



National Drug Trend Monitoring System (DTMS)

Pilot Study

Summary Report

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Mairéad Lyons

Director NACD

Terminology

Drug indicator (Griffiths *et al.*, 1999; Alvarez *et al.*, 2003)

A drug indicator is any data source on drug use (together with a set of agreed rules for recording and reporting) to measure drug use prevalence or incidence. Typically indicators include; first treatment demand; all treatment demand; drug seizures; drug arrests; drug-related deaths; survey data; price and purity information; drug related medical emergencies etc. The term 'indicator' is employed to emphasise the point that the data is not a direct measure of drug use in the general population. Thus, treatment demand may be indirectly related to wider patterns of drug use, but cannot be assumed too directly represent the wider and unknown patterns of drug use found in society.

Drug Information System (DIS) (Griffiths *et al.*, 1999; Alvarez *et al.*, 2003)

It is a system that seeks to understand patterns of drug use by analysing data from one or more data sources'. Drug information systems should be able to meet the needs of different information consumers. A drug information system consists of data sources; procedures for analysis, evaluation and dissemination; and data providers and consumers.

Early Information Function (Alvarez *et al.*, 2003)

Early information function is one of the purposes of a drug information system. It is intended to quickly identify, assess and categorise and emerging drug phenomena in order to allow the production of relevant information and its timely dissemination to target audiences.

Early warning system (Griffiths *et al.*, 1999; Alvarez *et al.*, 2003)

An early warning system refers to a drug information system designed specifically for the purpose of identifying changes at an early stage only. Such systems generally focus on changes that have implications for policy, for interventions or other public health concerns. They may also focus on one particular drug-related concern such as HIV infection.

Emerging drug phenomena (Griffiths *et al.*, 1999; Alvarez *et al.*, 2003)

This is a drug related change, which is observed for the first time. The fact that it is a first observation can be linked to the fact that it is a new phenomenon or that it is a pre-existing phenomenon that has not been observed before but is perceived now for the first time.

Integrated information system (Griffiths *et al.*, 2000; Alvarez *et al.*, 2003)

An integrated drug information system views data gathered on drug use and related issues, as an ongoing process, whereby data from different data sources are compared and evaluated.

By using a range of different information sources, the weakness in individual data sources can be compensated for. The task of an integrated drug information system is to balance the strengths of one information source against the weakness in others. An integrated drug information system requires more than the simple collection of information from different sources. It also requires an ongoing dialogue between information producers (those responsible for data collection) and consumers (those who require data for informing action). This dialogue is essential for critically analysing the significance of the available information, identifying information deficits that hamper development of effective policies or interventions, and for improving the sensitivity of existing drug indicators.

Lagged indicator and/or lagged data (Griffiths *et al.*, 1999; Alvarez *et al.*, 2003)

The term lagged is used to describe an indicator or data that has a structural and pronounced time lag in terms of reporting drug incidence. Treatment demands are a classic lagged indicator as individuals typically consume an illicit substance for several years before approaching treatment services. Lagged indicators should be viewed as indicating a position on a continuum rather than an explicit category, and may vary by drug type, and geographical and temporal location.

Leading edge indicators (Griffiths *et al.*, 1999; Alvarez *et al.*, 2003)

A leading edge indicator is any indicator that can be considered particularly sensitive to change i.e. those indicators that respond first to changes in drug consumption patterns (drug incidence). Most developed indicators of drug consumption can be considered lagged to some extent. The term leading edge indicators therefore refer to those data sources that may be most efficient in identifying changes at an early state in their development. The sensitivity of leading edge indicators, by definition is associated with volatility. As such these indicators may be unreliable in the medium term if viewed in isolation from other data sources.

Regional Drugs Task Force (RDTF)

The information contained in this report is analysed according to Regional Drug Task Force (RDTF) areas. These areas follow the boundaries of the former health boards. Therefore, in the Dublin area there are three RDTFs: *East Coast Area RDTF, the Northern Area RDTF and the South Western Area RDTF*. In the rest of the country, the RDTFs are as follows: *the Midlands RDTF, the Mid-Western RDTF, the North Eastern RDTF, the North Western RDTF, the Southern RDTF, the South Eastern RDTF, the Western RDTF*.

Trend (Last, 2001; Alvarez *et al*, 2003)

A trend is a long term movement in an order series; e.g. a time series. An essential feature is that the movement, while possibly irregular in the short term, shows movement consistently in the same direction over a long period of time. However, the term is also used loosely to refer to an association which is consistent in several samples or strata but is not statistically significant.

Executive Summary

Introduction

The availability of reliable and timely data on trends in illicit drug use (such as the types of drugs being used, how they are used, in what combinations, by which social groups, and in which geographical areas) is essential for informing appropriate policy responses and service provision.

To date, much of the existing information on illegal drug use in Ireland is based on indicators of drug use which are limited in terms of identifying new drug trends in that they are time-lagged with the data often published two or more years after the time-period, and that they mainly provide information on sub-groups of the drug-using population (e.g. those who have come into contact with the criminal justice system and/or the drug treatment services) rather than on the wider drug-using population.

In 2004, in response to the objectives set out under the Programme for Government (2002) and the National Drugs Strategy regarding the identification of new drug trends - particularly the concern over the spread of heroin into new areas – research staff at the National Advisory Committee for Drugs (NACD) developed a model for a Drug Trend Monitoring System (DTMS) (see Section One, Figure 1) This model sought to bring together and contextualise data gathered through new data collection systems with data from traditional indicators and research findings, which would help identify emerging or changing patterns of drug use, unknown drug users groups, as well as regional patterns of drug use and drug markets.

Following a review of the European and International literature, three new data collection mechanisms were identified which offered the most potential for identifying emerging drug trends in the Irish context; these were:

1. a **media monitoring system** to monitor current drug seizures, drug-related court cases, and local drug issues around the country
2. a **network of trend monitors** consisting of frontline workers from around the country to complete a twice yearly trend questionnaire (see Appendix 1) on the drug situation in their area, and notify the DTMS when new trends arise
3. a series of **focus Groups** with drug users to assess latest drug trends.

During the second half of 2004, the NACD decided to pilot-test these three new data collection mechanisms for a six-month period to establish their potential for identifying new drug trends. This document describes the development of the DTMS model and presents an analysis of the findings.

Understanding the Findings

Media Monitoring

For the DTMS pilot study, the coverage of drug-related court cases and seizures in national, regional and local newspapers was monitored for four and a half months from mid-June 2004 to the end of October 2004. Data on the type and quantity of drug, the location of the seizure, and demographic data on the person(s) involved were coded and analysed to demonstrate the type of trend data that can be produced from this source. For the pilot study, data were also analysed at the Regional Drugs Task Force (RDTF) level.

The main findings from the media monitoring aspect of the DTMS showed a regional variation in the number of drug-related media reports. While these numbers may reflect the extent of drug use in the different areas, they are also influenced by the priority given by newspapers to this issue and the consistency with which drug-related reports are published, as well as the level of Garda activity in each area.

Drug possession offences were the main drug-related issue dealt with by the courts in the majority (six out of ten) of the RDTF areas; offences for the sale and supply of drugs were the main issue dealt with by the courts in the South Eastern, Southern, Northern Area and South Western Area RDTF areas – indicating a higher level of drugs market activity in these areas.

In all areas, cannabis was the main drug involved in the seizures and court cases – on average 53% of all cases, ranging from over one-third of cases (39%) in the North Eastern RDTF area, to almost three-quarters of cases (74%) in the Western RDTF area. This data was substantiated by evidence from the NACD/DAIRU 2002/2003 Drug Prevalence Survey, that cannabis is the most widely used illegal drug.

The main other drugs identified in the media reports were ecstasy (16%, n=70); cocaine (13%, n=55); heroin (12%, n=54); and amphetamines (5%, n=21). Again, there were regional variations in the extent to which these drugs feature in the newspaper reports in each area. Ecstasy cases accounted for a high proportion of the media reports in the North

Western (42%), North Eastern, South Eastern and Southern RDTF areas (each 19%). Cocaine-related cases were prominent in the media reports in the Northern (25%), North Eastern (22%), South Eastern and Southern RDTF areas (each 21%). High proportions of heroin-related cases were reported in the media in the East Coast Area (40%); South Western Area (29%) and the Midland (23%) RDTF areas. Amphetamine-related cases were mostly clustered in the Midlands RDTF where they accounted for almost one-fifth (19%) of the drug-related reports.

The classification of the quantity of drug seized and/or reported on in the court cases into the categories of lower drugs market (personal/friends and retail) and upper drugs market (middle, wholesale distribution and importation) provides a useful means of understanding the type of drugs market in operation in each area. Overall, two-thirds (68%) of the court cases and seizures were for amounts categorised at the lower level of the drugs market – 41% for amounts for personal/friends use; and 27% at the retail (user-dealer) level. The regional variation in the proportion of cases at the lower level of the market ranged from 96% of cases in the North Western RDTF to 32% in the Northern Area RDTF areas. A high proportion of the cases reported in the Northern Area (67%), South Western Area (51%), South Eastern (50%) and Southern (49%) RDTF areas were at the upper level of the drugs market – indicating higher level supply networks operating in these areas and, potentially, a greater availability of drugs.

In almost all areas, cannabis was the main drug at both the lower and upper levels of the market. The RDTF areas where drugs other than cannabis featured prominently at the upper level of the drugs market were the: North Western (ecstasy), Western (cocaine and ecstasy), East Coast Area (heroin) and South Western Area (heroin) RDTFs.

Overall, at a county level, the newspaper reports of drug-related court cases and seizures indicate a clustering of cases in the urban centres of Dublin (20%, n=85), Waterford (14%, n=59), Cork (11%, n=48), and to a lesser extent in Tipperary (7%, n=28).

Trend Monitors' Survey Data

In October 2004, 210 questionnaires were despatched to the network of Trend Monitors (TMs) that had been established for the DTMS. One hundred and fifty-six TMs reported on drug use trends among the drug users they were in contact with through their work, and on the drug situation in the geographic area where they worked.

a. Drug using behaviour of Trend Monitors' contacts

Almost all the TMs reported cannabis (99%) and alcohol (96%) use by their contacts. A high proportion reported ecstasy (85%), cocaine (81%), heroin (72%), and amphetamine use (62%). Over three-quarters of the TMs in the North Eastern, East Coast, Northern Area and South Western RDTF areas reported heroin use by their contacts. Three-quarters in the Midland, North Eastern, East Coast Area, Northern Area and South Western RDTF areas reported this drug (heroin) as among those most frequently used by their contacts.

Over three-quarters of the TMs in the South Eastern, East Coast Area, Northern Area and South Western Area RDTF areas reported both that cocaine was used by their contacts and that it was among the drugs most frequently used. Increases in cocaine use were noted by three-quarters of the TMs in the Mid-Western, North Eastern, and Southern RDTF areas as well as in the East Coast Area, Northern Area and South Western Area RDTF areas.

Intravenous (IV) drug use by the TMs' contacts was noted in all RDTF areas. All areas reported IV heroin use. In addition, IV cocaine use was noted in four RDTF areas (Southern, East Coast Area, Northern Area and South Western Area); IV steroid use was noted in five RDTF areas (North Eastern, South Eastern, East Coast Area, Northern Area and South Western); IV amphetamine use in three RDTF areas (South Eastern, Northern Area, and South Western Area); and IV crack cocaine use in four RDTF areas (South Eastern, East Coast Area, Northern Area, and South Western Area).

b. Area drug trends

The main drugs reported by TMs as being available in their area were cannabis (100%, n=156), ecstasy (97%, n=151), cocaine (90%, n=141), heroin (84%, n=131), solvents and inhalants (78%, n=122), and amphetamines (78%, n=121).

A high proportion of TMs (75% and over) in the Midland, North Eastern, South Eastern, East Coast Area, Northern Area and South Western Area RDTF areas identified heroin availability in their area. A similarly high proportion identified cocaine availability in all areas, with the exception of Mid-Western and North Western RDTF areas.

Street markets were identified as the main source of drugs in four RDTF areas – the Southern, East Coast Area, Northern Area, and South Western Area RDTF areas, indicating an open drugs market and relatively easy access to drugs for the local population.

The use of prescription drugs (mainly sedatives, tranquillisers and anti-depressants, (ST/ADs); and Viagra[®]/Cialis[®]); over-the-counter (OTCs) medication; and steroids were the main new trends identified by the TMS.

c. Drug User Focus Groups

Six focus group discussions with third level students and youth groups demonstrated the acceptability of illicit drug use in young people's lives and the low risk perception associated with drug-taking, particularly in relation to cannabis and ecstasy, and to a lesser extent cocaine; and in the combination of these drugs with alcohol.

Overall Comment and Assessment

Data from each of the above elements of the DTMS are presented in-depth in the following chapter. Overall, this data provides current knowledge on:

- Regional patterns of drug use trends (drugs available in area, how obtained, how taken, cost, method of administration etc.)
- Profiles of drug users in terms of gender and age
- The operation of drug markets (street markets etc.)
- Risk behaviour and risk areas (such as new drugs, injecting practices, hotspots)
- Drug-related issues in area (overdoses, deaths, crime)

More importantly, the data establishes a baseline on trends from which future changes can be tracked over time.

a. Media Monitoring

While there are some caveats with regard to the data from the monitoring of media reports, it is important to remember that the aim and rationale of a DTMS is to gain an immediate and reliable picture of current and emerging trends in drug use - information which is not available through other sources in the same way and in the same time-frame, and which is vital for the NACD to fulfil its advisory role to government.

Ideally, the DTMS would have access to the District Court Case Tracking System, as this would eradicate the issue regarding inconsistencies in newspaper reporting on court cases. However, this data would only be useful to a DTMS if the raw data file was made available so that all

the relevant data on the drugs such as drug type, and most importantly, quantity; and the location of the seizure/arrest along with the age, gender, ethnicity and area of residence of the persons involved. However, up to date data on seizures would not be available through this system. There is scope to negotiate with the An Garda Síochána and the Forensic Science Laboratory (FSL) for access to records of seizures on an ongoing basis. Again, the minimum information required to track trends would be on the type and quantity of the drug and the location where it was seized. The data would be required at least on a quarterly basis so that analysis could be conducted in a timely fashion. However, the confidentiality of this data is such that it is difficult to envisage such access being granted in the short-term.

b. Trend Monitors Network

The data from the TMs survey provided very useful local knowledge on drug trends. The establishment of the Trend Monitor Network was a time consuming resource during the pilot phase and this work requires additional resources to extend and consolidate the network. In particular, the number of TMs needs to be increased to ensure that there is adequate representation from all the RDTF areas, from each county, and for each Local Drug Task Force (LDTF) area in the Dublin area. The use of electronic communication (mobile phones, email, e-discussion/alert groups) to maintain the network requires further exploration.

c. Drug User Focus Groups

The drug user focus groups demonstrated real potential for understanding drug-using behaviour and emerging drug use patterns and trends. This qualitative work requires sufficient human resources to gain access to young drug users who are not in touch with treatment or helping services or the criminal justice system; and to explore the use of IT solutions (such as electronic drug surveys) as a mechanism for identifying drug trends among this 'hard to reach' population.

d. DTMS Model

For the purposes of the pilot study, three components of the DTMS model were assessed and their findings presented in this feasibility report. It is important to stress that that these components are part of an overall integrated model (see Section One, Figure 1) and it is not proposed that they stand in isolation. Data from these three sources must be linked in with data from indicators of drug use as well as other data sources such as laboratory data, in order that emerging trends may be assessed in a reliable and valid fashion. In addition,

although it was beyond the scope of the pilot study, it is envisaged that the establishment of a DTMS would use IT and electronic communication to streamline both data collection and data dissemination processes in order that service providers can rapidly respond to changes in the drugs environment.

