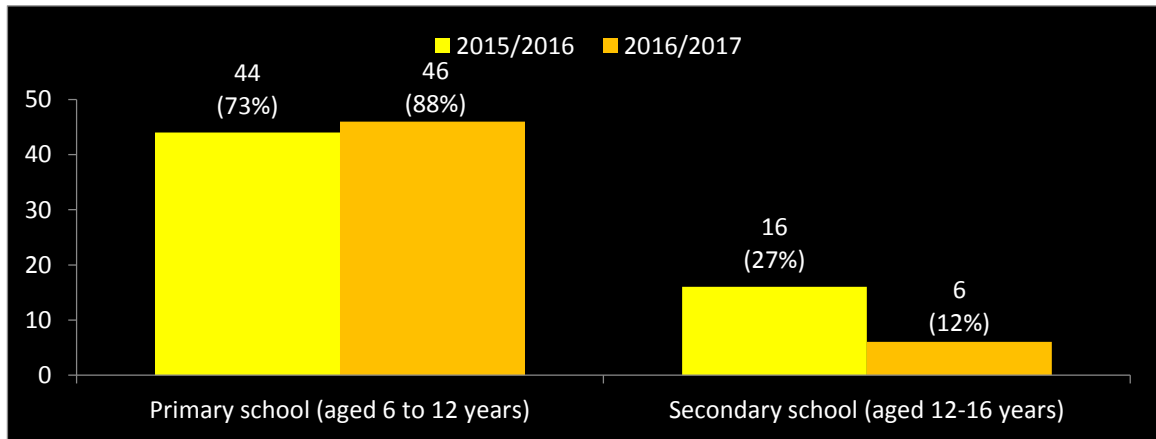
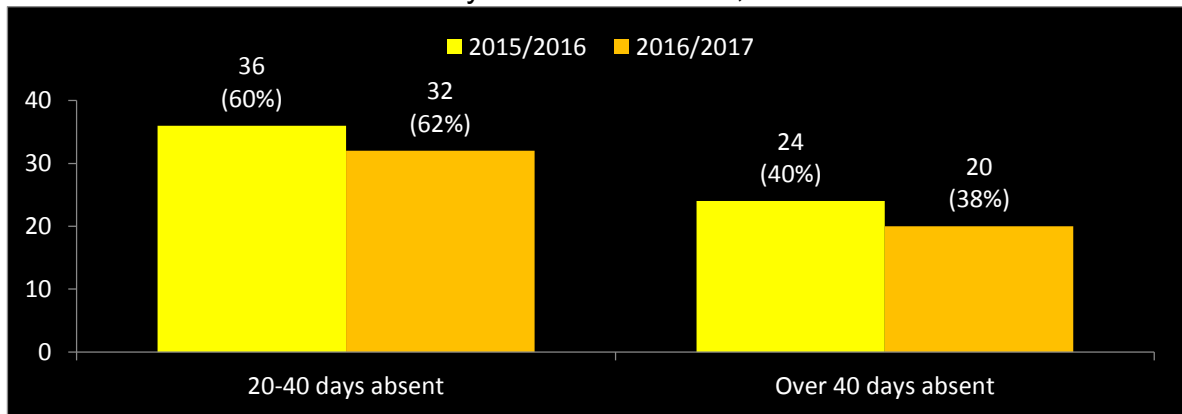


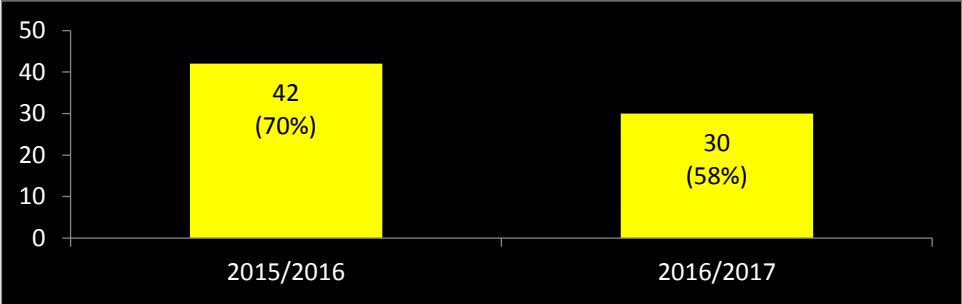
Chart 8.15: Number of cases by absenteeism rate, EWO 2015/16 & 2016/17



There were a number of legal proceedings for school absenteeism in both academic years, though the number was too small to be reported. During both academic years, there were suspicions that for some cases drugs and/or

alcohol were an issue. In the majority of cases it was parental drug use and the minority was young person’s use (Chart 8.16).

