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for Drugs and Drug Addiction

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DRUG POLICY PROFILES

Ireland



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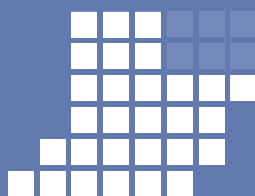


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Introduction

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is publishing this series of profiles with the aim of describing some of the main characteristics of national drug policies in Europe and beyond. In contrast to other approaches, we do not attempt to assess these policies, but instead to outline their development and main features. Our objective is to help readers — from researchers to policymakers — gain a better understanding of the way in which countries control drugs and respond to drug-related security, social and health problems.

National drug policies are the result of the interaction of multiple factors, such as political and administrative structures, the role and influence of stakeholders, financial resources, the drug situation, other public policies (e.g. health, security) and international agreements. There is no model for how to combine these factors and assess their respective weight and interrelations. However, this should not prevent analysts from exploring the significant changes in these factors that may have shaped drug policy in the short and long term. This series uses a historical perspective to identify such drug policy changes. While some of these changes may have occurred in parallel in many countries because they were facing the same issues (e.g. the adoption of new UN conventions, HIV/AIDS epidemics, diffusion of new drugs), this series of policy profiles will also show that each country has its specific drug policy timeline.

This profile, the second in the series, describes the development of drug policy in Ireland. The evolution of illicit drug policy in Ireland has followed an interesting course, which bears similarities and differences with that experienced by other European countries. Below, we explore the national strategies, the legal context within which they operate, and the public funds spent, or committed, to implement them. The profile also describes the political bodies and mechanisms set up to coordinate the response to the multi-faceted problem of drug use. The profile puts this information in context by outlining the size, wealth and economic situation of the country as a whole, as well as the historical development of the current policy. One note of caution for the reader is that the availability of information and analysis is much greater in the area of demand reduction, as with most national and international drug policy studies, than in the area of supply reduction.

What is a drug policy?

The responses to this question range from 'all activities that are related to illicit drugs' to 'a set of principles or an ideology that conducts public action in this field (e.g. war on drugs, harm reduction)'. To prevent both a too large and a too restrictive approach, we will use here a definition that has been adapted from Kilpatrick's (2000) definition of public policies as: 'A system of laws, regulatory measures, courses of action and funding priorities concerning (illicit) psychoactive drugs and promulgated by a governmental entity or its representatives.'

Ireland in figures

		Year	Ireland	EU (27 countries)
Population		2011	4 480 858	502 476 606 (p)
Population by age class (% of total population)	15–24	2011	11.7	
	25–49		38.5	
	50–64		16.3	
GDP per capita in PPS (1)		2010	128	100
Total expenditure on social protection (% of GDP) (2)		2009	27.9	29.5 (p)
Unemployment rate (%) (3)		2011	14.4	9.7
Unemployment rate of population aged under 25 years (%)		2011	29.4	21.4
Prison population rate (per 100 000 of national population) (4)		2010	97.4	
At risk of poverty rate (%) (5)		2010	16.1	16.4
Political system		Centralised		

(p) Eurostat provisional value.

(1) Gross domestic product (GDP) is a measure of economic activity. It is defined as the value of all goods and services produced less the value of any goods or services used in their creation. The volume index of GDP per capita in purchasing power standards (PPS) is expressed in relation to the European Union (EU-27) average set to equal 100. If the index of a country is higher than 100, that country's level of GDP per head is higher than the EU average and vice versa.

(2) Expenditure on social protection contains: benefits, which consist of transfers in cash or in kind to households and individuals to relieve them of the burden of a defined set of risks or needs.

(3) Unemployment rates represent unemployed persons as a percentage of the labour force. Unemployed persons comprise those aged 15 to 74 who were: (a) without work during the reference week; (b) currently available for work; (c) actively seeking work.

(4) Situation in penal institutions on 1 September 2010.

(5) Share of persons aged 0+ with an equivalent disposable income below the at-risk-of-poverty threshold, which is set at 60% of the national median equivalised disposable income (after social transfers).