Conclusion

Overall, the DTMS gives an insight into the drug using behaviour not currently available though other sources. The main trends identified through this pilot study are:

- Nationwide use and availability of cannabis, ecstasy (and alcohol)
- Cannabis, ecstasy, solvents and inhalants consistently identified as 'very easy' to obtain in all RDTF areas
- Amphetamines in all areas especially in Midlands, Mid-Western and South Eastern
- Cocaine in all areas especially Mid-Western, South Eastern and three Dublin RDTF areas
- Heroin in all areas, less so in North Western and Southern RDTFs
- Use of prescription drugs (particularly ST/ADs, other opiates, and Viagra®)
- Drug overdoses and deaths – reported in all areas
- Drug-related crime reported in all areas – drug dealing main issue reported in the Midlands, Mid-Western, North Western, South Eastern, Northern Area and South Western RDTFs areas.

Among the new emerging trends noted were:

- Use of over-the-counter medication
- Use of crack cocaine
- Use of anabolic steroids noticeably in the Southern, Northern Area and South Western RDTF areas
- The development of street-based drug markets outside of Dublin
- The availability of drugs sourced by phone, and the internet.

Section One – Introduction and Methodology

1.1 Introduction

The availability of reliable and timely data on trends in illicit drug use (such as the types of drugs being used, how they are used, in what combinations, by which social groups, and in which geographical areas) is essential for informing appropriate policy responses and service provision.

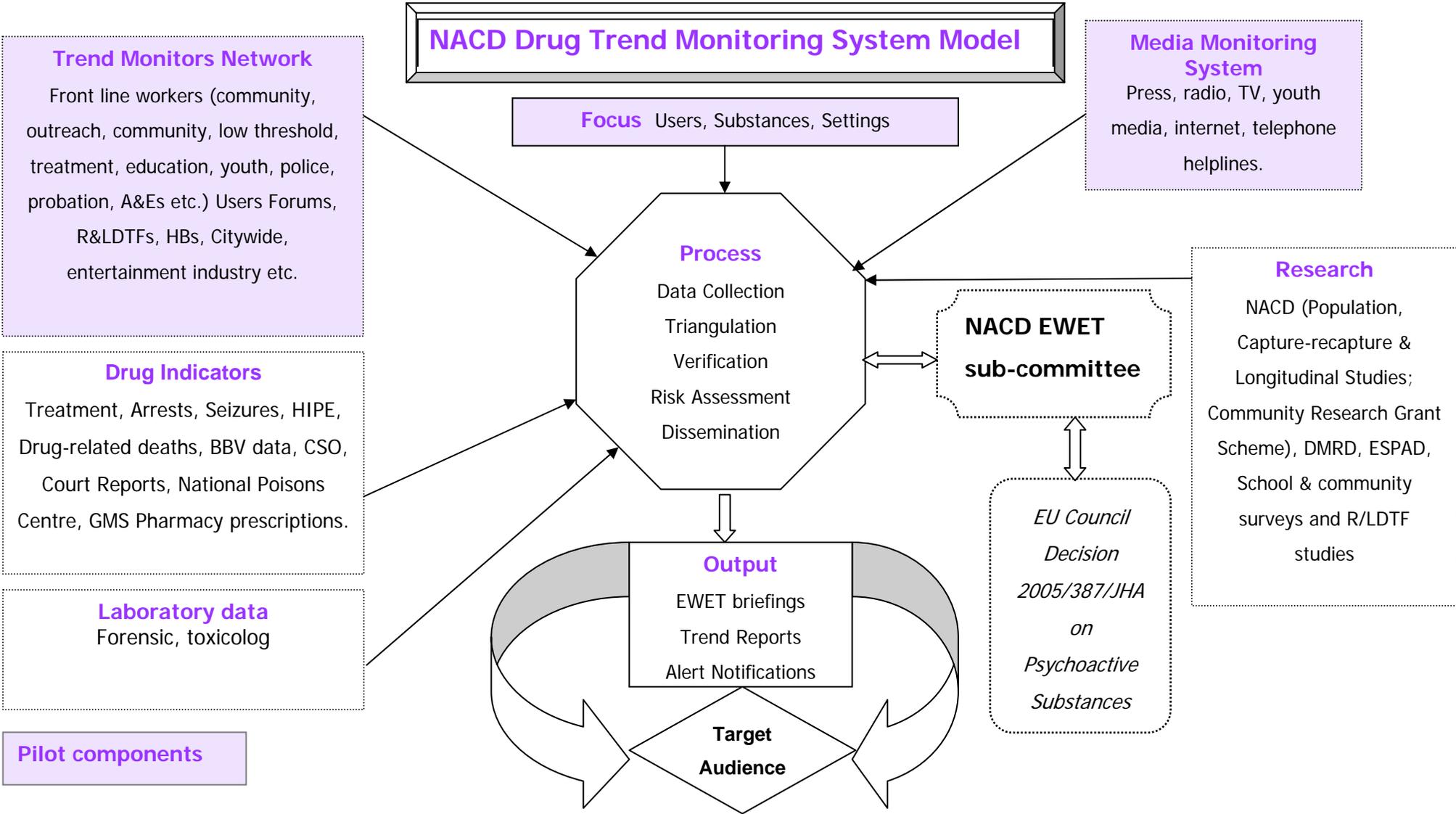
To date, much of the existing information on illegal drug use in Ireland is based on indicators of drug use, such as:

- data on offences under the Misuse of Drugs Act (1977) - provided by the An Garda Síochána and the Customs and Excise branch of the Revenue Commissioners
- data on drug users receiving treatment for problem drug use provided through the National Drug Treatment Reporting System (NDTRS) and the Central Drug Treatment List
- the drug prevalence estimate studies commissioned by the National Advisory Committee on Drugs (NACD).

While each of these data sources provides useful information, they have two main limitations with respect to identifying new drug trends. First, they are time-lagged in that the data are published retrospectively, often two or more years after the time-period. And, secondly, they provide (with the exception of the NACD/DAIRU 2002/2003 Drug Prevalence Survey) information on sub-groups of the drug-using population (e.g. those who have come into contact with the criminal justice system and/or the drug treatment services) rather than on the wider drug-using population. Consequently, these data sources are not suitable for identifying new trends; this type of information requires a different methodology, one which can tap into trends at an early stage in their life-cycle.

In 2004, in response to the objectives set out under the Programme for Government (2002) and the National Drugs Strategy regarding the identification of new drug trends - particularly the concern over the spread of heroin into new areas – research staff at the NACD developed a model for a Drug Trend Monitoring System (DTMS) (see Figure 1). This model sought to bring together and contextualise data gathered through new data collection systems which would identify new patterns of drug use, new drug users groups, as well as regional patterns of drug use and drug markets; with data gathered through by traditional indicators of drug use and other drug research findings.

Figure 1 DTMS Model



Following a review of the European and International literature, three new data collection mechanisms were identified which offered the most potential for identifying new drug trends in the Irish context; these were:

1. a **media monitoring system** to monitor current drug seizures, drug-related court cases, and local drug issues around the country
2. a **network of trend monitors** consisting of frontline workers from around the country to complete a twice yearly trend questionnaire on the drug situation in their area, and notify the DTMS when new trends arise
3. a series of **focus Groups** with drug users to assess latest drug trends.

During the second half of 2004, the NACD decided to pilot-test these three new data collection mechanisms for a six-month period to establish their potential for identifying new drug trends.

This report presents the findings of this pilot study. Section One examines the literature on drug trend monitoring systems; describes the implementation of the DTMS pilot study and outlines the methodological challenges of establishing and operating the system. In Section Two, the findings from the pilot study are presented on a national basis.

1.1.2 Review of literature on drug trend monitoring systems

The limitations of existing routine drug information systems have inspired methodological development in 'leading edge indicators' which are sensitive to detecting new patterns of drug consumption (Griffiths *et al.* 2000). Many countries have now established monitoring systems to identify emerging drug trends using leading edge indicators such as media reports, surveys of frontline workers, and interviews with drug users.

In Germany, there are two local monitoring systems, the *Monitoring System Drug Trend (MoSyD)* in Frankfurt, and the *Local Monitoring System (LMS)* in Hamburg (Alvarez *et al.*, 2003). The MoSyD uses an expert panel of key informants and two surveys: one of 1,500 students aged 15 to 18, the other of 150 active drug users. The three data sources of the LMS are similar, key informant interviewing, focus groups and a school survey. Key informants in both systems include DJ's, barkeepers, outreach workers and drug counsellors

The *Antenna project* has been in operation in Amsterdam since 1995. It follows the use of alcohol and drugs among youngsters in Amsterdam. It consists of a qualitative part (continuous panel study) and a quantitative part (an annual survey among a variety of target groups). In the panel study, key informants who are in touch with young clubbers and problem youngsters are interviewed twice a year about developments in drug use and the social environment of youngsters. In addition quantitative surveys are conducted with school pupils, visitors of pubs, coffee shops or clubs in Amsterdam (Korf & Nabben, 2000).

In 1999 the French OFDT set up the Trend device. The *French 'TREND device'* is composed of three data collection tools. The national network of Trend sites collects information from key informants by the use of observation, qualitative questionnaires, focus groups and quantitative ad hoc surveys. SINTES, which is the national identification system for toxins and substances, collects samples of synthetic drugs which are analysed by a network of five laboratories. In addition a questionnaire is filled in by users of these drugs on issues such as expected effects, mode of administration and user's opinion of drug. The final aspect of the Trend device is the 'media watch,' this consists of the reading and analysis of the views expressed on drugs in six French monthly magazines which target young adults - every explicit or implicit reference to drugs is noted and feeds into core indicators. Additional information is fed in through partner organisations include an annual survey of the users of psychotropic substances seen by the health and social facilities, sales of medical opiate substitutes and injection materials and a survey which examines psychotropic substance experimentation and consumption by 17/18 year olds (Alvarez *et al*, 2003).

The *Illicit Drug Reporting System (IRDS)* is Australia's national illicit drug monitoring system. First trialled in New South Wales in 1996, it is conducted every year in each state by participating research institutions throughout the country (Darke, *et al* 2002a). In addition to acting as an early warning system, it TMs the price, purity, availability and patterns of the main illicit drugs (Darke *et al* 2002b; Day *et al*, 2003). It consists of three main data sources a qualitative survey of key informants or experts who work in the field of illicit drugs, a quantitative survey of injecting drug users (IDU) and a compilation of existing indicator sources such as Customs data, seizure purity data arrest data and so on.

National monitoring systems operating in the US include the *Community Epidemiology Work Groups (CEWG)* organised by the US National Institute on Drug Abuse (NIDA, 2006). Data

sources include drug-related deaths, DAWN¹ mentions, clients in drug treatment agencies, arrestee urinalysis, drug seizures, drug prices, arrest information and qualitative data from ethnographers. In addition quarterly 'Pulse Check' reports summarise qualitative information from key informants working in the drug field. The information found in Pulse Check reports are gathered from telephone conversations with sources, including ethnographers, epidemiologists, non-methadone and methadone treatment providers and law enforcements. The CEWG consist of 21 member states. A similar monitoring system is in operation in Ohio – the Ohio Substance Abuse Monitoring network. In this instance ten key informants gather information on substance abuse trends in their area and prepare biannual reports. These key informants recruit active drug users and front-line professionals to participant in up to 6 biannual focus groups. Quantitative data include statistics on substance abuse related arrests, emergency room admissions, crime laboratory data, substance abuse treatment admissions and other sources (Siegal *et al*, 2000*a*).

The media as a useful early warning information source has been advocated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). A retrospective study conducted by the EMCDDA (1999), on the emergence of ecstasy in the late 1980's and 1990's and the growth of heroin smoking in a number of European countries during the late 1970s and 1980s, revealed that a review of specialist youth press and tabloids detailed information in advance of other reports of the trend. They revealed how it took specialised drug information sources a considerable period of time to obtain information on the drugs which had been widely published in the specialist youth press. In 1999, the EMCDDA commissioned a small scale youth media study in France, Italy and the UK. They concluded that youth media monitoring provides insights into the context of illegal drug trends. A follow-up pilot study was conducted in 2003 by five member states including Ireland. The benefits of the monitoring of media were also propounded by the Addiction Research Institute in Rotterdam who also conducted a retrospective study on media coverage of particular drugs. While their review did not focus on underground magazines, it did focus on alterative lifestyles magazines which catered for opiate/cocaine/polydrug users. They concluded that the review of the magazines and journals acted as a reliable and sensitive source to describing emerging trends.

A European working group, under the direction of the French Focal Point the OFDT (Observatoire Francais des drouges et des toxicomaines) was set up to develop an Early Information Function (EIF) to detect emerging drug trends. Based on the results of this work

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¹ Drug Abuse Warning Network (DAWN), measures emergency department drug mentions.

produced during the Euro-TREND Project from January 2002 until December 2003, a useful manual outlining the key elements of an effective model of an Early Information Function for emerging drug trends was developed. According to this report, the main objective of an Early Information Function for emerging drug phenomena is,

'Quickly to identify, assess and categorize Emerging Drug Phenomena in order to allow the production of relevant information and its timely dissemination to target audiences.....It is regarded as a dynamic, permanent, ongoing process, which could have five different but linked steps: data collection, identification, assessment, dissemination and feedback/follow-up' (*Alvarez, et al 2003;p 22*).

The reports lists a number of components which could potentially act as key information data sources, these include, drug users; self help-groups and ex-user groups; low-threshold facilities; health services; treatment and emergency facilities; law enforcement authorities; forensic and toxicological department/laboratories; organizations producing sale statistics; telephone help-lines related to drug use; users' family/social environment; youth welfare facilities; drug prevention and counselling centres; prisons and other criminal justice settings; and mass media and internet and nightlife recreational settings. The report asserts that combinations of quantitative and qualitative methods are essential when developing an EIF. Suggested methods to obtain information from some of above listed sources include population surveys, ad-hoc surveys, sentinel system/surveillance, spontaneous notification, observation, interviewing, focus groups and expert panels. Similar recommendation are made by the United Nations Office of Drug and Crime (2002), who suggest that the use of key informants from organisations such as those listed above is an essential element of an integrated drug information system.