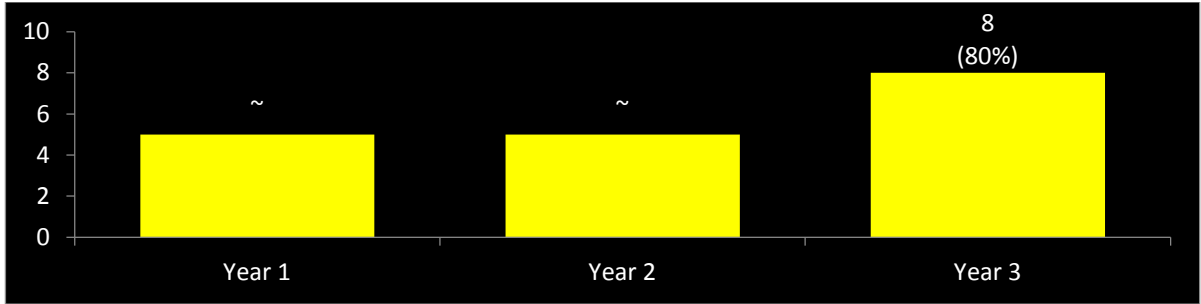
Chart 8.16: Number of cases affected by drug use, EWO 2015/16 & 2016/17



DRUG USE IN DUBLIN 15 SECONDARY SCHOOLS

Year 1 to 3 reported that some secondary school student's education was compromised due to drug use before and during school time. There are ten secondary schools in Dublin 15. Chart 8.17 reports the number of schools with evidence of drug use before and/or during school from Year 1 to Year 3.

Chart 8.17: Number of Dublin 15 secondary schools with evidence of drug use before&/during school time, DATMS Year 1 to 3



~Number of schools too small to be reported (5 or less)

The increase reported in Year 3 was more likely to be related to an increase in the quality of the data rather than an increase in drug use in local schools. In Year 3 these schools were in both disadvantaged and affluent areas.

PROFILE OF SCHOOL-BASED DRUG USERS

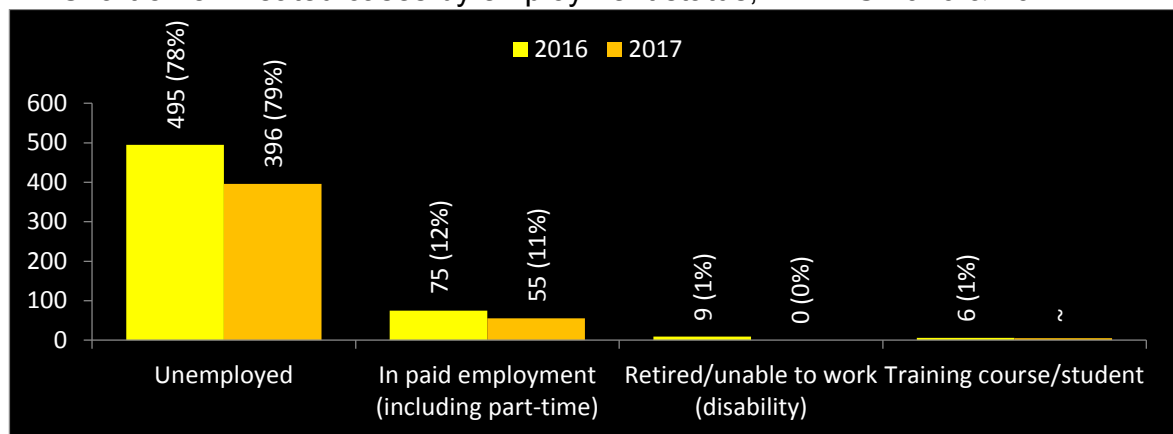
Year 1 and 2 students were predominately White Irish males aged from 14 years, though there were reports of younger students also using drugs during school time. This was also reported in Year 3, along with evidence of drug use among Irish African, Asian and Eastern European students. All three years

reported the use of cannabis during school time; Year 3 also reported the use of Cocaine powder and MDMA. The change in profile of drug users was likely to be related to an increase in the quality of the data.