Source: EMCDDA Country overview — Ireland

(<http://www.emcdda.europa.eu/publications/country-overviews/ie>)

Policy timeline — key dates

International and EU developments		National developments
	1934	Dangerous Drugs Act 1934
UN Single Convention on Narcotic Drugs	1961	
	1966	Report of the Commission of Inquiry on Mental Illness
UN Convention on Psychotropic Substances	1971	Report of the Working Party on Drug Abuse
	1973	Ireland joins the European Economic Community
	1977	Misuse of Drugs Act 1977
	1983	Report of Special Government Task Force on Drug Abuse
	1984	Misuse of Drugs Act 1984
UN Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances	1988	
European Plan to Combat Drugs	1990	
	1991	Government Strategy to Prevent Drug Misuse
Report on the European Plan to Combat Drugs	1992	
EU Plan to Combat Drugs 1995–1999	1995	
	1996	First report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs
	1997	Local drugs task forces become operational
UN General Assembly Special Session on the World Drug Problem	1998	
EU Drugs Strategy 2000–04 EU Action Plan on Drugs 2000–04	2000	National Advisory Committee on Drugs established
	2001	‘Building on experience: national drugs strategy 2001–2008’ launched
	2004	Mid-term review of the national drugs strategy
EU Drugs Strategy 2005–12 EU Drugs Action Plan 2005–08	2005	Regional drugs task forces become operational
	2007	Report of the Working Group on Drugs Rehabilitation
EU Drugs Action Plan 2009–12	2009	National Drugs Strategy (interim), 2009–16 launched
	2010	Criminal Justice (Psychoactive Substances) Act 2010 becomes law
	2012	Steering group report on a national substance misuse strategy

Developing Irish drug control, 1921–1979

Irish drug control legislation was enacted when the country was still part of the United Kingdom. The Poisons (Ireland) Act 1870 controlled the sale of a range of substances, initially including opium and morphine. The first central drug control law following the Anglo Irish Treaty in 1921, when 26 of Ireland's counties became politically independent, while six counties in Northern Ireland remained within the United Kingdom, was the Dangerous Drugs Act 1934. It was enacted to fulfil Ireland's obligations under the League of Nations Convention for the Limitation of the Manufacture of Narcotics of 1931. The law updated the system for regulating the availability of drugs, setting out record-keeping requirements for pharmacists and doctors and established unauthorised possession as an offence punishable by a fine, imprisonment or both (Working Party on Drug Abuse, 1971). A number of complementary regulations were adopted between the mid 1950s and mid 1960s in order to scale up drug control and respond to the emergence of new drugs, such as amphetamines, barbiturates and tranquilisers, and to the lack of adequate restrictions on the availability of medications based on them.

The Mental Treatment Act 1945 was the first legislation focusing on mental health issues, and it made specific reference to 'addicts' when setting out provisions for voluntary and compulsory admissions to psychiatric hospitals. This reference to addiction, stated as being to drugs or intoxicants, however, was primarily concerned with alcoholics (Butler, 2002). In 1966, a review of Ireland's mental health services by the recently created Commission of Inquiry on Mental Illness noted that there was little drug use and that out of 19 829 patients in mental hospitals in March 1963, only 16 were in receipt of treatment for drug addiction. On the basis of these numbers and the delivery of treatment solely by psychiatrists, the Commission advocated the use of a single centralised treatment facility for drug addiction (Commission of Inquiry on Mental Illness, 1966). Developments in drug treatment occurred some years later, and were based on a model of centralised, abstinence-orientated, service provision, influenced by British developments. In 1969, the first drug treatment facilities were established in Dublin by the Department of Health, with an out-patient unit at Jervis Street Hospital, later renamed the National Drug Advisory and Treatment Centre, and an in-patient centre at Saint Brendan's Hospital. A voluntary sector treatment body was established in 1973, when the Coolmine Therapeutic Community started to treat drug users in Dublin (Butler, 2002).

While remaining at a low level, drug use in Ireland was gradually changing. In the early 1950s, the drugs most commonly used were sedatives, tranquilisers and barbiturates, with amphetamines being taken in the early 1960s and a shift towards

Drug control laws in Ireland

The Misuse of Drugs Acts 1977 and 1984 (MDA) are the main Irish drug laws. There are five schedules (lists) of drugs in the legislation, based on the usefulness of the drugs and the nature of the controls required. New substances are not 'added' to a list, but are 'declared' by government declaration orders to be equivalent to drugs under the MDA. Ireland uses a 'generic' system, where substances within a defined chemical 'family' are automatically considered controlled drugs.

On discovery of drugs, the police have the options of confiscation and informal warning, caution, juvenile diversion, arrest referral or prosecution. In the Irish criminal justice system, crimes may be tried in a lower or higher court, depending on the seriousness of the charge. A summary offence is a minor offence chargeable by way of summons, tried before a district court judge, who can usually impose a sentence of no longer than one year in prison. Offences considered too serious for the district court follow the indictment proceeding and are referred to the circuit criminal courts. Here, the defendant is entitled to a trial by jury. In addition to custodial measures, a range of non-custodial options are available. The decision may be influenced by a pre-sanction report compiled by the Probation Service that includes information on factors that may have contributed to the individual's offending, such as drug addiction. Cases can also be permanently stayed, struck out, withdrawn, or taken into consideration (added to a sentence for a different offence) (Alcohol and Drug Research Unit, 2008; EMCDDA, 2009).