More recently, Action 40 of the European Parliament and Council, EU Drugs Action Plan (2005-2008) recommends by 2007 the development,

'of clear information on emerging trends and patterns of drug use and drug markets' (*European Parliament and the Council on an EU Drugs Action Plan 2005-2008, p18*).

1.2 Methodology - Development of the DTMS model

1.2.1 Media Monitoring System

The aim of developing a media monitoring system was to collect information on drug-related seizures, court cases and local issues reported throughout the country; this type of work has been identified by the EMCDDA as a potentially useful source for monitoring drug trends.

In order to establish the most cost effective and efficient method of monitoring the relevant media reports, the DTMS needs were discussed with the Department of Community, Rural & Gaeltacht Affairs (Dept of CRGA), the Garda Press Office, the Health Research Board (HRB) National Documentation Centre (NDC), and five Media Monitoring companies. While each of these organisations were able to address part of those needs, none could do so in full. For example, the NDC has facilitated NACD access to their monitoring service, however, they do not monitor for local court cases and seizures. Likewise, the Garda Drug Division's Press Office does not cover smaller seizures. And, while the Dept. of CRGA's press office monitors drug-related news items, it was found after a trial run that it would not be guaranteed these would be despatched to the NACD on a systematic basis.

Of the commercial media monitoring companies, the 'Media Markets' agency offered the best service to meet the needs of the pilot DTMS. Following a free five-week trial they were contracted to provide their service. The company are fully digital and provided us with electronic version of the newspaper reports which met the designated search criteria. All national, regional papers and a range of Irish magazines were scanned. The cost of this service was €99 per month and €1.55 per article.

Youth Media

Lifestyle or music magazines can provide useful information in terms of new drugs on the market and current trends in drug taking. With this in mind, the researchers met with Brigid Pike of the Drug Misuse Research Division (DMRD) who had worked on an EMCDDA youth media pilot project in conjunction with five other states. Based on her experience in the study, she made a number of recommendations in terms of tracking youth media. A preliminary decision was made to manually monitor a number of youth magazines on a monthly basis to investigate whether any useful drug trend information could be gained. However, as a number of relevant magazines such as The Slate, Clubbing.com and BBm

were no longer operating, there were no systematically published Irish magazines providing drug-related information and this aspect of the study was discontinued.

Broadcasting media

The Department of CGRA provided the NACD with a one-week trail of Broadcast media alerts that are produced by the Communication's Office in the Department of An Taoiseach. However, the analysis of these reports was found to be impractical as the list of broadcast reports was too large and thus too time consuming to trawl through, and as the broadcasts are supplied by audiotape, this would prove too resource intensive to analyse.

Data analysis of media reports

Media reports were received on a daily basis from the media monitoring company. The articles were read and key points summarised in an Excel database. Reports were recorded under the following headings:

1. Name of newspaper/s reporting incident
2. Date of publication
3. County
4. Drug
5. Town/location of incident
6. Topic of newspaper (e.g. court case, seizure, Garda operation/raid, drug death, robbery, drug driving, criminal activity)
7. Court case (e.g. possession, sale and supply, courier, minder, robbery, drug driving)
8. Quantity and value of drug
9. Date of incident
10. Place of seizure (e.g. street, house, pub, vehicle, airport/port, in transit, festival)
11. Method of arrest (e.g. apprehended while selling, Garda operation/raid, opportunistic)
12. Particulars of individual/s involved.

Time taken to input the data varied, depending on the number of articles received weekly and the ability to input reports as received. On average, at least ten hours were needed weekly to input and file media reports.

Where a drug-related incident was reported in more than one paper all articles were read in order to cross validate information and also to obtain as much detail as possible relating to

the incident. Because an individuals court case may be adjourned or postponed, names of accused were crossed checked to ensure replication of data was not made. To obtain a breakdown of media reports received per month and costs incurred see **Table 1.2.1**.

Table 1.2.1 Number of Media Monitoring Reports received monthly & relevant costs

	Total no of media reports	Average weekly no. of media reports
June to October	1123	50
June	90	22
July	279	70
August	271	68
September	204	51
October	279	70
Total number of quantitative incidents 449		
Total number of qualitative incidents 74		
Total cost €2440.69		
Average cost per month €10.17		

SPSS Analysis of Media Reports

An SPSS media monitoring coding scheme was established and Excel media monitoring data was subsequently coded into the statistical analysis software. The SPSS data entry ensured a quality check of media reports entered in SPSS format. Time allocated to the market level coding of media reports and entry of same for the four-month period was two to three weeks.

The identification of market levels operating within a locality can give a useful indication of the level of drug activity occurring in an area. Consequently, a coding scheme was developed based on the research literature on drug markets and discussions with drug users, drug workers, and members of An Garda Síochána familiar with the operations of the drugs market. Using the information from the media reports' Excel database on the type and quantity of drug involved in each case, the value of the drug, and the details of the court, each case (of seizures, arrests, etc.) was coded at the relevant tier of the drugs market outlined in **Table 1.2.2**.

Table 1.2.2 Drug Market Classification

<i>LOWER LEVEL DRUGS MARKET</i>	
Personal/Friends	Person buying drugs for his/her own personal use and his/her immediate friends use, usually on a not for profit basis. Would not consider themselves as dealers or sellers.
Retail market	Typically user-dealers selling direct to other users in small retail units to finance their use by selling drugs to others. Has direct contact with drug users and may act as a runner for person at the middle market level.
<i>LOWER LEVEL DRUGS MARKET</i>	
Middle level	Operates between runners/user-dealers and area distributors. Deals in 'weights' i.e. ounces and kilos. More profit-orientated dealer.
Wholesale/Distribution	Suppliers who cover large areas and large amounts of drugs, deal with small number of individuals, tend not to have direct contact with drug users
Importation	Large scale importers bringing drugs in from other countries

Methodological issues regarding Media Monitoring

Analysis revealed that the number of drug-related incidents reported by the newspapers varies widely across counties. The high number of drug-related court cases in certain counties may be a reflection of a newspaper's agenda in relation to drugs; and/or could reflect the level of Garda activity on drug-related issues in the area as opposed to the actual occurrences of drug incidents.

In addition, the numbers of newspaper reports during the pilot monitoring period were relatively small at the regional level. However, the aim of this pilot study is to demonstrate the type of analysis and information these data can produce and the trends which could be identified if the monitoring were continued over time.

The monitoring period was seen to be affected by the seasonal activities of the courts with more court cases being reported by the newspapers in September and October than in other months. In contrast, reports of seizures were highest during the summer months.

The majority of the newspaper reports related to current court cases dealing with drug-related incidents which had mainly occurred during the previous years. In contrast the seizures related to current incidents. Over time, these two data sources should be examined separately. However, for the purposes of the pilot study both were examined together.

In monitoring newspaper coverage, the paper's accuracy and thoroughness in reporting the drug-related issue is relied upon. The quality and extent of reporting varied and as a result

data useful for our monitoring purpose - on the age, gender etc. of the people involved - were not always provided.

1.2.2 Establishment of a Drug Trend Monitoring Network

Work on this aspect of the model began with a literature review of the monitoring networks operating internationally including those recommended by the United Nations International Drug Control Program (2002) and the European manual on the Early Information Function for Emerging Drug Phenomena (Alvarez *et al*, 2003). A review of international systems suggests that what is required is an integrated information system in which data from different sources are collected and evaluated on an ongoing basis. A vital component of this system is the use of key informants as TMs. At first, a meeting was convened with a sample of front line workers to brainstorm how the network might operate in an Irish context. It was estimated that 150 TMs would be needed to capture trends nationally and ensure adequate representation for different drug using groups. The questionnaire would then be administered 2-3 times each year to build a database of changing drug trends.

In order to identify suitable TMs, the researchers were reliant on the help and recommendations of key stakeholders. The selection criteria chosen for persons to be eligible as TMs were that they:

- a) have direct contact with drug users (any illegal drugs) on a weekly basis
- b) interact with drug users in one of the following capacities - drug services, health, youth, community, education, or criminal justice.

Persons contacted and methods used to identify potential TMs included:

- Meeting with RDTF/LDTF co-ordinators
- Mail-out to regional RDTF members
- Mail out to Garda Síochána Drug Squad
- Mail out to Directors Regional Youth Services
- Mail out to Probation and Welfare Services
- Mail out to NACD database contacts
- Distribution of Flyer/Pamphlet at National NACD conferences.

RDTF/LDTFs Co-ordinators

The DTMS was presented to co-ordinators of both the Local Drug Task Forces (LDTFs) and the Health Board Drug Services (most of whom are also the co-ordinators of the RDTFs) to inform them of the system and ask for their co-operation in identifying key informants. Concerns were raised at both these meetings, in particular by the RDTF Co-ordinators that the DTMS would be operating outside of Drug Task Force (DTF) and Health Board structures.

Following the meeting, reminder e-mails and telephone calls were made to the co-ordinators in an effort to hasten the process of identifying potential TMs. Some co-ordinators were reluctant to pass on contact information of front-line workers as they had concerns regarding the validity of the information the TMs would provide. One suggestion was that the data be filtered through the DTFs for validation; however the NACD considered that it would be more suitable to present the collated and analysed information to the DTFs for their review and comment to feed into the final trend report.

The methods by which LDTF/RDTF disclosed contact information varied. A number provided a list of the projects they worked with; requesting the NACD to approach these projects and enlist participation. Others contacted project workers in their area and forwarded the names of those interested in participating as TMs to the NACD. In the majority of instances, both these processes took longer than anticipated and subsequently impacted the number of TMs that could be recruited for the pilot phase.

RDTF Members

There were 202 letters sent to RDTF Members. The backgrounds of these people included persons working in Health Promotion, County Council, Drug Services, Adult Education and Training, Community Projects, Youth Projects and Criminal Justice. They were informed of the background and aims of the DTMS and asked to nominate any persons in their locality who fit the selection criteria and may be interested in becoming a TM. In instances, where response rates were low, follow-up phone calls were made to enquire if the letter had been received and ability to nominate relevant persons.

The response from RDTF members was mixed – ranging from no response to the provision of a large amount of names. As with RDTF/LDTF co-ordinators some approached potential

TMs before disclosing contact information, while others offered the contact details, requesting the NACD to approach the named persons.

Probation Service

A register of National Senior Probation and Welfare Officers was obtained. After consultation with a number of Senior Probation Officers in relation to obtaining nationwide representation of the Probation Services - 16 letters outlining the DTMS were distributed. Officers were invited to nominate themselves or a colleague who met the selection criteria for TMs.

Obtaining information on relevant persons within Dublin city and county proved more difficult. Consultation with Assistant Principal Probation and Welfare Officer in Dublin was helpful in identifying a representative spread of Probation Officers from Dublin. Unfortunately due to time constraints, we were unable to secure the participation of sufficient Probation Officers within the Dublin area was not secured during the pilot phase. The Probation and Welfare Service have stated that participation will be extended should the DTMS be continued.

Youth Services

A Directory of Regional Youth Services was obtained from the National Youth Council of Ireland. A letter outlining the DTMS and inviting persons to nominate potential TMs was sent to the Directors of 20 Regional Youth Services. A number of the Youth Services were happy to enlist themselves as TMs – while other forwarded on the contact information of youth groups who had a focus on drugs.

An Garda Síochána

A meeting was convened with the Detective Superintendent of the Garda National Drug Unit. Particulars of the DTMS and the importance of Garda involvement were outlined. As a consequence of this meeting, the DC sought approval from the Garda Commissioner to enlist the participation of Divisional Officers with responsibility for drugs, and subsequently contacted these Officers explaining the background of the DTMS and the Commissioner's agreement to their participation. A total of 35 Gardaí were subsequently contacted and invited to act as TMs.

NACD Database

Existing directories of drug-related services including family support, homelessness, drug treatment services and voluntary/community services were reviewed. Agencies were contacted and names of key personnel/outreach workers were obtained. The contact information of over 300 agencies was recorded. A letter outlining the DTMS and inviting persons to nominate potential TMs was sent to organisations and persons on the database who had not already been contacted through other means.

Flyers/Pamphlet

A two-sided A5 flyer briefly describing the DTMS and inviting interested persons to contact the NACD regarding involvement was designed. These pamphlets were distributed at two NACD national conferences and included in mail-outs of NACD reports as well as circulated at a workshop of South Eastern Health Board Workers.

Contacting Potential Trend Monitors

Each potential TM received an outline of the DTMS, the selection criteria and information on who had recommended their involvement. This was followed, in the vast majority of cases, by a follow-up phone call to explain the DTMS and provide details on the questionnaire that they would be required to complete. In many instances, those contacted requested time to consult with colleagues to check whether the questionnaire would be best completed as a team or allocated to one colleague for completion.

The vast majority of people contacted were happy to act as TMs. Many welcomed the opportunity to voice their concerns about drug issues, believing that currently there was no outlet for them to do so. A small number of organisations were concerned about the implications for their service if knowledge of their clients drug use became known. Others were concerned that their involvement in the DTMS could have a stigmatising effect on the community they worked in if they disclosed information about the extent of drug use in their area. Reassurances were given to them that information relating to specific localities and organisations would not be disseminated publicly.

A selection of organisations contacted felt they did not have sufficient information to justify completing a questionnaire three times a year – but affirmed their willingness to become

involved in an 'e-mail alert' system where information regarding any new trends/drugs could be posted.

Presentations of the DTMS were also made at a South Eastern Health Board Drugs Research Workshop, and to a number of potential TMs in Dublin and the Western Health Board, who requested that the DTMS be explained to them in more detail.

A small number of TMs enquired about incentives and the type of information that would be fed back to them. For several groups who had considered setting up an evaluation/tracking system of drug issues amongst their clients, the idea of the DTMS was welcomed and seen as a way for them to evaluate their service. A few respondents, who mentioned the difficulties relating to staff numbers and funding for their organisation, hoped the questionnaire would offer them an opportunity to relay these frustrations. In both instance, it was stressed that the DTMS was a pilot project and that the NACD was not in a position to guarantee the type of feedback that could be provided until the data analysis was complete.

Some issues that arose less frequently included concern about the time constraints and the need to receive authorisation from a Manager/Supervisor before agreeing to become a TM. Those organisations that opted to complete the questionnaire as a team experienced delays in returning the questionnaire as they found it difficult to take time out of their work schedule to complete the questionnaire together.

1.2.3 Questionnaire Development

The trend questionnaire was developed following a review of the literature of other drug trend monitoring systems and a consideration of the key data that could be collected using this method. The most influential issues taken into consideration in designing the questionnaire was that it be user friendly, take approximately ten minutes to complete, and that the information requested would be based on the TMs immediate experience of drug use among those they worked with and in the geographical area where they were based.