• EMPLOYMENT

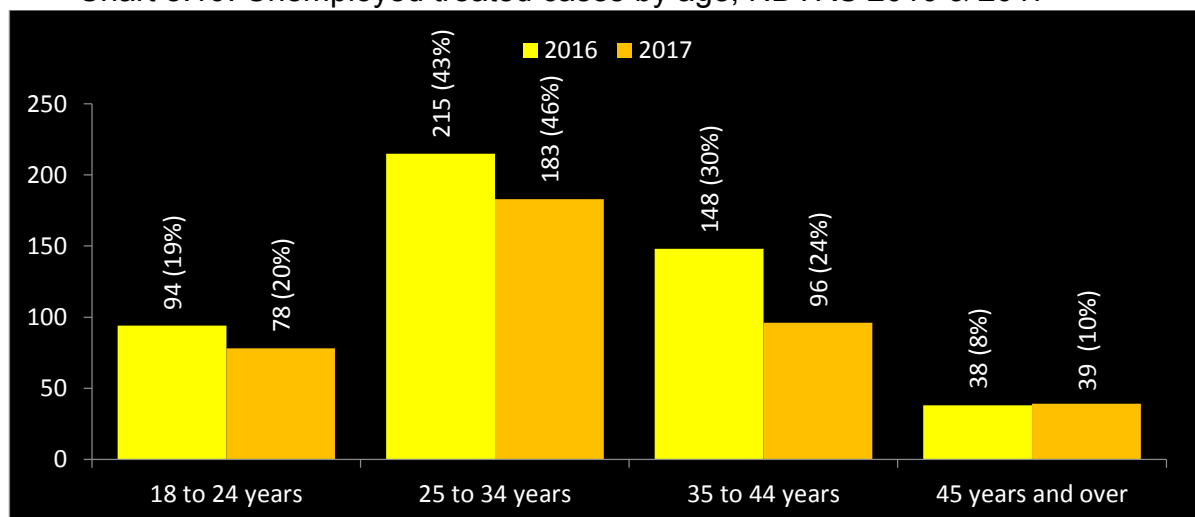
Treated drug users reported difficulties maintaining employment due to drug use, with many unemployed. They also reported leaving employment to enter treatment. For those in recovery, getting back into the workforce after being out for a length of time proved challenging. NDTRS data reports that the majority of treated cases in 2016 and 2017 were unemployed (Chart 8.18); Chart 8.19 reports unemployed treated cases by age.