The MDA distinguishes between possession (for personal use) and possession for sale or supply. Possession of cannabis for personal use is punishable by a fine on first or second conviction; from a third offence onwards, it may be punished by fines, up to one year imprisonment, or both, on summary conviction, and imprisonment for up to three years on indictment. Possession of other controlled substances may incur a penalty of imprisonment for up to one year, a fine or both, on summary conviction, and up to seven years imprisonment on conviction on indictment. Possession of any drug for sale or supply attracts penalties of up to one year on summary conviction and up to life imprisonment if on indictment. The law states that the court can presume the drugs were for selling based on quantity or other relevant matters. A mandatory minimum 10-year sentence is also available for supply offences involving more than EUR 13 000 of drugs.

lysergic acid diethylamide (LSD) and cannabis in the late 1960s and 1970s, with little use of heroin or other opioids being reported. At that time, a commercial scale trade in illicit drugs was not observed (Butler, 2002; Commission of Inquiry on Mental Illness, 1966). Supplies of amphetamines, barbiturates and tranquillisers for the illicit drugs market were chiefly sourced through thefts from pharmacies, while LSD and cannabis were reported to be trafficked only in small amounts (Working Party on Drug Abuse, 1971). Garda Síochána (police) statistics for 1969 showed that there were 350 known drug users, increasing to 940 by 1970 (Butler, 2002).

In 1968, drug issues were considered sufficiently important for the establishment of a government working party on drug abuse, which was tasked with examining

the extent of drug use and making recommendations to the Minister for Health. Its 1971 final report placed an equal focus on prevention and treatment, and called for the establishment of different offences for personal use and supply, with cannabis offences dealt with differently from other drugs. The working party also sought the creation of a permanent advisory body, and in 1972 an inter-departmental committee on drug abuse was established. Formed on a non-statutory basis, however, the committee did not meet regularly, and failed to have an impact on policy (Butler, 2002). The working party also supported a specialist, centralised system of treatment for drug users with a limited referral role for general practitioners. The adoption of the Misuse of Drugs Act 1977 (see the box 'Drug control laws in Ireland'), which replaced the 1934 legislation, implemented the differentiation of offences suggested in the working party's final report, and facilitated Ireland's accession to the 1961 UN Single Convention on Narcotic Drugs and the 1971 UN Convention on Psychotropic Substances, respectively, in 1980 and 1992 (Butler, 2002).

Heroin use and the road towards a new drug policy, 1980–1995

A marked change in the drug situation occurred in the early 1980s, mainly in the capital city of Dublin, with increased heroin use, the emergence of an injecting drug culture and commercial scale drug dealing. Crime statistics show an increase from 501 persons charged with drug offences in 1978 to 1 593 in 1982, and from five charged with heroin offences in 1979 to 449 in 1983 (¹). Treatment presentations at the National Drug Advisory and Treatment Centre increased from 319 in 1979 to 1 307 in 1982. A Medico-Social Research Board study reported 10 % last year prevalence of heroin use among 15- to 24-year-olds in the north inner-city (Butler, 2002; Dean et al., 1983). In 1985, 27.8 % of 636 individuals tested at the National Drug Advisory and Treatment Centre and 22 % of 190 drug users in the largest prison tested positive for the human immunodeficiency virus (HIV) (Quigley, 2010).

Ireland was also facing economic difficulties and political instability, with four different ministers for health between 1979 and 1982, and three general elections between 1981 and 1982. These circumstances contributed to the slow development of a policy response to heroin use, and triggered groups of community activists formed in some Dublin inner-city neighbourhoods, for example Concerned Parents Against Drugs, to take action against drug dealers. In 1983, responding to the changing drug situation and growing community tensions, the Minister for Health established the Special Government Task Force on Drug Abuse, comprising six ministers of state, to report on drug abuse, with particular reference to Dublin's inner city and focusing on heroin use (Butler, 2002). Following its report, supply reduction measures received more attention, including the adoption of the Misuse of Drugs (Amendment) Act in 1984. The report also noted that the existing inter-departmental committee had not effectively monitored the drugs problem, and recommended a new structure be developed. In 1985, the Minister for Health created the National Coordinating Committee on Drug Abuse to advise government and provide the minister with annual reports. Like its predecessor, the Committee was established on a non-statutory basis, contributing to infrequent meetings, and published only one annual report in 1986 (National Coordinating Committee on Drug Abuse, 1986). Thereafter, it had little impact (Butler, 2002) until 1989, when it was restructured and developed the first Irish drug strategy (see below).