Following the design of a draft questionnaire, approximately 50 key stakeholders were asked to pilot test the questionnaire and provide a critique of its content, these included:

- Members of the NACD Early Warning and Emerging Trends (EWET) sub-committee

- All LDTF coordinators – a number distributed the questionnaire among the projects they were involved with – subsequently feeding back any relevant comments
- The Garda Superintendent of the Garda National Drug Unit, to ascertain the relevance of the questions to Garda Drug Squad members
- A sample of ten TMs covering different sectors and regions
- Four community groups in Dublin and a group of addiction counsellors in the Western Health Board reviewed and completed the questionnaire with an NACD researcher.

Based on the pilot feedback a number of questions were modified and others were added or omitted. Noteworthy changes included amendments to the list of drugs given; the removal of questions relating to access to drug services and HIV/HCV; and whether clients were in treatment – the latter was felt to be too confusing as there were multiple understandings of the word ‘treatment’.

TMs based outside the Dublin area were particularly concerned that alcohol would not be adequately covered in the questionnaire. It was felt if alcohol was excluded – the information obtained in the questionnaire would be skewed and would not be a true representation of their client base. For this reason the questionnaire was amended to include alcohol. Once all necessary changes were made the questionnaire was published by a design company so that the format would be as user–friendly as possible.

Final TM Questionnaire

The final questionnaire had a total of 19 questions (see Appendix 1). Topics covered in the questionnaire included:

- a) availability and use of drugs (new and existing drugs)
- b) mode of administration of drug (injecting, snorting, smoking) and change in injecting practices
- c) ease of obtaining various drugs
- d) geographical location of drug distribution
- e) report of new drugs/increased availability of drugs
- f) the price and unit of drugs for sale in the area and
- g) drug-related crime

In an effort to reduce the possibility of guess-work and under/over reporting, each question had an ‘unsure/don’t know’ option. To allow people to provide additional information

relevant to their work and their area four open-ended questions were included. This permitted the TMs to make additional comments on drugs trends in their area, the increased availability and use of drugs in their area, new drugs they may have come across, and incidents of non-fatal overdoses and drug-related deaths.

Questionnaire Mail-Out and Return

A total of 210 questionnaires were sent out, together with a Freepost envelope and information pamphlet on the DTMS in mid-October. Considerable effort was made to ensure an optimum response rate. Two weeks following the mail-out of the questionnaire, all TMs received a reminder letter asking them to return the questionnaire and thank them if they had done so in advance. At this point approximately one-third of the questionnaires had been returned. Two weeks following the reminder letter, follow-up telephone calls were made to those who had not responded. In an effort to boost the response rate – a second follow up call was made to all non-respondents approximately six weeks after the initial mail-out of the questionnaire.

Contacting TMs, who in the majority of instances, worked in various locations and were not office-based, proved a time-consuming exercise. In many cases six-to-eight phone calls were made before the relevant person was contacted.

A number of TMs phoned to clarify certain questions and ensure their understanding of the questionnaire was correct. After receiving the questionnaire ten TMs felt they were not in a position to answer the questionnaire due to a lack of the necessary information.

Overall, 156 questionnaires were returned from the 213 despatched. When figures are amended for those unable to answer the questionnaire and those who collaborated with other TMs in their area, the percentage response rate was 84%, see **Table 1.2.3** .

Table 1.2.3 Breakdown of Trend Monitor Response rate.

Total number of completed Questionnaires	Total number of people unable to complete	Total Number not returned	Number of People who joined up with another Trend Monitor to complete
156	12	32	10

Evaluation of Trend Monitors Network

An evaluation of the TMs' participation in the DTMS and their view of the questionnaire was conducted after all questionnaires were returned. A short evaluation form was e-mailed to 100 TMs for whom we had a contact e-mail asking them to evaluate the format and layout of the questionnaire and their participation as a Monitor.

A total of 24 TMs returned a completed evaluation form. An analysis of these results show:

(a) Clarity of questions: Almost three-quarters of the respondents (73%, n=19) reported the questions as being 'clear', the remaining 27% reported them as being 'fairly clear'.

(b) Ease of Answering questions: Just under three-quarters of the respondents (73%, n=19) reported that they found the questions 'fairly easy' to answer, close to one-fifth of the respondents reported is as 'very easy' to answer, while two respondents reported it as being 'difficult' to answer.

(c) Relevance of Questionnaire: Over half of the respondents stated that the questions were of relevance to their line of work; 38% said that is was 'fairly relevant', while two respondents stated the questions were not of direct relevance to their work.

(d) Time taken to complete the Questionnaire: The majority of the respondents reported that the time taken to complete the survey was as expected, five respondents (19%) reported that it took them longer than expected to complete. Two of the respondents who reported that the time taken to complete the questionnaire was longer than anticipated said it was because they needed to convene a meeting with other staff members and prepare them in advance for the data collection.

(e) Usefulness of DTMS: Respondents were asked to rate the usefulness of the DTMS. Almost two-thirds (62%, n=16) reported is as being 'very useful', close to one-third believed it was 'fairly useful', while two respondents thought they were unable to comment at this point but hoped that it would be able to spot new drugs/trends. One respondent who believed it was 'very useful' stated: "I think the system is an extremely useful tool in identifying current drug use patterns so appropriate solutions can be put in place".

(f) Continue as Trend Monitor: All, but one of the respondents who completed the evaluation form stated that they would be happy to continue as TMs.

Methodological issues regarding the Trend Monitors' questionnaire

Despite best efforts to have an equal number of TMs from each service type in each RDTF area, the number of TMs and the types of service they worked in, varied by areas. Further work on addressing these inconsistencies needs to be addressed in the future development of the Trend Monitor Network.

The geographical coverage of a number of respondents did not fit neatly into a county or RDTF area, particularly in the Dublin area and also by people working in the police and probation services who work to a different territorial area than the Health Boards. In terms of analysis, this can make it difficult to identify with precision the area for which a TM is reporting. In instances, where geographical location was ambivalent, TMs were telephoned and asked to clarify the location.

1.2.4 Youth Focus Groups

In order to obtain a snapshot of the drug use patterns of young people, a number of focus groups were conducted in third-level institutions and with community youth groups around the country. As well as complementing and in some instances validating information from the DTMS questionnaire, the focus groups provided information on young people who may not be adequately represented through the DTMS survey i.e. drug users who do not utilise youth or drug treatment services or come to the attention of the criminal justice system.

Gaining access to a regional sample of young drug takers in a limited time-frame proved difficult. Officers from national and local Students' Unions were consulted to work out the best method of convening groups of third-level students knowledgeable about student drug trends. Welfare Officers at all the third level institutions were e-mailed and subsequently follow-up phone calls were made. The vast majority showed a high level of interest, but a number did raise concerns as to how they would recruit students who were active drug users. All Welfare Officers received an information sheet on the DTMS and the aims of the focus groups, which they were encouraged to distribute in an effort to obtain willing participants with varying degrees of success.

The issue of incentives was raised amongst a large number of Welfare Officers – it was their belief that if a monetary incentive were available it would be easier to recruit willing participants. For example, University College Dublin, stated that they have a policy, whereby

involvement of students in external research projects is only encouraged when incentives are offered.

In all, six focus groups were convened, four at third-level institutions in Athlone, Cork, Carlow and Galway, and with youth groups in Cork and Dublin. **Table 1.2.4** outlines the breakdown of male and females and age range of participants for each of the focus groups.

Table 1.2.4 Focus Group participants

	No. male participants	No. female participants	Total No participants	Approx. age range of participants (years)
Galway students	8	6	14	18-22
Cork students	6	0	6	18-22
Carlow students	2	3	5	18-22
Athlone students	2	2	4	18-22
Cork Youth Group	0	6	6	13-17
Dublin Youth Group	3	1	4	16-20

The focus groups took place on the university/college campus and ranged in size from 4 to 14. Prior to the focus group, the research objectives were explained and the confidentiality of the information given was assured. At the end of the session, an information pamphlet containing information on drugs and services was made available. Permission to tape the interviews was requested and given in all cases. In order to avoid breaches of confidentiality for the participants, questions on their drug use were phrased indirectly and in the third person. The focus groups were semi-structured using a topic guide to direct the flow of the discussion, these topics included;

- availability of drugs
- ease of obtaining drugs
- location of drug taking – and drug taking scene
- perception of various drugs
- cost of drugs
- new drug trends or new drugs available.

Ethical Issues

The NACDs guidelines on ethical research practice were followed. Participants in the focus groups were not asked to identify themselves and complete anonymity and confidentiality

were assured. They were reassured that the group would not be identified in any research report, unless specifically requested by that group. Participants were asked to discuss drug use in their area rather than report directly on their own drug use.

Methodological limitation of Focus Groups

Further development work on accessing information on the drug using habits of young people needs to be examined in the future development of the DTMS, for example using an electronic survey to capture information on their patterns and trends in drug use.

Section Two - National Findings from the Drug Trend Monitoring System

2.1 Reading the Data

The findings from the Pilot Study of the DTMS, which follow, are intended to highlight new and existing drug trends in the RDTF areas. While the number of media reports and questionnaires collected during the pilot monitoring period may appear relatively small at the regional level, the aim of this pilot study was to demonstrate the type of analysis and information this system can produce, and the trends which could be identified if the monitoring were continued over time.

The analysis of the DTMS focuses on highlighting issues which are potentially indicative of drug use trends in an area. For example:

- The number of drug-related court cases and seizures in an area may reflect the level of drugs activity in an area. However, it may also reflect the extent of Garda activity. As a result, where the information was available it was noted whether the arrests/seizures were the result of a planned Garda operation or part of routine activities.
- The information on the drug market levels, the types of drugs involved, the degree of overlap between markets for different drugs, the location of seizures and arrests, the method by which drugs are obtained - whether there is an active street drugs markets in an area etc. - can give a useful indication of the level of drug activity in an area.
- The mix of drugs involved in a drug-related incident may indicate the level of integration between the markets for different drugs. In an integrated drugs market, a range of drugs is available to the buyer from the same person. This type of market has the potential for increasing the access to drugs associated with higher level of risk behaviour to more recreational users. For example, cases involving quantities of heroin with cannabis may indicate an integrated market for these two drugs.
- A high proportion of young people (in the 15-24 age group) involved in drug-related incidents, may indicate that drug use is continuing to increase in the area.

- The proportion of males and females involved in drug-related incidents may indicate a normalisation of drug use in the area as more females become involved in drug-related activities.
- The proportion of people from outside the area involved in drug-related incidents may indicate that a local drugs market has not yet been established in the area.
- The price of a drug in an area can be an important unit of currency on the local informal market. For example, the price of a 'bag' of heroin may be the equivalent of the price paid for a stolen CD, or the charge made by sex workers in the area.

2.2 Media Monitoring Findings

2.2.1 Background

For the DTMS pilot study, the coverage of national, regional and local newspapers (see Methods section) was monitored for four and a half months from mid-June 2004 to the end of October 2004. In this section, an overall analysis of the newspaper coverage of drug-related court cases and seizures is presented to demonstrate the type of analysis and information these data can produce and the trends which could be identified if the monitoring were continued over time.

2.2.2 Cases

Overall, details on 462 drug-related incidents were collected during the monitoring period. The majority (76%, n=349) of the newspaper reports were of current court cases dealing mainly with incidents that had occurred during 2003 and the first six months of 2004. These court cases were described by the newspapers as relating to charges of possession (49%, n=169); the sale and supply of drugs (45%, n=158); and a small number of cases of drug driving (n=3), drug couriering (n=12), drug minding (n=5), and drug robbery (n=1). The remainder of the newspaper reports related to current drug seizures (23%, n=106), which had occurred in the area during the monitoring period, six (5%) drug-related deaths (which had mainly occurred before the monitoring period), and one drug robbery.

2.2.3 Profile of cases

The socio-demographic details of the people involved in drug-related incidents were reported intermittently. However, from the information given, the profile is predominantly male (89%, n=384) and Irish (95%). The age of those involved was given in just over half of the reports (54%, n=250), of these half were in the 15-24 age group (50%, n=126), and just under one-third in the 25-34 age group (30%, n=75). Details on the area of residence of those involved was given in 84% (n=386) of the reports, of these 83% were living in the area where the incident occurred.

Just over four-fifths of the newspaper reports (82%, n=377) gave details on the location of the drug-related arrest or seizure, of these most incidents took place in a house (36%, n=137) and over a quarter (28%, n=104) took place on the street. Where the information was given (71%, n=329) the reason for the arrest or seizure was noted, the majority of these had resulted from planned Garda operations (65%, n=215), and one-third (33%, n=108) resulted from routine work by the Gardaí.

2.2.4 Drugs and Market Level

Almost all of the newspaper reports (94%, n=434) identified the drug(s) involved in the seizures and court cases, these were then categorised into the main drug groups. The majority of the reports were cannabis related (53%, n=228) – 177 cases of cannabis on its own and 51 of cannabis with stimulants. Reports of other drugs were fewer – mainly ecstasy (16%, n=70); cocaine (13%, n=55) – 45 cases of the drug on its own, and ten cases of the drug with other stimulants; heroin (12%, n=54) – most of which were of heroin/methadone (n=44); and amphetamines (5%, n=21).

Where information on the amount of drug involved in the seizures and court cases was reported (86%, n=399), these were categorised into different levels of the drug market (see methods section). Of these known cases, the majority (41%, n=162) concerned amounts for personal/friends use; and over one-quarter (27%, n=109) were at the retail (user-dealer) end of the market. Almost one-third (32%, n=128) of the cases were for amounts at the upper market level – these were mainly at the middle market level (21%, n=82) with a

smaller number at the wholesale distribution level (6%, n=24) and at the importation level (5%, n=21).

Where information on both drug type and market levels was given in the newspaper reports (85%, n=391), these data were cross-tabulated to provide a deeper understanding of the type of drug markets in operation. From this data, the main drug involved at the personal/friends level of the market (n=154) was cannabis which accounted for two-thirds of the cases (66%, n=102); ecstasy (13%, n=20); heroin (8%, n=12); cocaine (6%, n=10); and amphetamines (6%, n=9). At the retail level of the market (n=109), cannabis was also the main drug accounting for over half of the cases (53%, n=58); ecstasy accounted for one-quarter of the cases (25%, n=27); and heroin over one-tenth of cases (13%, n=14). At the upper market level (n=128), cannabis was again the main drug representing over two-thirds of the cases (39%, n=50); over one-quarter of the cases were cocaine related (29%, n=37); followed by ecstasy (15%, n=19) and heroin (14%, n=18).

On examining the geographical data where the type of drug is known (94%, n=434), the newspaper reports of drug-related court cases and seizures indicate a clustering of cases in the urban centres of Dublin (20%, n=85); Waterford (14%, n=59) and Cork (11%, n=48); and to a lesser extent in Tipperary (7%, n=28); Carlow and Westmeath (each 4%; n=19); Galway (4%, n=18); Donegal (4%, n=17); Limerick (4%, n=16); and Kilkenny (4%, n=15).