Chart 8.18: Treated cases by employment status, NDTRS 2016 & 2017



Category totals less than 100% as category 'unknown' removed

Chart 8.19: Unemployed treated cases by age, NDTRS 2016 & 2017



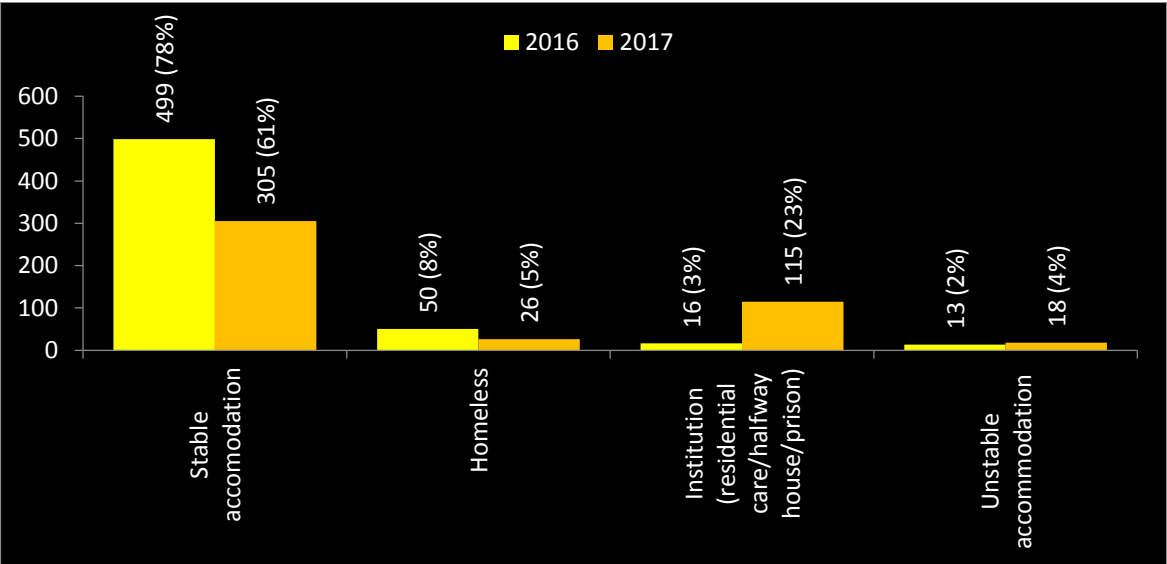
• **FINANCIAL**

Service providers and treated drug users reported high levels of drug-related poverty. Drug use was prioritised over living expenses and some reported using moneylenders. Increasing housing costs, unemployment and drug debts added further to levels of poverty.

• **HOUSING**

Participants reported that housing was compromised due to drug use and anti-social behaviour, including drug dealing and drug debt intimidation. These anti-social behaviours also impacted negatively on drug users’ families and community. The financial difficulties reported above further compromised housing. This affected treated drug users living in local authority, private rental and owner occupied housing. Consequences included eviction and homelessness, with some residing in emergency accommodation for long periods of time. NDTRS data from 2016 to 2017 reports a reduction in the number of treated cases in stable accommodation (Chart 8.20).