Significant changes in the organisation and provision of health-related measures started in the 1980s, notably the introduction of harm reduction interventions in a low

(¹) The quantities of heroin seized across these years also rose, from 5 g in 1979 to almost 1.3 kg in 1983 (Butler, 2002).

profile manner, without any national level strategic policy document (Butler, 2002). In 1982, the first low-threshold treatment agency in Ireland, the Ana Liffey Drug Project, was established in Dublin city, receiving statutory funding from 1985 on (Butler and Mayock, 2005). During 1983, the Eastern Health Board (EHB), the regional health authority for Dublin, established a network of addiction counsellors, and in 1987 moved away from services primarily focused on abstinence, making methadone maintenance treatment more widely available at the National Drug Advisory and Treatment Centre. The EHB implemented additional harm reduction measures in 1989, establishing an AIDS resource centre, a needle and syringe exchange programme, and an outreach service (Butler, 1991). That same year, Merchants Quay Ireland, the largest harm reduction orientated drug service operated by the voluntary sector, began to receive statutory funding.

Changes continued in the early 1990s, when the EHB moved towards service provision in local communities outside of Dublin city, creating small 'satellite clinics' for drug treatment services, including methadone maintenance. In 1992, the National AIDS Strategy Committee delivered its report, supporting methadone maintenance for HIV prevention, its use in satellite clinics and the standardisation of prescribing practices (National AIDS Strategy Committee, 1992). This triggered the establishment of the Expert Group on a Protocol for the Prescribing of Methadone by the Department of Health. It called for the creation of treatment identity cards, a central treatment list, a registration system for general practitioners and the provision of methadone treatment within their practices (Department of Health, 1993; Quigley, 2010).

The adoption of the Misuse of Drugs (Amendment) Act in 1984 was the main legislative development during the 1980s (Butler, 2002). It addressed loopholes in the 1979 legislation relating to cannabis cultivation, undertaking drug searches, increased sentences for trafficking and removed the requirement for pre-sentencing medical and social reports on drug users (Butler, 2002; Flynn and Yeats, 1985; O'Mahony, 2008). Ireland also signed the 1988 UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances in December 1989 ⁽²⁾. Precursor chemicals used in the manufacture of drugs, such as acetic anhydride (for heroin) and ephedrine and pseudoephedrine (for methamphetamine), became subject to controls in the 1977 and 1984 Misuse of Drugs Acts and the 1988 Misuse of Drugs Regulations (National Coordinating Committee on Drug Abuse, 1991). Further legislation and policing efforts were put in place in the mid 1990s. The Criminal Justice Act 1994 included provisions for seizing and confiscating assets derived from drug trafficking proceeds and, in 1995, the Garda National Drugs Unit was established to tackle national and international drug trafficking.

⁽²⁾ It was ratified in 1996.

In 1991, drug policy was expressed for the first time in the form of a national drugs strategy (National Coordinating Committee on Drug Abuse, 1991). The adoption of a top-level policy document mirrored developments in other European countries, where drug policies were being set out in this way (Butler, 2002). Treatment, harm reduction and outreach received official backing, and it was acknowledged that established responses to drug problems, primarily based on supply reduction, needed to be balanced with demand reduction measures (National Coordinating Committee on Drug Abuse, 1991). The strategy also discussed the use of primary care, in conjunction with clinics for methadone maintenance, to extend local service provision. The role of environmental factors in drug use was acknowledged, specifically, the concentration of heroin problems and injecting drug use in deprived inner city areas. The establishment of multi-disciplinary community drug teams in the worst-affected areas was provided for, two of which were developed in Dublin during 1992 (Butler, 2002). However, the strategy lacked an implementation plan, and its execution schedule remained therefore vague (National Coordinating Committee on Drug Abuse, 1991).

Changing policy frames and responses, 1996–2008

In the 1990s, several factors led to lasting changes in Irish drug policy. These included changes in public policy formulation and expression, a continued sense of crisis surrounding HIV/AIDS and injecting drug use and tensions within communities affected by drugs. Such tensions became increasingly visible in 1996, when community groups such as the Inner City Organisations Network and the Coalition of Communities Against Drugs organised anti-drug protest marches. Fourteen demonstrations, involving between 500 and 3 000 people, were held between August and December 1996 (Quigley, 2010). The murder of Veronica Guerin, a prominent crime journalist covering the illicit drugs trade, on 26 June in 1996, added to the perception that drug problems were at crisis point (Butler, 2007).