The main areas where amounts at the upper-level drugs market were reported were Dublin (38%, n=49) – mainly cannabis (n=19), cocaine (n=14), and heroin (n=11); and Cork (16%, n=20) – mainly cannabis (n=9, cocaine (n=7) and ecstasy (n=4); and to a lesser extent Limerick and Waterford (each 5%, n=6).

2.3 Trend Monitors Survey Findings

In October 2004, 210 questionnaires were despatched to the network of TMs that had been established for the DTMS. The TMs were asked to report on the drug using behaviours of those they were in contact with and the drug situation in the geographic area where they worked.

2.3.1 Profile of the Trend Monitors and their contacts

One hundred and fifty-six TMs reported on drug use trends. Almost half of the TMs (49%)² filled out the questionnaire in conjunction with colleagues, with an average of 2.9 people completing each questionnaire. Overall, the result of the TM survey reflects the views of a minimum of 416 people working or in contact with drug users.

The services in which the TMs worked were: community drug projects (24%, n=37); police and customs (19%, n=30); youth (19%, n=29); addiction counselling/health (17%, n=26); and vulnerable groups (10%, n=16). The main target group of these services were drug users (36%, n=56); offenders (29%, n=45); young people (14%, n=22); the community (6%, n=10); the homeless, and disadvantaged youth (each 5%, n=8); Travellers, and early school leavers (each 2%, n=3); and sex workers (1%, n=1).

The TMs had contact with a wide range of age groups; almost two-thirds (64%, n=100) worked with young people including those who were under 18 years-of-age. The majority (94%, n=147) of the TMs had contact with both males and females; five had contact with males only, while four had contact with females only. Eighteen TMs (12%) reported that they worked with minority ethnic groups - 18 (12%) reported working with all minority ethnic groups, eleven (7%) reported working with Travellers, while one TM reported that they worked with the Asian community.

Of the TMs, 117 reported having weekly contact with drug users and 25 TMs reported they had monthly contact with drug users. The number of drug users they were in contact with varied. Overall, the TMs had weekly contact with a minimum of 2,859 drug users.

2.3.2 Drug used by Trend Monitors' contacts

TMs were asked to assess which drugs, from a given list, were currently used by those they had direct contact with through their work (**Figure 2.2.1**). Almost all the TMs reported the use of cannabis (99%, n=154) and alcohol (96%, n=149) among their contacts. Ecstasy use among the TMs contacts was reported by 85% of the TMs (n=133), while cocaine use was reported by 81% (n=127). More than two-thirds (72%, n=112) of the TMs reported the

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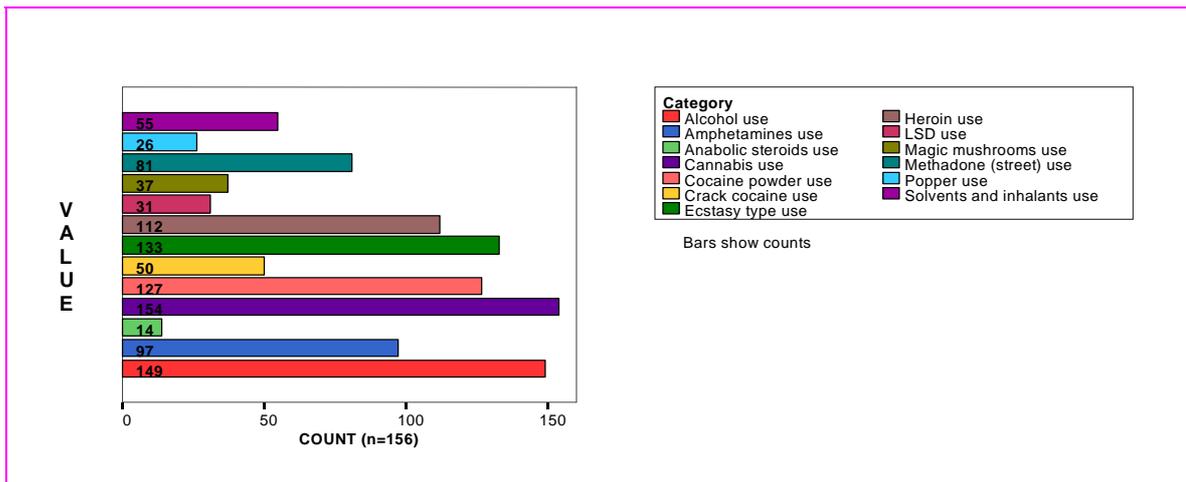
² Sixteen TMs did not specify whether they had completed the questionnaire alone or with the help of a colleague.

usage of heroin among their contacts, while less than two-thirds (62%, n=96) reported amphetamine use. Over half (52%, n=81) of the TMs reported the use of methadone. Use of solvents and inhalants among the TMs contacts was reported by over one-third (35%, n=55), while under one-third (32%, n=50) of the TMs reported the use of crack cocaine.

Drugs used to a lesser extent among the TMs contacts were magic mushrooms (24%, n=37), LSD (20%, n=31), poppers (17%, n=26) and anabolic steroids (9%, n=14).

TMs were given the opportunity to add to the given drugs list any additional drug use (both illegal and legal drugs which were misused) by their contacts. More than one third (n=55) of the TMs reported the use of ST/ADs. Eighteen (12%) of the TMs noted the use of unspecified prescription drugs, prescription drugs identified among their contacts were Viagra[®] (n=3) and Cialis[®] and Tadalafil (n=1). Other opiate use was reported by eleven (7%) of the TMs. Opiates identified included DF-118[®] (n=3), Distalgesic[®] (n=3), codeine (n=2), and DHC Continus[®] (Napp), morphine sulphate tablets and Zydol SR[®] (each, n=1). Seven TMs reported the use of over-the-counter medication among their contacts; drugs identified included cough bottles (n=3), Solpadine[®] (n=2), and Creatinine (n=1). New synthetic drugs reported to be used by the TMs contacts included Ketamine, specified by two TMs, and MDMA powder reported by one TM, additional drug listed as being used were Nortem, Largactil[®] (by two TMs), Barbiturates and DOB (snowballs).

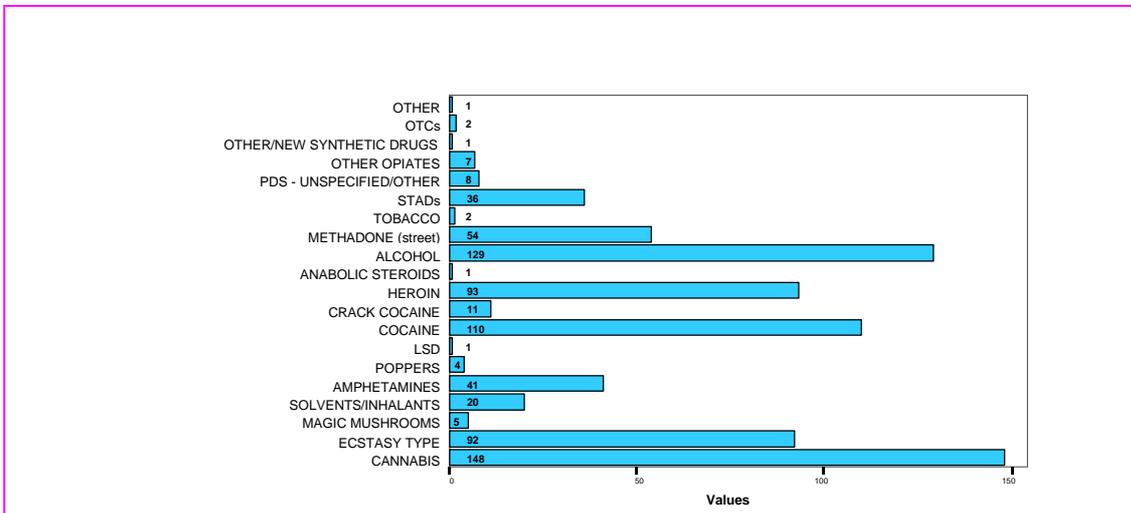
Figure 2.2.1 Drug used by Trend Monitors contacts



2.3.3 Drugs most frequently used by Trend Monitors' contacts

In order to get a sense of the extent to which the drugs identified were being used, TMs were asked to identify which of the drugs were the most frequently used by their contacts (Figure 2.2.2). The main drugs reported were cannabis (95%, n=148), alcohol (83%, n=129), cocaine (71%, n=110) heroin (60%, n=93) and ecstasy (58%, n=92). Additional drugs reported by a smaller number of the TMs were methadone (35%, n=54), amphetamines (26%, n=41) ST/ADs (23%, n=36) and solvents and inhalants (13%, n=20).

Figure 2.2.2 Drugs most frequently used by Trend Monitors' contacts



2.3.4 Reported changes in the use of drugs by Trend Monitors' contacts

TMs were asked to note if there had been any changes (increase, decrease, or no change noted) in the use of the drugs taken by their contacts³ (Figure 2.2.3). The highest increases noted were in relation to the use of cocaine with 80% (n=64) of the TMs reporting its increase. Just over half (51%, n=25) of the respective TMs who reported the usage of crack cocaine (51%, n=25) and alcohol (51%, n=76) reported an increase in its usage among their contacts. More than one-third (39%, n=44) of the TMs whose contacts reported

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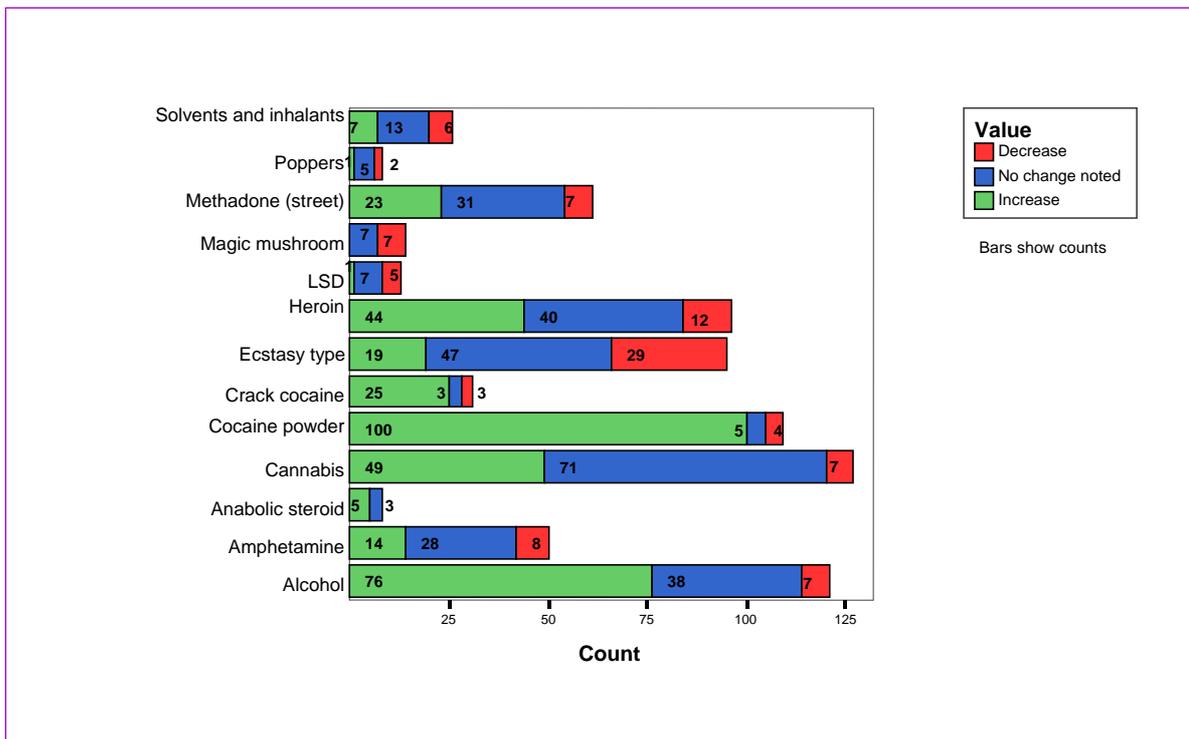
³ In this section the valid percent is given based on the number of TMs who identified the drug as being used by those they are in contact with, not the total number of TMs.

an increase in heroin, while under one-third (31%, n=5), of the TMs who identified anabolic steroids reported its increase.

Of the 55 TMs who reported ST/AD, more than half (56%, n=31) reported an increase in their usage. Similarly, an increase in un/specified prescription medication and other opiates was reported by the TMs (50%, n=8, 50%, n=5 respectively). Of the four TMs who reported the usage of over-the-counter medication, three noted their increase. The TM who reported the usage of MDMA powder also reported its increase.

Drugs that in the main were reported as showing ‘no change’ in use, were cannabis (46%, n=71), ecstasy (36%, n=47), solvents and inhalants (23%, n=13) amphetamines (29%, n=28) and methadone (39%, n=31).

Figure 2.2.3 Change in use of drugs by Trend Monitors’ contacts



2.3.5 Main method of taking drugs by Trend Monitors' contacts

TMs were asked to note, from a list of six drugs, the main method their contacts used to take the drug (Figure 2.2.4). This question was asked to highlight injecting risk behaviour and to set a benchmark by which future changes could be identified.⁴

Exactly 90% (n=125) of the TMs who reported ecstasy use identified ingestion as the main method of taking the drug, while one TM reported injecting. Amphetamines in the main were seen as being ingested (43%, n=44) or sniffed (40%, n=41), a smaller number reported them as being injected (3%, n=3) or ingested and injected (2%, n=2), one TM reported the main method as smoking. Half of the TMs (50%, n=58) identified injecting as the main mode of administration of heroin, 17% (n=19) stated smoking and injecting; close to one-third (30%, n=33) reported the main method as smoking alone, one TM reported it as ingestion.

Sniffing of cocaine was reported by three-quarters (75%, n=95) of the TMs as being the main method of taking the drug. Just over one-tenth (11%, n=14) reported injecting of cocaine as the main method of administration, 8%(n=10) reported it as sniffing and injecting, while 2%(n=2) reported it as smoking and injecting. Crack cocaine was in the main (69%, n=36) reported to be smoked by the TMs contacts, just over one-tenth (12%, n=6) reported the main method of administration as injecting, while three TMs (6%) reported it as smoking and injecting.