Chart 8.20: Treated cases by accommodation status, NDTRS 2016 & 2017

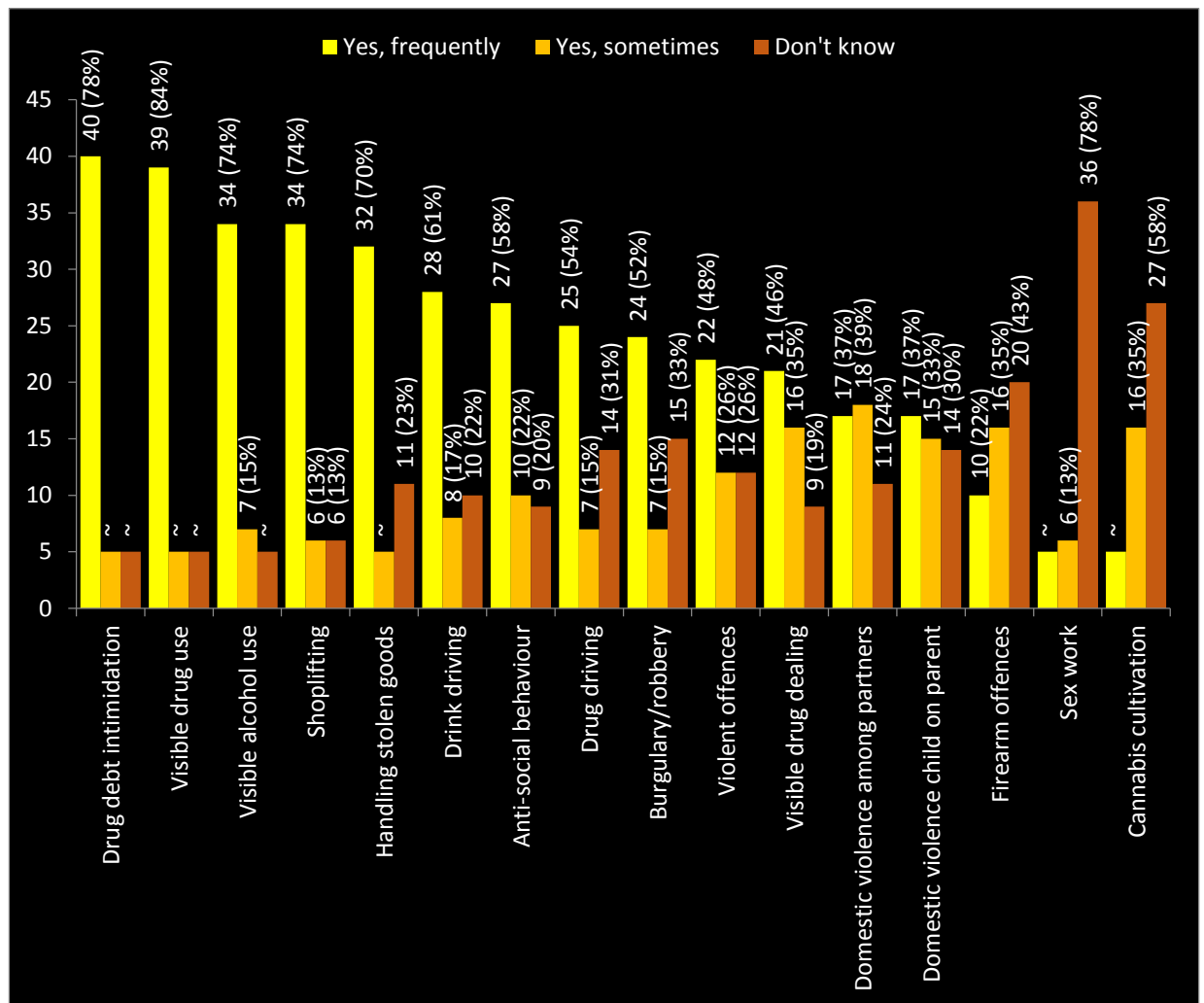


Category totals less than 100% as category 'unknown' removed

3) DRUG AND ALCOHOL-RELATED CRIME

All three years of the DATMS reported the existence of drug-related crime in Dublin 15. Year 3 participants reported perceptions concerning the frequency with which drug-related crime occurred in Dublin 15 in 2017 (Chart 8.21)²¹. Drug debt intimidation was the most frequently reported followed by the visible use of drugs (predominately cannabis and alcohol) in the community.