Available data indicate that Ireland was confronted with serious and often rising drug problems. According to a 1997 government discussion paper, 'Tackling crime', the number of drug offenders doubled between 1990 (2 071) and 1995 (4 021) (Department of Justice, 1997). A Garda Síochána (police) study reported that out of 19 046 detected indictable crimes (warranting a jury) in the Dublin Metropolitan Area during one year, 66 % were committed by drug users (Keogh, 1997). Additionally, a 1996 prevalence study provided an estimate of 13 460 opioid users aged 15 to 54 in Dublin city, with 40 % being males aged 15 to 24 (Comiskey, 1998). Five years later, another study calculated 12 456 opioid users in Dublin and 14 452 in the whole country (Kelly et al., 2003).

External factors played an important role in drug policy changes in Ireland, and 1996 was a pivotal year in the development of new structural arrangements in this area. 'Delivering better government' was published that year, and it developed the Strategic Management Initiative, an Irish version of New Public Management (Department of the Taoiseach, 1996). This triggered changes in the civil service in terms of accountability, assigning of responsibility and management of cross-departmental issues. One example of this is the establishment of the Ministerial Task Force on Measures to Reduce the Demand for Drugs in July 1996 (Randall, 2011). Their first report, concerning heroin use, marked a shift in policy, its expression and delivery (Ministerial Task Force on Measures to Reduce the Demand for Drugs, 1996), and had a lasting impact on the area. Using epidemiological data, it stated the connections between economic deprivation, crime and the use of drugs, alongside the links between injecting drug use and the transmission of human immunodeficiency and hepatitis C viruses (Butler, 2007; Quigley, 2010).

The report also called for new drug policy structures such as the Cabinet Drugs Committee, designed to provide intra-governmental coordination and bringing

together different ministers and the Taoiseach (Prime Minister) to consider policy issues. Below it, the Inter-Departmental Group on Drugs, comprised of high-ranking civil servants, oversaw policy implementation and acted as a link between local and central government. The National Drugs Strategy Team assisted the Inter-Department Group, while managing the work of the ten local drugs task forces (Ministerial Task Force on Measures to Reduce the Demand for Drugs, 1996). The latter were implemented in areas with serious heroin problems (Sinclair, 2006), and included statutory, voluntary and community sector members (Ministerial Task Force on Measures to Reduce the Demand for Drugs, 1996). This mirrored the 'social partnership' approach to policy-making pursued since the adoption of the Programme for National Recovery in 1987 (Department of the Taoiseach, 1987). By involving those affected within the solutions being applied, the approach reduced local dissatisfaction (Quigley, 2010). Ten task forces were originally planned, but the number was later increased to fourteen, thirteen of which were located in Dublin (Drug Misuse Research Division, 1999).

The new policy coordination structures were set up in 1997, and underwent modifications following a change of government. The Cabinet Drugs Committee was renamed the Cabinet Committee on Social Inclusion, and a minister of state was given responsibility for both the drugs strategy and local development. The overall responsibility for coordinating drugs policy was also moved from the Department of Health to the new Department of Tourism, Sport and Recreation. This department was regarded as being in a position to provide a neutral handling of the different policy spheres covered by the strategy, alongside the fact that it also held responsibility for local development and was in charge of coordinating several programmes addressing social inclusion (Pike, 2008).

The Ministerial Task Force's report also reviewed the organisation of drug treatment services, backing methadone maintenance, through expanding the number of general practitioners and community pharmacists delivering it, and endorsing the use of a low-threshold mobile clinic. The Eastern Health Board's programme of developing local drug treatment clinics, which was facing opposition from communities campaigning for services but opposing facilities in their neighbourhoods, also received support (Ministerial Task Force on Measures to Reduce the Demand for Drugs, 1996). In 1998, the Methadone Treatment Services Review Group supported the adoption of a protocol to roll out methadone treatment nationally and the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations implemented this new methadone prescribing system (Drug Misuse Research Division, 1999) (see the box 'The methadone treatment protocol'). This led to significant increases in both the numbers of patients and of providers (general practitioners, community pharmacies and health board clinics) over the following decade (Quigley, 2010). Prison based methadone treatment also expanded in 2001, following reports

The methadone treatment protocol

The Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations 1998 set out rules for general practitioners prescribing methadone. Prior to the protocol, a limited number of general practitioners prescribed methadone, with those prescribing receiving a high volume of patients, and requiring many drug users to travel long distances.