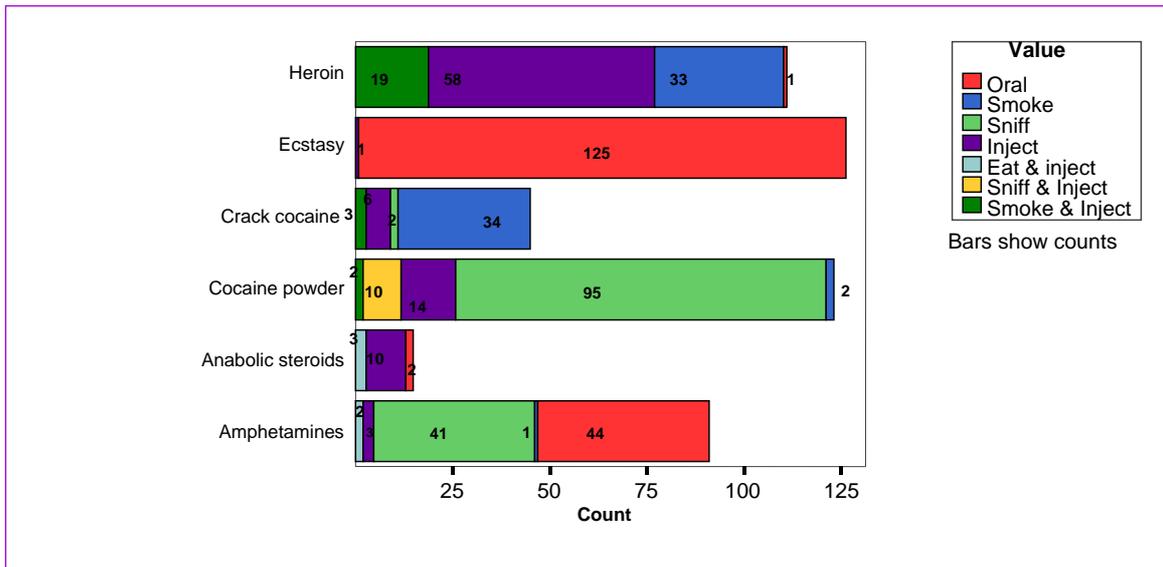
A large number (32%, n=7) of the TMs reported that they were unsure of the main method of taking anabolic steroids among their contacts. Just under half reported injecting as the main mode of administration, while 14% (n=3) reported it as ingestion and injecting. Two TMs reported the main method as ingestion.

Other drugs reported to be injected by the TMs contacts were Zimovane[®], unspecified prescription tablets, Dalmane[®], Ritalin[®] and DHC Continus[®] (Napps), two TMs reported the injecting of unspecified benzodiazepines. One TM reported an increase in speedball injecting. Increases in injecting were also noted in respect of Zimovane[®], MDMA powder, Dalmane[®] and DHC Continus[®] (Napps).

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⁴ In this section the valid percent is given based on the number of TMs who identified the drug as being used by those they are in contact with, not the total number of TMs.

Figure 2.2.4 Main method of taking drugs by Trend Monitors' contacts

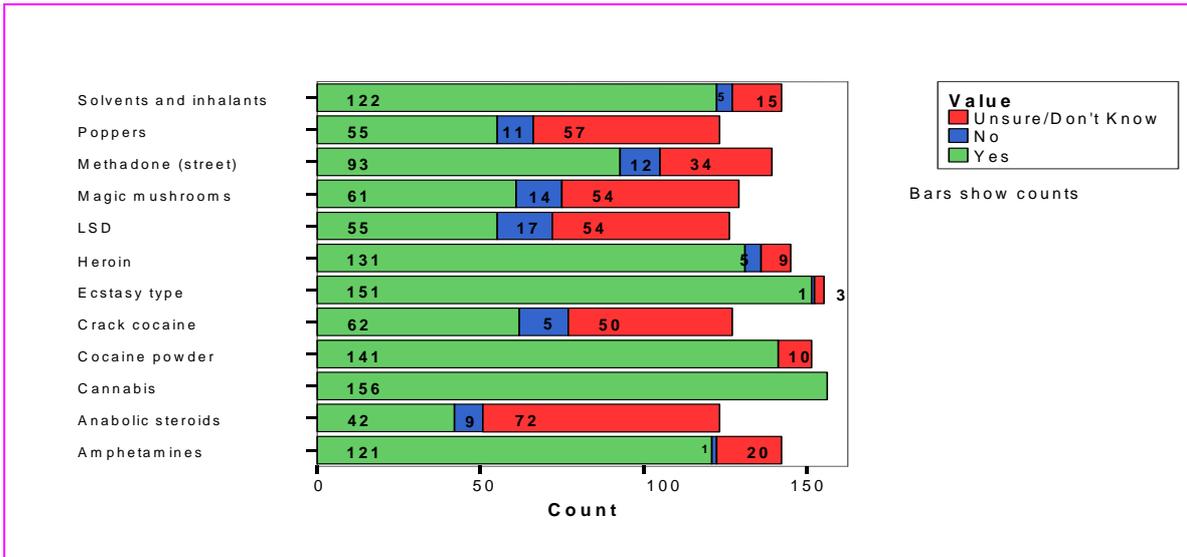


2.3.6 Availability of drugs

TMs were asked to identify, from a given list, the drugs currently available in their area. The main drugs reported as being available were cannabis (100%, n=156), ecstasy (97%, n=151), cocaine (90%, n=141), heroin (84%, n=131), solvents and inhalants (78%, n=122) amphetamines (78%, n=121) and methadone (60%, n=93) (Figure 2.2.5). A lesser proportion of TMs reported the availability of crack cocaine (40%, n=62), magic mushrooms (39%, n=61), poppers (35%, n=55), LSD (35%, N=55) and anabolic steroids (27%, n=42).

TMs were also given the opportunity to add to the given list any additional drugs available in their locality. Over one-quarter (26%, n=41) of the TMs noted the availability of ST/ADs. One-tenth (10%, n=16) of the TMs noted the availability of other/unspecified prescription drugs, with three TMs reporting Viagra® availability and one noting the availability of Cialis®. Two TMs (6%, n=9) reported the availability of DF-118®, Distalgesic®, DHC Continus® (Napps) and Codeine. One TM reported Oxycodone availability. New synthetic drugs noted as being available were MDMA powder, liquid ecstasy and Ketamine. The availability of over-the-counter medication namely Solpadine®, cough bottles, Panadol® and Aspirin was noted by three TMs. Alcohol availability in respect of under-18s was noted by 13 TM (8%), while tobacco availability was noted by three TMs. One respective TM noted the availability of Largactil® and Barbiturates.

Figure 2.2.5 Availability of drugs in Trend Monitors' locality



2.3.7 Ease of obtaining drugs in area

To gauge the level of availability of these drugs TMs were asked to rate how easy it was (very easy, fairly easy or difficult) to obtain the drugs they reported as available in their area⁵ (Figure 2.2.6). The largest number of reports of 'very easy' to obtain related to cannabis (88%, n=136), solvents and inhalants (78%, n=96) and ecstasy (67%, n=100). More than half of the TMs reported cocaine (55%, n=77) and heroin (54%, n=71) as being 'very easy' to obtain.

A more mixed picture emerged in relation to the ease of obtaining other drugs. Methadone and amphetamines were seen as 'very easy' to obtain by 44%(n=42) and 42% (n=51) of the TMs. Just over one-third (34%, n=22) of the TMs identified magic mushrooms as 'very easy' to obtain, while crack cocaine was seen as being 'very easy' to obtain by 29 (n=18) of the TMs. Drugs which in the main were seen by the TMs as 'fairly easy' to obtain were LSD (48%, n=27), anabolic steroids (39%, n=17) and poppers (38%, n=21).

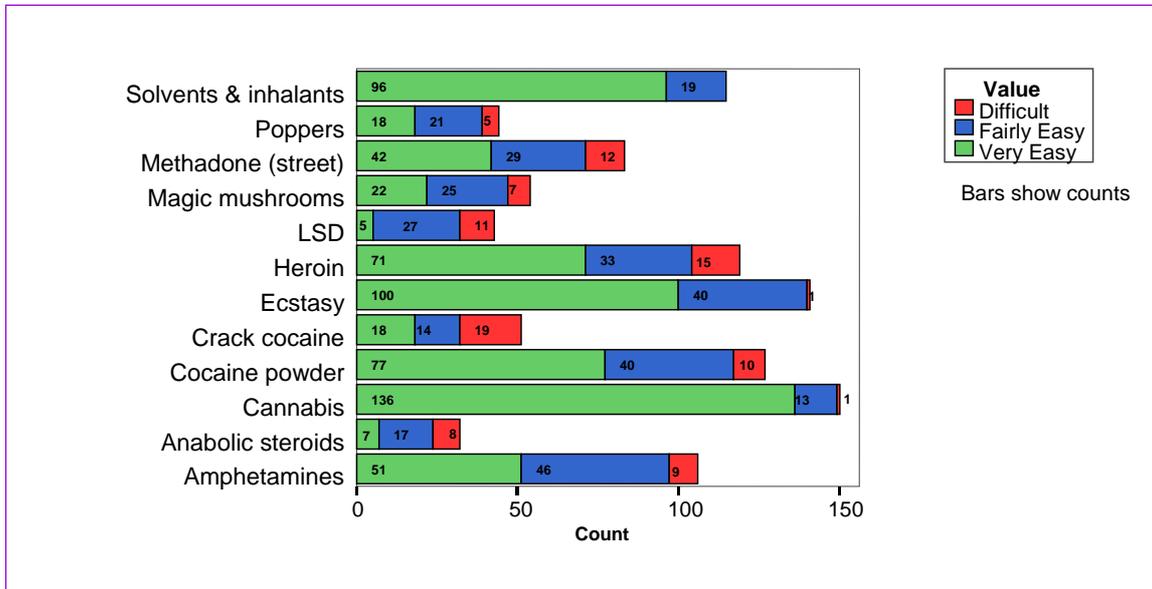
Finally, ST/ADs (54%, n=19), other/unspecified prescription drugs (60%, n=9) and other opiates (57%, n=4) were seen by the majority of TMs who noted their availability as being 'very easy' to obtain. All the TMs who noted the availability of over-the-counter medication, alcohol, and tobacco rated them as 'very easy' to obtain. MDMA Powder was viewed as 'very

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⁵ In this section the valid percent is given based on the number of TMs who identified this drug as being available in their area.

easy' to obtain by the one TM who noted its availability. Ketamine was seen as 'difficult' (n=1) to obtain, while the TMs who noted Liquid Ecstasy availability was unable to qualify the ease of obtaining the drug.

Figure 2.2.6 Ease of obtaining drugs in Trend Monitors' locality



2.3.8 Main method of obtaining drug

TMs who had reported that a drug was available in their area were asked to identify the main method (from a given list) that people used to obtain these drugs in their area (Figure 2.2.7). A number of TMs ticked more than one source for each drug; this was then coded as 'multisource'. 'Unsure/don't know' responses were included in the relevant valid percentage.⁶

Sources varied for different drugs. 'Through a friend or personal contact' was mentioned as the main source, by the majority, in respect of cannabis (21%, n=33), poppers(18%, n=10), LSD (27%, n=15), anabolic steroids(32%, n=14), methadone (21%, n=20) and ST/ADs (22%, n=8). Obtaining drugs 'from a dealer in the pub/club' was seen as the main source of ecstasy (29%, n=44) and cocaine (15%, n=21). While, 'ordering by phone from a dealer' was reported as the main method of obtaining amphetamines (22%, n=27), cocaine (31%, n=43), crack cocaine (37%, n=23), heroin (25%, n=33) and anabolic steroids (18%, n=8).

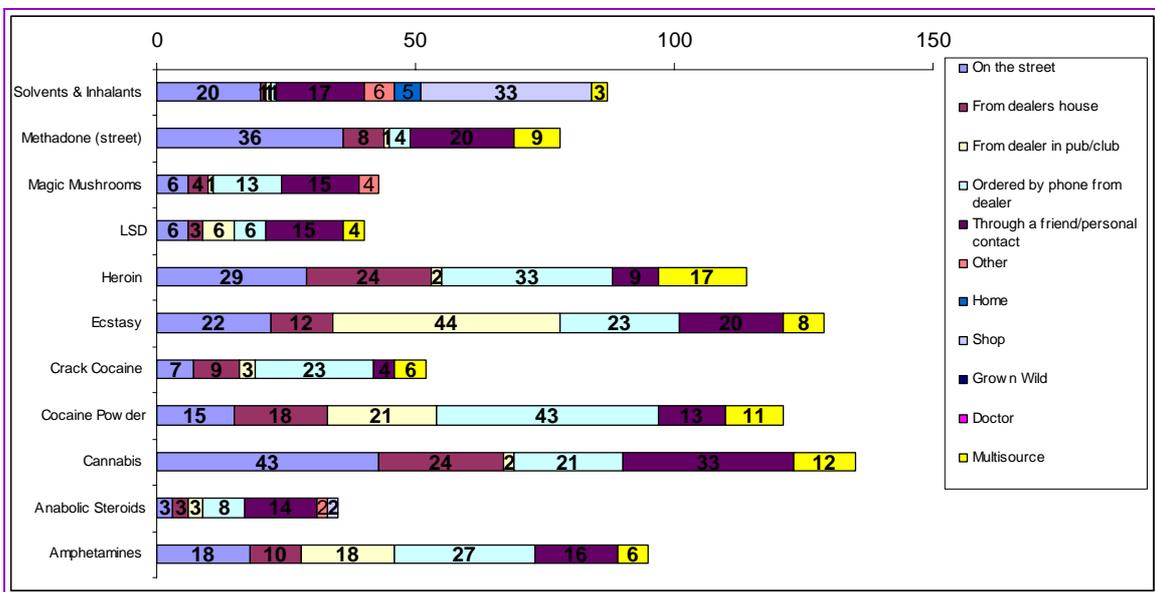
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⁶ In this section the valid percent is given based on the number of TMs who identified this drug as being available in their area, not the total number of TMs in the area.

The 'dealers house' as a main source of drugs was reported by a considerable number in relation to heroin (18%, n=24) and crack cocaine (14%, n=9).

There were 238 reports of drugs being available 'on the street'. These mainly related to, STAD (44%, n=16), methadone (40%, n=36), cannabis (28%, n=43), heroin (22%, n=29) solvents and inhalants (16% n=20) and amphetamines (15%, n=18). Drugs reported as being available to a lesser extent on the streets were cocaine (11%, n=15), crack cocaine (11%, n=7), LSD (11%, n=6), poppers (11%, n=6), anabolic steroids (7% n=3) and other unspecified prescription drugs (n=4) and other opiates (n=2).

Figure 2.2.7 Main method of obtaining drugs



2.3.9 New drugs in area

New drugs identified by TMs as being available in their area in the past 12 months were, crack cocaine (n=10), cocaine (n=6), heroin (n=3), anabolic steroids (n=4), MDMA Powder (n=2), DOB (n=2) OxyContin® (n=1), Viagra® (n=1), Zispin® and Ritalin® (n=1), Somantil (n=1), LSD (n=1), speed (n=1), Rohypnol® and GBH (n=1), Ketamine (n=1), herbal cannabis (grass) (n=1) and 'D10s' (n=1).