Chart 8.21: Frequency of drug-related crime in Dublin 15 in 2017, DATMS Year 3



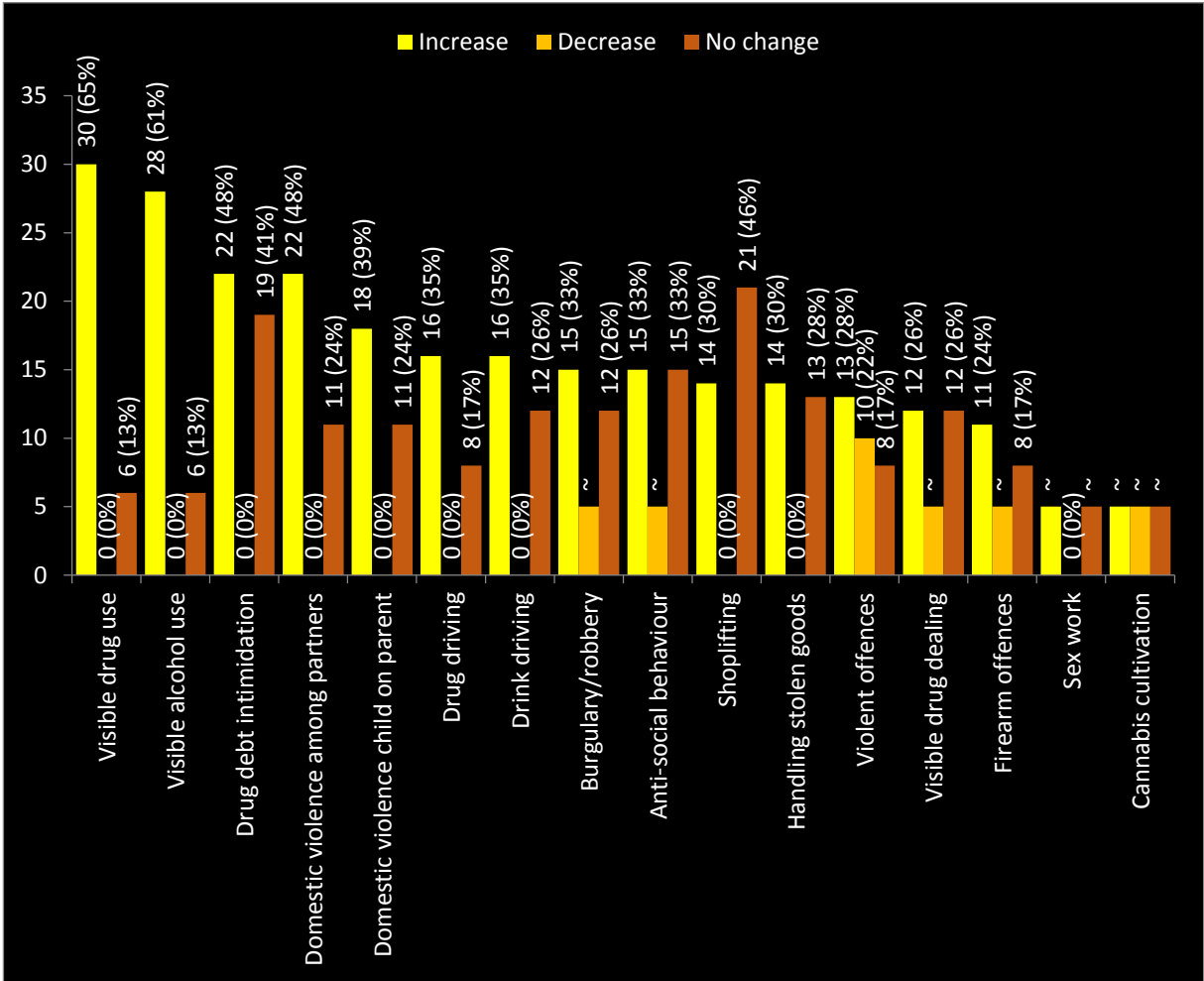
~Number too small to be reported (5 or less)

Participants reported perceived changes in the frequency of drug-related crime from DATMS Year 2 to Year 3 (Chart 8.22). Drug-related crimes with

²¹ Analysis based on 46 participants (Treated and untreated drug users, young people and service providers)

the largest increase included visible use of drugs and alcohol in the community and drug debt intimidation.

Chart 8.22: Changes in frequency of drug-related crimes in Dublin 15, DATMS
 Year 2 to 3



Category totals do not add up to 100% as category 'unknown' not included
 ~Number too small to be reported (5 or less)

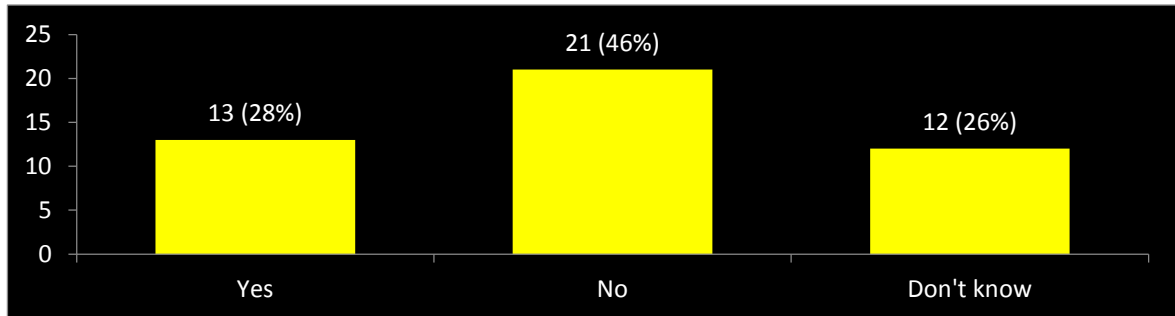
DRUG DEBT INTIMIDATION

Similar to previous DATMS reports, drug debt intimidation was an issue for treated and untreated drug users. The profile of victims has also remained the same: predominately males from the age of 14 and from all socio-economic groups. Intimidation takes many forms including forcing victims to hold or deal drugs or hold firearms to pay off debts. This could partly explain the perceived increase in the number of young people dealing drugs in 2017²². Gardai

²² Reported in the chapter ‘Factors contributing to drug use’

intervention was rarely sought (Chart 8.23), with victims and families paying debts to protect their families.