The protocol reduced the potential for overprescribing practices and the diversion of methadone to the illicit market. It standardised treatment provision and contributed to the development of the capacity of the drug treatment system through use of the primary care system, involving general practitioners and community pharmacists. A two-tier system of general practitioners was created. Level 1 doctors cannot initiate treatment and take a maximum of 15 referred patients from level 2 general practitioners or Health Service Executive (HSE) (formerly health boards) drug treatment clinics. Level 2 doctors can initiate treatment, receive extensive training from the Irish College of General Practitioners and treat 35 patients alone or up to 50 in tandem with another level 2 doctor (Drug Misuse Research Division, 1999).

The name, address and date of birth of a person receiving treatment, the name of the prescribing practitioner and the dispensing pharmacist are notified to the Health Service Executive. A drug treatment card, valid for up to one year is issued by an HSE regional office for a person receiving treatment. The central treatment list contains details of all individuals receiving methadone. Since October 1998, general practitioners cannot issue prescriptions for methadone other than to a person issued a drug treatment card. The community pharmacy contactor agreement increased treatment delivery in local areas, allowing pharmacies to dispense methadone. Pharmacists cannot supply methadone to anyone without a drug treatment card, and must forward a record of all prescriptions to the Minister for Health. The protocol has been reviewed several times, and is subject to ongoing improvements (Drug Misuse Research Division, 1999; Farrell and Barry, 2010; Methadone Prescribing Implementation Committee, 2005).

from review groups (Irish Prison Service, 2000, 2001). The same year, a pilot drug court commenced operation (see the box 'The Dublin drug court').

Supply reduction legislation was also scaled up, particularly following the murder of the journalist Veronica Guerin. In July 1996, the Criminal Justice (Drug Trafficking) Act made provision for the detention of a person suspected of committing a drug trafficking offence for a maximum of seven days. The Disclosure of Certain Information for Taxation and other Purposes Act, launched at the same time, facilitated information exchange between the Revenue Commissioners and the Garda Síochána. In August, the Proceeds of Crime Act 1996 facilitated the freezing and forfeiture of the proceeds of crime. This allowed the recently established Criminal Assets Bureau to identify assets acquired through criminal activity and take measures to deprive the suspected individuals of them (Drug Research Division, 1997; Quigley,

The Dublin drug court

A pilot drugs court was established in Dublin in 2001 under the jurisdiction of the district court. It is treatment-orientated, where people with drug problems, charged with non-violent offences, are referred to treatment programmes rather than sent to prison.

Irish criminal courts are adversarial, but the drug court judge has a central and active role. The prosecution and defence counsel promote public safety while protecting the participant's due process rights. Applicants to the programme should be resident in the areas of County Dublin north of the River Liffey or be attending Castle Street drug treatment centre in Dublin city. They should be over 17 years of age, be motivated to cease drug use, have pleaded guilty or been convicted of certain offences in the district court with a likely outcome of imprisonment (Reitox National Focal Point, 2011).

By 2009, out of the 323 people referred to the court since it started, 22 had successfully completed the programme, which has three phases (¹). A further 32 remained within it, while 143 were ineligible and 109 had had their participation terminated. A review of the court was published in 2010 (Department of Justice, Equality and Law Reform, 2010). It found that only 14 % of participants had successfully completed the programme since its establishment, but participation was seen to have had a positive effect on offending behaviour, health and personal relationships, even when participants failed to complete the programme. The review recommended the programme be extended to offenders aged 16–18 years who are before the Children's Court (Department of Justice, Equality and Law Reform, 2010) and suggested measures to improve the programme's effectiveness and success rate (Connolly, 2010). It was decided that the drug court should continue for another two years, following the implementation of the recommendations (Reitox National Focal Point, 2011).

(¹) Participants move through three phases of the drug court programme: (1) stabilisation and orientation; (2) continuation and progression; and (3) reintegration and self-management. A set of expectations about the participant's behaviour and achievements are defined for each phase.

Further information about the drug court can be accessed at: <http://www.courts.ie/offices.nsf/fd1b5d60ef39f31380256e43003d0107/cfaf3511b9b9639e80256e45005861cf?OpenDocument>

2010). Additional measures were adopted in the Proceeds of Crime (Amendment) Act 2005 (Pike, 2008).