2.3.10 Drug-related overdoses or deaths

Of the TMs, 38% (n=59) reported that non-fatal overdoses had occurred in their area in the last year. Just under one-third (29%, n=17) of the TMs quantified the number of non-fatal

overdoses as being between one and three overdoses, 14% (n=8) of the TMs reported the occurrence of between four to six non-fatal overdoses, two TMs (3%) reported seven to nine overdoses, while 10% (n=6) reported that 10 or more non-fatal overdoses had occurred in their area in the past twelve months. Less than half (44%, n=26) of the TMs were unable to specify the exact number of non-fatal overdoses that had occurred in their area.

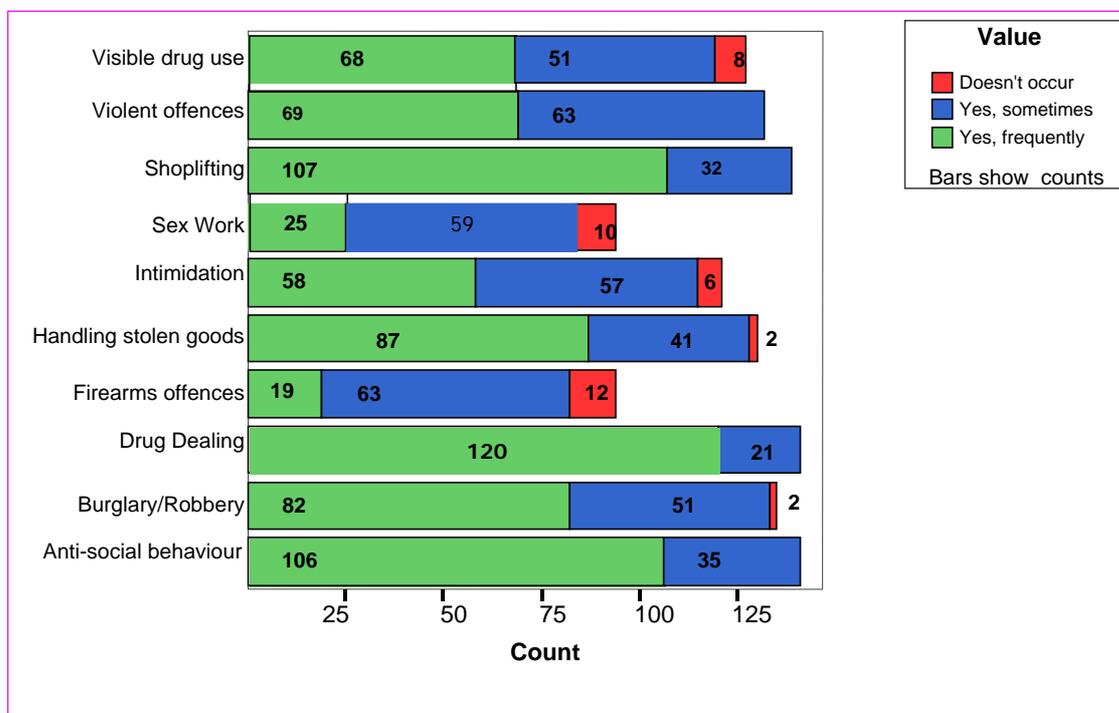
Almost half (47%, n=73) of the TMs reported the occurrence of a drug-related death in their area in the past year. Just under half (49%, n=34) of the TMs quantified the number of drug-related deaths in their area as being between one and three persons, 16% (n=11) reported four to six deaths in their area, while two TM reported between seven to nine deaths. One-third (33%, n=23) of the TMs were unable to specify the exact number of people who had died from a drug-related death in their area over the past twelve months.

2.3.11 Drug-related behaviour

Almost all, 96% (n=149) of the TMs reported on the existence of drug-related crime in their area (**Figure 2.2.8**). The main offences reported (from a given list) as 'frequently occurring' were drug dealing (77%, n=120), shoplifting (69%, n=107), anti-social behaviour (68%, n=106), burglary (53%, n=82) and the handling of stolen goods (56%, n=87). Crimes, which were reported as 'frequently occurring' by a smaller number of the TMs, included violent offences (44%, n=69), visible drug use (44%, n=68) and intimidation (37%, n=58). Sex work and firearms offences were reported to occur 'sometimes' by 38% (n=59) and 40% (n=63) of the TMs.

Other offences added to the given list by TMs included joy riding (n=8), domestic violence (n=5), public order offences (n=4) and drug driving (n=2).

Figure 2.2.8 Drug-related crime in Trend Monitors' locality



2.4 Focus Group Interviews

Six focus group interviews were held with young people across the country to establish the role and meaning of drug use in their lives. The issues explored in these groups included the types of drugs available and used by their peers, and in their area; how these drugs and their users were perceived; and the drug-taking settings and behaviour associated with different drugs. In total, 37 young people took part in the focus group interviews with participants ranging in age from 13 to 22 years. Four of the focus groups were held with third-level students from Athlone, Carlow, Cork and Galway, and a further two with youth groups in Dublin and Cork (see Methodology section for further details).

2.4.1 Drug availability

Participants were asked to identify the types of drugs that were generally available – the drugs most commonly talked about by the participants, and the drugs participants were most knowledgeable about, were cannabis, ecstasy and cocaine.

Cannabis

The consensus across the focus groups was that the use of cannabis was widespread among young people and tried, at least once, by the vast majority.

'Hash that's accepted, you have hash everywhere'

'The culture among the students out of all the drugs would be hash'

'There's not a house in the college were hash isn't smoked'

Described by the young people as a 'hippy drug' and a drug that gives you a 'giddy bang', cannabis was seen as a drug associated with little to no risk. This low level of risk was seen to be related to the view that cannabis was a more natural substance:

'you feel safer with marijuana than ecstasy, cos ecstasy is chemically based and marijuana is more natural, seems a safer drug.'

In addition, few ill-effects were seen to be connected to cannabis use:

'nothing bad happens to you [taking cannabis] you just get a laugh'

Many respondents spoke of smoking cannabis as something you would do at home, while watching DVDs' or 'chilling out', and as a substance that provided a cheaper alternative to drink:

'couple of my mates say they smoke hash to save money cos its cheaper, they just sit in the house and get stoned.'

Indeed the normalisation of cannabis use among the young people was such that it was hardly considered a drug:

'that's not like a drug ... its just there, no one gets stoned on hash around here they're just immune to it they are ... because its so available, people have just used for so long.. Its like a smoke'

Ironically, many of the participants regarded smoking cannabis as less damaging and more socially acceptable than tobacco smoking;

'hash wouldn't come in as a drug, I know people who occasionally smoke hash and they would get less hassle than my friends who are full-time smokers'

However, some risks were recognised in relation to cannabis, namely the illegality of the drug and the potential consequences of being caught:

'Once I'm careful I can smoke a joint on the streets but if that day comes that a policeman stops me and searches me and I get a criminal conviction and I can't work - that's absolutely ridiculous. I smoke cannabis regularly and I don't see myself as a criminal.'

'the only thing socially unacceptable about hash is getting caught.'

However, the uncontrolled use of cannabis was largely frowned upon particularly for its potential impact on students' college careers – the third-level students cited evidence of students who had dropped out of college or failed exams as a result of constant cannabis smoking. In this sense the acceptability of cannabis was seen to be based on the individual's ability to control their use, as with alcohol consumption, as long as a person was not over-using the drug its use was socially acceptable:

'same as someone who's drunk [someone smoking cannabis] they're only acceptable if they're funny and they're adding to the party, but if they're being a manky drunk, no one wants them'.

Ecstasy and other synthetic drugs

The use of ecstasy was also common among young people, albeit its use was considered not to be as widespread as cannabis and the drug was viewed with more caution than cannabis. Despite suggestions that ecstasy use is waning among young people, in contrast it would appear from the focus group discussions that ecstasy use had become normalised, with young people first experimenting with the drug at an earlier age – one youth group estimated that of the 26 people in their peer group all except 3 would use ecstasy.

'with people I know, who are a bit younger, ecstasy had become normalised with them, there's no big deal with it.'

For the older students, ecstasy use was viewed as an integral part of the club/party scene, to be taken either shortly before going out, or in the nightclub itself. Typically a person would take more than one ecstasy tablet in a night:

*'might see how the night is going and see if you need that extra
boast'*

At approximately €5 a tablet, ecstasy, similar to cannabis, was viewed by a number of the young people as a cost effective replacement to drink:

*'its cheap and its easy, one or two cans and then off to the
nightclub'*

*'I'd rather do E every week, its a better buzz like, its cheaper as well
...you're jumping around the place having a great laugh'*

*'a lot of my friends say that that about ecstasy that they're rather
take ecstasy than spend the money on drink cause they couldn't
afford to do it and the effects of ecstasy is better than going out
drinking seven vodkas and four shots'.*

Students also suggested that ecstasy had become bigger in the entertainment scene since the smoking ban as it was easier to take pills unnoticed than smoke a joint in a public place

The main reasons that ecstasy was perceived as having a higher risk profile than cannabis were the synthetic nature of the drug, its changing quality, and the consequent unpredictable side effects. Despite the fact that up to ten different ecstasy tablets may be in circulation at any one point in time, users reported that they had little choice in the type of tablet they are given:

*'you could take it once and be fine and take it another time and not,
because you don't know what its mixed with'*

*'every week there's something different, snowballs, stardust,
Tasmanian Devils ... some of them the come down off them are
horrible, other ones you just come down off them like that ... you
just have to take what's offered'*

*'you wouldn't have a choice in what type of pills you get, its all what
people supply you're not going to question it – if you want
something unusual you have to actually go looking for it you've to
wait for it – most times you'd find it in the city but you'd have some
lads that would go out of their way to get it'*

However, despite some negative experiences of the drug, few reported that these incidents would deter their use of the drug, and many were sceptical of the urban myths circulating around ecstasy use. For example, two groups spoke of taking DOB in the mistaken belief

that it was ecstasy and despite the negative effects of the drug, they continued to use ecstasy subsequently:

'there a lot of horror stories but I haven't heard any in a long time – apart from snowballs haven't heard any bad experiences'

'everyone thought they [DOB] were Es, people were going around selling them as Es for weeks and people taking them - everyone off their head and up the walls ... you'd think people would be afraid to do it, but it kind of set a trend then'

Knowledge of harm reduction in relation to ecstasy use was almost non-existent, the focus group participants spoke of taking three-to-four ecstasy tablets in a night, and of going through binge phases where the drug was taken a few nights a week, although subsequently consumption decreased to once every few months:

'a few years ago my friends were taking them every week or something now it would be the odd time – maybe every second or third month or something – everyone I knew just went through a binge phase when they first discovered them they thought they were the best thing ever'

Discussions in the group indicated a high level of confusion on the hydration issue and how much water should be drunk to avoid dehydration when using ecstasy:

'People would be taking 4 or 5 pills in a night, people don't think about drinking water and stuff '

'I have no idea what it does ..., there's people who feel they're dehydrated and actually aren't and over-drink water and die, and, or else, they don't drink and 'cause they are dehydrated they die 'cause of that ... so honestly I don't know what's going on, that's bad, because one of the biggest drugs out there is ecstasy and there are a lot of people taking it.'

In addition, there was little concern or awareness of the risk of combining ecstasy and alcohol:

'You end up taking them the odd day when you're locked and slow, full of vodka or something and just taking them, you wouldn't take them sober or anything, if you're on a bender you'd take them'

And there were some bizarre perceptions and high-risk behaviour among the younger people focus group participants as to how you should use ecstasy:

'Do you know what you do? Take a yoke [ecstasy pill] and come up on it first by drinking water and get warm then drink sugar and wear a good few jackets and then you'd be out of your head'

However, the main harm reduction technique to buy the drug from a reliable source so as to minimise the risk involved with the dubious quality of the drug, as one participant who distributed drug information leaflets at a rave reported:

'I was amazed by the number on ecstasy, taking 3-4 ecstasy, maybe more ecstasy tablet at once – no issue with it and they were saying they got it from the same person, who got it from the same person, they bought it from and once you stick to someone you know who is reliable, you don't worry about it, they said they'd go without, rather than buy off some else, that's their safety approach'

Cocaine

The increased availability and use of cocaine was a much discussed topic in the groups, however, while the drug was regarded as being fashionable among a broad cross section of society the drug had not yet become a common part of the youth or students' scene; its use appears to be seem largely confined to older and more affluent 'yuppy' adults, particularly young women:

'The type of people who are taking cocaine now are socially quite different to the type of person who would have taken ecstasy, a lot of the people who take cocaine are more yuppie types'

'Cocaine is seen as posh, the cool thing, a lot of girls do it 'cause of the label that goes with it – I've got my _____ skirt and bla, bla top, I take cocaine, I'm great.'

'ecstasy and hash I've seen more guys taking it, with cocaine its girls, girls wouldn't take the same amount but there would always be the same numbers.'

Participants from other provincial towns commented that while cocaine use was unusual among the student population many of their former classmates working in their home town, and hence with a higher disposable income, were frequent users of cocaine,

'I don't know any student who takes cocaine, but know in my home town, people who work in factories or whatever, so they have a bit of money, cocaine is huge there, absolutely massive.'

The drug was largely associated with the pub and club scene. However, unlike ecstasy, which seemed to be easy to purchase in a club, the routine for cocaine users was to use the drug before going out and bring their own supplies with them to the club:

'a lot of people take that [cocaine] at home before they go out, just put it on the coffee table in the middle of the room, whoever wants to take it does and they head out straight away'

'you'd have cocaine before you go out and when you're out, you wouldn't get a lot of people now in a club with bags of coke in their pocket that would sell it, it's not like kinda of sold like an E in club'

Unlike the taking of ecstasy which seemed to be a more impromptu act, interviewees spoke of cocaine use as something done in a more planned manner and on a systematic basis:

'One of the circle I've seen, I've been surprised, cause they use it as almost the equivalent of a joint, well you know, obviously not in the same situation, but it would be something you would do fairly regularly, as in once every two weeks, on a night out with your friends in a very posh pub'

The overall view of cocaine was that it was a low risk, 'clean', drug and there was little awareness of any negative effects that may occur:

'cocaine is the cleanest of all drugs'

'Lots of people would say you can go out take a load of cocaine and get up the next morning without too much of a bother'

In particular, the use of cocaine to prolong or enhance the effects of alcohol was perceived as a major attraction:

'I've heard people take it to prolong the sense of drunkenness, when they're really lingers and they want to prolong it for the rest of the night - prolong a good night that's why they take it'

'Cocaine – you hear of a lot more people using it – using it every weekend or second weekend cocaine complements drinking you can drink a lot more after drinking it – if you're going for a long piss-up, it complements it more.'

Rather than identifying any negative health risks resulting from cocaine use, the issue of cost seemed to be the main deterrent to taking the drug:

'if the price of coke came down they would be serious problems in every college in the county – cost is the only thing that puts people off.'