Chart 8.23: Reporting of drug debt intimidation to Gardai in 2017, DATMS Year 3



Year 3 participants reported that drug debt intimidation was rarely reported to the Gardai because:

- Victims fearful the intimidation would escalate
- Victims fearful of highlighting their criminal activity
- Perception that Gardai cannot provide much assistance
- Victims would be considered a 'grass' within the community

Gardai data for Year 1 and 2 stated that the number of families reporting drug debt intimidation to Gardai were too small to be reported (to uphold confidentiality). No data concerning drug-related offences was provided for 2017.

9. GAPS IN SERVICE PROVISION

This section reports gaps in local service provision identified by research participants in DATMS Year 3. The majority of these gaps are actions in the national drug strategy (Department of Health, 2017). The NDS actions are identified below, with their description provided in Appendix 1. Gaps underlined were also reported in previous DATMS reports.

PREVENTION

- Improve drug prevention programmes (NDS Action 1.1.2); service provision to include:
 - School based programmes
 - Information about drug use, mental health and reducing the stigma associated with seeking help for drug or mental health issues
- Funding for public awareness campaign 'Think before you buy' that highlights the link between recreational drug use and the consequences for individuals, families and communities (NDS Action 4.1.42)
- Increase access to skills based mental health wellbeing programmes for young people and adults that focus on the development of mental health protective factors (NDS Action 1.2.5 b for young people)

TREATMENT

- Improve treatment programmes for under 18s and young people aged 18 to 25 years (NDS Action 2.1.13 a,b; Action 2.1.22 a,b,c); service provision to include:
 - Non-opiate based treatment model, with mental health and harm reduction service provision
 - Pro-actively attract the most vulnerable and hard-to-reach as most young drug users do not perceive the need for treatment
- Improve access to benzodiazepine and heroin detoxification programmes including community based services (NDS Action 2.1.13 a,b)

- Resume community drug and alcohol team and community alcohol programme service provisions that were suspended while treatment services were organised (NDS Action 2.1.13 a,b)
- Improve access to childcare to increase access to treatment and rehabilitation services (NDS Action 2.1.19 b)
- Develop out-of-hours treatment services for drug users in employment (NDS Action 2.1.13 a,b)
- Increase public knowledge of local service provision
- Increase access to counselling, mental health clinical assessments and treatment services for children, young people and adults; service provision to include:
 - Out-of-hours services (NDS Action 2.1.24 a,b)
 - School based free of charge counselling to increase accessibility for the most vulnerable

REHABILITATION

- Improve access to aftercare services including peer-led support services such as Narcotics Anonymous, Cocaine/Cannabis Anonymous (NDS Action 2.1.13 a,b; Action 2.1.16)
- Increase access to training and employment (NDS Action 2.1.19 a,b)
- Increase access to housing

FAMILY SUPPORT SERVICES

- Improve support services for families of drug users (NDS Action 2.1.17 a)
 - Develop respite for family units (NDS Action 2.1.17 a)

SUPPLY REDUCTION

- Develop guidelines for the management of drug debt intimidation without involving the Gardai (due to the fear of exacerbating the extent of intimidation Gardai intervention is rarely sought)

GAPS IN DATMS EVIDENCE BASE

- A comprehensive profile of family members affected by drug use and untreated adult drug use is required
- To create a more robust profile of treated drug use the quality of data returns to the NDTRS needs to be improved
 - This is evidenced by knowledge of local services provision whereby some services were either under-reporting or not reporting any data to the NDTRS; also, identified by variables which reported a high amount of 'not known' values

REFERENCES

Cannon M, Coughlan H, Clarke M, Harley M & Kelleher I (2013) *The Mental Health of Young People in Ireland: a report of the Psychiatric Epidemiology Research across the Lifespan (PERL) Group*. Dublin: Royal College of Surgeons in Ireland.

Central Statistics Office (2006, 2011, 2016) Electoral Division and Small Area Analysis Pobal Maps CSO Population Census 2006, 2011, 2016. Downloaded from www.census.cso.ie

Department of Health (2017) *Reducing harm, supporting recovery. A health-led response to drug and alcohol use in Ireland 2017 - 2025*. Dublin: Department of Health.