The Criminal Justice Act 1999 added a new section (15A) to the Misuse of Drugs Act 1977 to create an offence of possession of drugs valued at EUR 12 700 or more, for the purpose of sale or supply (Drug Misuse Research Division, 2000). This offence should be punished by a mandatory minimum sentence of ten years in prison. Courts were, however, reluctant to apply it because of its impact on the primacy of judicial discretion in determining sentences and of a potential for disproportionate sentencing. The gap between the legislation and sentencing practices was addressed in the Criminal Justice Acts 2006 and 2007. The former introduced a new minimum

ten year sentence for the offence of importing ⁽³⁾ drugs with a value of EUR 13 000 or more, while the latter facilitated a more effective response to organised crime gangs. In 2009, however, the Law Reform Commission noted that the presumptive drug offences regime had created a ‘discriminatory system of sentencing where all cases are treated alike regardless of differences in the individual cases’ (Connolly, 2012; Law Reform Commission, 2011).

An increase in drug policy research occurred from the mid 1990s on, following the Strategic Management Initiative. At this time, the Health Research Board’s Drug Misuse Research Division (DMRD) ⁽⁴⁾ undertook epidemiological studies and functioned as Ireland’s national focal point to the EMCDDA ⁽⁵⁾. In 1999, the establishment of an (Interim) Advisory Committee on Drugs allowed the level of research to be expanded (Drug Misuse Research Division, 2001). Bringing together representatives from different sectors, the committee was designed to advise government (Quigley, 2010), and was allocated funds of EUR 3.8 million for its initial triennial work programme. It funded studies covering the consequences of drug use, prevalence, prevention and treatment and rehabilitation (National Advisory Committee on Drugs, 2003a) ⁽⁶⁾.

A new drug strategy ‘Building on experience: national drugs strategy 2001–2008’, was adopted in May 2001 (Department of Tourism Sport and Recreation, 2001), following a review by the Inter-Departmental Group on Drugs. The new strategy increased public involvement in drug policy development, which was evident from the inviting of submissions and the hosting of eight regional consultation events, attended by 600 people. Ongoing community action was also present during the years after the strategy’s launch, with civil society organisations seeking to influence the content and direction of drug policy through different means, including holding conferences, undertaking research, political lobbying and publishing policy discussion papers (Pike, 2008).

The new strategy focused on heroin use, and endorsed the existing structures and approach, essentially restating the policy in a way that reflected the Strategic Management Initiative’s continuing influence (Drug Misuse Research Division, 2001; Quigley, 2010). International developments at the United Nations (1998 UNGASS Political declaration and plans of action) and, particularly, the European Union (EU drugs strategy 2000–04) also influenced its style and content (Pike, 2008). Built

⁽³⁾ Instead of possessing.

⁽⁴⁾ Later renamed the Alcohol and Drug Research Unit.

⁽⁵⁾ The Health Research Board’s electronic library, including the work of the National Focal Point, can be accessed at: <http://www.drugsandalcohol.ie/>

⁽⁶⁾ The National Advisory Committee on Drugs reports can be accessed at: <http://www.nacd.ie/index.php/publications.html>

on four pillars covering supply reduction, prevention, treatment and research, and accompanied by key performance indicators, one hundred actions associated to policy actors were set out (Drug Misuse Research Division, 2001; Pike, 2008). A focus was placed on increasing access to treatment in communities and prisons and reducing the volume and availability of drugs (Department of Tourism Sport and Recreation, 2001). Support was also given for the rollout of the drugs task force model on a regional level with ten regional drugs task forces being established by 2005. Their action plans often considered both alcohol and drug issues, reflecting the conceptual latitude they were given and the ability to incorporate stakeholders from different sectors (Drug Misuse Research Division, 2006; Pike, 2006, 2008). A similar process was present in the local drugs task forces' plans, which had different focuses on harm reduction issues depending on the views and opinions of their members (Butler, 2007; Quigley, 2010).

In June 2002, following restructuring in the Department of Tourism, Sport and Recreation, responsibility for drug policy coordination, including the Drugs Strategy Unit, transferred to the new Department of Community, Rural and Gaeltacht Affairs (Pike, 2008). In 2004 and 2005, for the first time, a progress review and a mid-term review of the drugs strategy were undertaken (Department of Community, Rural and Gaeltacht Affairs, 2004, 2005). One of the main findings was a need for increased efforts in the area of rehabilitation, which became the strategy's fifth pillar (Pike, 2008). This included the establishment of the Working Group on Drugs Rehabilitation, which recommended in its 2007 report the development of inter-agency working protocols and increased detoxification and residential treatment places (Department of Community, Rural and Gaeltacht Affairs, 2007; Keane, 2007) ⁽⁷⁾. The mid-term review also recommended the range of available treatment options needed to expand to address cocaine use (Department of Community, Rural and Gaeltacht Affairs, 2005; Pike, 2008). This followed increases in the use and trafficking of the drug in Ireland ⁽⁸⁾. By 2009, trend data from the Health Research

⁽⁷⁾ In 2009, the Health Service Executive established a National Drugs Rehabilitation Implementation Committee which later devised a national drugs rehabilitation framework to utilise integrated care pathways to provide better rehabilitation services to current and former drug users (Alcohol and Drug Research Unit, 2009; Doyle and Ivanovic, 2010; Keane, 2011).