'I don't really do coke that much 'cos its too dear, can't afford it, if it was offered to me like I'd do it, but I wouldn't pay for it'

However, those most familiar with cocaine using groups expressed concerns about the increase and frequent use of the drug and its impact on the social scene:

'Lot of people would stay up all night ... If going from Friday to Sunday without sleeping, would go through an eight each in a night. If you only had an eight between 4 or 5 it would be gone.'

'You don't really get anything out of coke like all you get is just the wanting for more – they can get a high and they're just trying to keep up with that high and they're just fucked, it's like you have to come down off it and then you're back down there and you're trying to get back up there to just get normal, they're just doing it to be normal'

'Next day a lot of people would be very depressed for a few days, they feel very low and would just want to stay in for a few days'

Cocaine was seen to have impacted on the social scene to the extent that users had become so transfixed on the drug while socialising that their only interest was in the drug itself:

'They use [cocaine] before they go out, that's all they think about, in the pub its all about whose going to the toilet next, there's not a group sitting together for longer than 10 minutes. Now they don't even go into the toilet they just do it, take it with a coin or a key, on the edge of a coin ... you can see the difference in some people from cocaine, some people that would have been loud and up for a laugh like they're sitting in the corner thinking about cocaine.'

'There's a lot more people not going out anymore to pubs 'cos of their coke habit, they're all bleedin' gaff monkeys sitting in gaffs all the time 'cos they're doing coke and they find it easier to sit there with the coke rather than be in the pub'

Amphetamines

There was little evidence of amphetamine use by the young people and the drug had an overwhelmingly poor reputation among the focus group participants, with its use associated with unsophisticated drug users in rural towns:

'that's out the window 'cos its shit, like speed is a real cheap drug like if you were sitting in a pub these days and you said, like I've got a quarter of speed like, they'd be laughing at you'

'I've only heard of one person using [speed], it's kind of among people who would just take anything, there's not really a speed culture'

Magic mushrooms

Magic mushrooms were regarded as a strange drug and rarely appeared on the drug scenes known to the focus group participants even though every year there would be a lot of discussion about magic mushrooms, few would actually take them:

'every September everyone talks about mushrooms and you'll find one person who's done it and everyone goes I'll do it next year but that never happens.'

their use was more associated with:

'arty students ... who would make a big thing of the season and going picking, that would be their thing ...and they'd be into taking other things, they'd be making hash pizza and all that kind of thing'

'would be extreme type of person that would want to go looking for [magic mushrooms], wouldn't be just someone looking to try something - they'd be really, really into other stuff before they go onto that, that's lunatic stuff.'

'mushies are dangerous big time you'd end killing someone or being killed'

Heroin

Heroin use was regarded as a high-risk activity by all of the focus group participants from the third-level students to the young people living in areas where its use was common. The third-level students associated the drug with people living in disadvantaged estates and criminal behaviour, and had little contact with these drug users: all reported that this was not a drug they intended to experiment with:

'I think everyone has a much greater fear of heroin, if you said to someone, "would you try cocaine?" or whatever, they'd say "ok". If you said "would you try heroin?" they'd think you were mad – the term junkie goes with heroin'

The participants from areas where heroin was part of the local landscape regarded it as a 'manky' drug; associating its use with HIV/AIDS; and viewed the heroin users as 'losers' who spent their time begging to score funds for their next hit – comparing them, unfavourably, with cocaine users:

'Cocaine users think that they're better than heroin users, they think they don't have the same problem as heroin usersand only 'skanks' are on heroin ... cocaine is a social drug - people on gear are skinny, like they can hardly walk to the shops no mind come out with you to the pub, can barely even talk. A lot of bouncers would know a junkie a mile away wouldn't let them in, now like they'd let someone on coke in, they wouldn't even notice you 'cos you're not physically looking bad on coke whereas you would on heroin, a lot of cocaine users would have the money to go out, like heroin users wouldn't, you know like, they're begging for their money for their gear, like, the best part of the coke users work 5 days a week.'

Other drugs

The main other drugs discussed in the focus groups were OTCs (Over-the-counter medication); pills; and solvents and inhalants. Otherwise, the participants had little knowledge or contact with fewer mainstreams drugs and regarded them (such as LSD, opium) as being used by isolated groups of people rather than part of the broader drug scene.

Over-the-counter medications were regarded as being highly popular among young people, among those mentioned were Nurofen Plus[®] – for its codeine effect, and cough bottles such as Robitussin[®] and Benylin[®].

The use of prescription drugs and the use of the internet as a source for both obtaining information about the effects of the drugs as well as for purchasing drugs was noted. Prescription medications tended not to be identified by brand name, aside from Valium, but were referred to as 'tablets' or 'smarties' which could be purchased for between 50 cents to €1.00.

Solvents and inhalants were additional drugs connected particularly with young people:

'they'd be like 12 year-olds, 8 to 12-year olds, petrol, gas, nail varnish, all that'

'ah yeah but you're not going to sit in a pub with a bottle of deodorant, sniffing, like you don't have to pay nothing for these'

things, they're household objects, as you get older you're starting to bring your own money in like when you're 8 years-of-age the only way to get a free buzz is from your bathroom cabinet, its nothing to do with that's the first type of drug of an 8 year-old 'cos it's the only thing an 8 year-old can get, things become more available at different ages'

Steroid use was reported in a provincial town and in Dublin. Unsurprisingly the users were described as body conscious males. Steroids were obtained in a different manner than other drugs;

'mainly used in gyms, give you a bad temper, send you off your rocker, its not like a drug that's bought in bulk to sell out - you bang them up don't you, you just put it in your muscle, put it in your arm, it strengthens you.'

The use of crack cocaine was only discussed by the interviewees in the Dublin focus group. They believed its use was linked with heroin users returning from England where they had used the drug;

'its not getting sold, people are making it up themselves with ammonia, but it's there, I'd say it won't be long before it is getting sold, a lot of people that moved to England for a few years that are heroin users, they're kinda bringing the whole crack thing back in, 'cos its so big in London, they're kinda bringing it back here with them ... the people that knows what its like in London will be bringing it back with them in rock form'

2.4.2 Conclusion

Overall the focus group participants had little informed knowledge of the risks consequences of their drug-using behaviour. Word-of-mouth (often of incorrect information), and in a few cases the internet, was the main source of obtaining information when it came to the side effects and repercussions of taking various drugs. Linked to this was a high level of risk behaviour, particularly in relation to ecstasy, and above all in relation to the combination of illicit drugs with alcohol. For all the interviewees drink was a drug that was inextricably linked with the consumption of illicit substances:

'alcohol doesn't come into it, doesn't count that's a constant, you'd probably only be drinking when you're out of it anyway'

The majority of the participants were deeply critical of the drugs information literature that was available, and there was a general lack of trust in the accuracy of government funded literature:

'Some guy throws you a leaflet on drugs you throw it away – leaflets on ecstasy written in the 80s – saying if you take this you might die rather than saying this is what happens and there are side effects and not being like a mother telling them what drugs are as opposed to telling them exactly- TV may be the best way of getting through to your target audience they're not going to read leaflets and they re not going to look up the website.'

'most people who decided they're going to take a drug will naturally be worried about the effects of a drug and I think it's absolutely essential to provide those people who will go looking for information – to give them better information on what to actually expect. Better information on how to deal with things if it goes wrong when you're on the drug - you get a feeling it's a document being written by people who have never taken drugs and who are copying it from other people who have never taken drugs and I think that is a serious problem because those people want to find information to help them make an adult decision on whether there going to take this drug or not, good – in fairness to the health promotion unit I know they have put a lot of materials in toilets and stuff and ok it does get people thinking but in reality I think its very, very obscure that material and needs drastic, drastic updating - to put in a simple term getting with it'.

Ironically however, for one young teenager, the various drug information pamphlets were seen as helpful for learning the street names of the drugs and knowing what to ask for when they were trying to score:

"if you want to ask someone have they got anything it tells you what to say to them, the book tells you different names for them".

Nonetheless, in terms of the potential for drug information campaign messages to be taken on board, the lack of tobacco smoking by the participants and among their peers indicates that some health promotion campaigns succeed in getting their message across:

Q: And do you all smoke tobacco as well?

A: No way, smokes like? There's no point in smoking, what's the smoke going to do for you, walking around going mental for smokes, don't even get a buzz out of it, gives you yellow teeth, it's filthy, gives you stinking breath and yellow fingers an all, it's pointless, rotten"

However, such drug information campaigns would have to contend with tackling the relatively low risk perceptions held by the young people we interviewed regarding drug use:

if drugs are available people will use them, if anything has a benefit, if anything makes you feel good, you'll use it

2.5 Overall comments on national drugs trends

Overall, there were 462 media-reported incidents in respect of drug seizures and court cases.

- Drugs reported in the media, in respect of seizures and court cases involved, cannabis (53%), ecstasy (16%), cocaine (13%) and heroin (12%).
- Thirty nine percent of reports were at the personal/friends level of the drugs market, 28% of reports were at the retail level of the drugs market, while 33% were at the upper level of the drugs market.
- One hundred and fifty six TMs completed the DTMS survey.
- The main drugs reported as being available in the TMs area cannabis (n=156), ecstasy (n=151), cocaine (n=141), heroin (n=131), solvents and inhalants (n=122) and amphetamines (n=121)
- The main drugs reported as being used by TMs contacts were cannabis (n=154), alcohol (n=149), ecstasy (n=133), cocaine (n=127) and heroin.
- The main increases noted in respect of TMs contacts' drug use were in relation to, cocaine (n=64), crack cocaine (n=25) and alcohol (n=76)
- Intravenous drug use was noted in relation to heroin (n=77), cocaine (n=26), crack cocaine (n=9), anabolic steroids (n=8), amphetamines (n=5).
- New drugs identified by TMs as being available in their area in the past 12 months were, New drugs identified by TMs as being available in their area in the past 12 months were, crack cocaine (n=10), cocaine (n=6), heroin (n=3), anabolic steroids (n=4), MDMA Powder (n=2), DOB (n=2), and cannabis grass, LSD, speed, GBH, Ketamine, OxyContin[®], Viagra[®], Zispin[®], Ritalin[®], Somantil, Rohypnol[®], and 'D10s' (each n=1).

Six focus group discussions with third level students and youth groups demonstrated the acceptability of illicit drug use in young people's lives and the low risk perception associated with drug-taking, particularly in relation to cannabis and ecstasy and to a lesser extent cocaine.

Appendix 1



Drug Trend Monitoring Project,
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FOR NACD USE

Drug Trends Monitoring System

Trend Monitor's Questionnaire October 2004

Instructions

This questionnaire covers three sections:

Section 1

asks for background information **on you and your work**

Section 2

asks for information on the drug use **of those you are in contact with**

Section 3

asks for information on drug trends **in your geographical area**

Please read each question carefully and answer each section.

If you are not sure what answer to give please tick the 'unsure' option.

If this questionnaire is being completed by a group of people, please fill in the sections on behalf of the group but with the contact details of your nominated person.

We would appreciate you completing this questionnaire as soon as possible and returning it in the FREEPOST attached by the 31st October at the latest.

If you have any queries, please contact:

Aileen O'Gorman or Martha Doyle
NACD Drug Trends Monitoring Project
Tel: (01) 667 0760



Section 1: Background Information

Q1 (a) Trend Monitor's name: _____
 (b) Position: _____

Q2 (a) Monitor's Tel No (mobile preferably): _____
 (b) Monitor's email address: _____

Q3 Number of people involved in completing the questionnaire?

Q4 Job/role of others involved in completing this questionnaire:

Q5 What geographical area do you cover in your work?

Q6 What is the main target group you work with?
 (e.g. young people; problem drug users; early school leavers; young offenders etc.)

Q7 What age group do you work with mostly? (✓ more than ONE if necessary)
 Under 18 19-24 25-34 35-44 45+

Q8 Are the people you work with:
 All male Mixed – male and females All female

Q9 Do you work with a specific ethnic minority group, if so please describe the group or groups?

Q10 Approximately, how often and how many drug users do you have contact with in the course of your work? (complete ONE row only)

	✓		Number
Weekly	<input type="checkbox"/>	Average No of users in contact with per week	
OR			
Monthly	<input type="checkbox"/>	Average No of users in contact with per month	

Section 2: Drug Trends Among Those You Have Contact With

Q11 Drug use – please complete all THREE columns (a), (b) & (c)

Drug	Q11 (a) Which of the following drugs are currently used by the group you have contact with? <i>Tick ONE response for each drug listed</i> <i>Un = Unsure/Don't Know</i>	Q11 (b) Which five drugs <i>tick</i> ed 'Yes' in Q11(a) are the most frequently used by those you have contact with? <i>Tick FIVE boxes, if not sure please leave blank and move on to Q12 (c)</i>	Q11 (c) With the group you have contact with, has there been any change in the use of the drugs <i>tick</i> ed 'Yes' in Q11(a) this year? 1. Increase 2. No change noted 3. Decrease 4. Unsure/Don't Know <i>Enter ONE number in box for each drug used</i>
Cannabis (Resin and herbal)	Yes <input type="checkbox"/> No <input type="checkbox"/> Un <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy type	Yes <input type="checkbox"/> No <input type="checkbox"/> Un <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Magic Mushrooms	Yes <input type="checkbox"/> No <input type="checkbox"/> Un <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Solvents and Inhalants	Yes <input type="checkbox"/> No <input type="checkbox"/> Un <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines (speed/whiz)	Yes <input type="checkbox"/> No <input type="checkbox"/> Un <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poppers (amyl/butyl nitrite)	Yes <input type="checkbox"/> No <input type="checkbox"/> Un <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LSD	Yes <input type="checkbox"/> No <input type="checkbox"/> Un <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine powder	Yes <input type="checkbox"/> No <input type="checkbox"/> Un <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack cocaine	Yes <input type="checkbox"/> No <input type="checkbox"/> Un <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	Yes <input type="checkbox"/> No <input type="checkbox"/> Un <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anabolic Steroids	Yes <input type="checkbox"/> No <input type="checkbox"/> Un <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	Yes <input type="checkbox"/> No <input type="checkbox"/> Un <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone (street)	Yes <input type="checkbox"/> No <input type="checkbox"/> Un <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other drugs used (both illegal and misused legal) – please list and complete (b) & (c)

	Yes	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	<input type="checkbox"/>	<input type="checkbox"/>

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Internet resources

Office of National Drug Control Policy – United States of America

<http://www.whitehousedrugpolicy.gov/drugfact/aboutpc.html>

Antenne Monitor – Amsterdam <http://www.jellinek.nl/>

The European Monitoring Centre for Drugs and Drug Addiction <http://www.emcdda.eu.int/>

European School Survey Project on Alcohol and Other Drugs <http://www.can.se/>

MAD – Regions and Towns Monitor for Alcohol and Drugs – Netherlands <http://www.trimbos.nl/>

The National Household Survey on Drug Abuse – United States <http://www.samhsa.gov/>