Gore FM, Bloem PJ, Patton GC, Ferguson J, Joseph V, Coffey C, Sawyer SM, Mathers CD (2011) *Global burden of disease in young people aged 10-24 years: a systematic analysis*. Lancet, 2011. 377(9783): p. 2093-102.

Health Research Board (2017) *National Drug-Related Deaths Index 2004 to 2015 data*. Available at: <http://www.drugsandalcohol.ie/28086> and at www.hrb.ie/publications.

Health Research Board (2016) National Drug Treatment Reporting System (NDTRS) Protocol for completing the hard copy form. Health Research Board, Dublin.)

Information Service Division Scotland & National Service Scotland (2014, updated 2016) *Estimating the National and Local Prevalence of Problem Drug Use in Scotland*. An Official Statistics Publication for Scotland.

Murtagh & Partners (2018) *Independent Strategic Review of Services at Blanchardstown Local Drug & Alcohol Task Force*. July 2018.

National Advisory Committee on Drugs and Alcohol (2016) *Prevalence of drug use and gambling in Ireland and drug use in Northern Ireland. Bulletin 1*. Dublin: National Advisory Committee on Drugs and Public Health Information and Research Branch, Dublin.

APPENDIX

NATIONAL DRUG STRATEGY (Department of Health, 2017) ACTIONS ASSOCIATED WITH GAPS IN SERVICE PROVISION

Action 1.1.2: Improve the delivery of substance use education across all sectors, including youth services, services for people using substances and other relevant sectors.

Action 1.2.5: Improve supports for young people at risk of early substance use:

- (a) Providing access to timely appropriate interventions such as resilience-building programmes, and/or counselling, educational assessments and/or clinical psychological assessments, as appropriate.

Action 2.1.13: Expand the availability and geographical spread of relevant quality drug and alcohol services and improve the range of services available, based on identified need.

- (a) Identifying and addressing gaps in provision within Tier 1 to 4 services
- (b) Increasing the number of treatment episodes provided across the range of services available, including: low threshold; stabilisation; detoxification; rehabilitation; step-down; and aftercare.

Action 2.1.16: Improve relapse prevention and aftercare services. Developing and broadening the range of peer-led, mutual aid and family support programmes in accordance with best practice.

Action 2.1.17: Further strengthen services to support families affected by substance misuse.

- (a) Developing addiction specific bereavement support programmes and support the provision of respite for family members.

Action 2.1.19: Increase the range of progression options for recovering drug users and develop a new programme of supported care and employment. Establishing a Working Group to:

- (a) Examine the range of progression options for those exiting treatment, prison, Community Employment

schemes including key skills training and community participation with a view to developing a new programme of supported care and employment.

- (b) Identify and remedy the barriers to accessing the range of educational, personal development, training and employment opportunities and supports, including gender specific barriers and the lack of childcare provision, for those in recovery.

Action 2.1.22: Expand the range, availability and geographical spread of problem drug and alcohol services for those under the age of 18.

- (a) Identifying and addressing gaps in child and adolescent service provision.
- (b) Developing multi-disciplinary child and adolescent teams.
- (c) Developing better interagency cooperation between problem substance use and child and family services.

Action 2.1.24: Improve outcomes for people with co-morbid severe mental illness and substance misuse problems.

- (a) Supporting the new Mental Health Clinical Programme to address dual diagnosis.
- (b) Developing joint protocols between mental health services and drug and alcohol services with the objective of undertaking an assessment with integrated care planning in line with the National Drug Rehabilitation Framework.

Action 4.1.42: Strengthen the effectiveness of the Drug-Related Intimidation Reporting Programme: An Garda Síochána and the National Family Support Network will each carry out its own evaluation of the Drug-Related Intimidation Reporting Programme to strengthen its effectiveness and, if appropriate, develop measures to raise public awareness of the programme.



Blanchardstown LDATF
37a Coolmine Industrial Estate,
Blanchardstown, Dublin 15, D15 X6XD
T: 01 824 9590 W: www.bldtf.ie