⁽⁸⁾ General population surveys conducted in 2002/03 and 2006/07 showed levels of last year prevalence of cocaine use among 15- to 34-year-olds at 2% and 3.1% respectively, while the number of cocaine seizures rose between 1995 and 2007 from 42 to 1 749 cases (Reitox National Focal Point, 2011). Increased policy focus on cocaine was reflected in a 2005 Oireachtas (Parliament) report on treatments for cocaine use and by the signing two years later of an inter-governmental treaty to participate in the Maritime Analysis Operations Centre — Narcotics (MAOC-N), targeting cocaine shipments in the Atlantic. The National Advisory Committee on Drugs had conducted two overviews of cocaine use in Ireland in 2003 and 2007, while in 2008, a review of crack cocaine use in the Dublin region and a strategy to address it was also developed (Connolly et al., 2008; National Advisory Committee on Drugs, 2003b; National Advisory Committee on Drugs, 2007).

Board showed that cocaine had been reported as a main or additional problem substance by one-fifth (10 764) of all cases treated for problem substance use between 2002 and 2007 (Bellerose et al., 2009).

Twenty drug-related laws were enacted during the timeframe of the new drugs strategy. Some of them, such as those aimed at drug trafficking, reflected the strategy's objectives, but others, like those making provision for drug testing, represented issues that were not covered in the policy document (Pike, 2008) ⁽⁹⁾. A change was also made to the main drug law in 2006 with the Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order. It addressed an early phase of the so-called 'legal highs' phenomenon, following media coverage of the availability of 'magic mushrooms' in 'head shops' and a related death in Dublin (Ryall and Butler, 2011). Consequently, psilocin or its esters and any substances, products, preparations or other fungi containing them were designated controlled drugs under the 1977 Misuse of Drugs Act (Drug Misuse Research Division, 2006).

⁽⁹⁾ International cooperation aimed at disrupting drug trafficking was addressed in the Criminal Justice (Illicit Traffic by Sea) Act 2003, the European Arrest Warrant Act 2003, the Garda Síochána (Police Co-operation) Act 2003, the Criminal Justice (Joint Investigation Teams) Act 2004 and the Europol (Amendment) Act 2006. Public nuisance linked to alcohol or drug intoxication was addressed in the Criminal Justice (Public Order) Act 2003, while joint policing committees were provided for under the Garda Síochána Act 2005, a broad piece of legislation concerned with the operation of the police force. The Criminal Law (Insanity) Act 2006 excluded intoxication from alcohol or drugs from the definition of 'mental disorder' in considering fitness to be tried. The Maritime Safety Act 2005, the Railway Safety Act 2005, the Safety, Health and Welfare at Work Act 2005 and the Prisons Act 2007 all made provision for drug testing in different contexts.

Extending the policy, 2009–2012

A new 'National drugs strategy (interim) 2009–2016' was launched in September 2009, and it largely reiterated the approach adopted in 1996 and in 2001. Public consultation meetings were hosted during its development phase, and the partnership approach to drugs policy, involving collaboration between the statutory, community and voluntary sectors was supported in the document. A pillar model was retained to provide structure, covering supply reduction, prevention, a combined treatment and rehabilitation pillar, research and information, alongside coordination as a cross-cutting theme, and 54 actions associated to policy actors were set out in an action plan under the different pillars. This was also conceptualised as facilitating a fit between the strategy's measures and those of the EU Drugs Action Plan 2009–12 (Alcohol and Drug Research Unit, 2009; Connolly et al., 2009; Department of Community, Rural and Gaeltacht Affairs, 2009).

The integration of illicit drug and alcohol policies into a new substance misuse strategy was considered in the 2009 drug strategy (see the box 'Alcohol and tobacco policies'). Consequently, a steering group delivered a report on this approach in February 2012, which envisaged illicit drugs and alcohol being addressed in separate documents until after 2016, with both strategies forming a new policy approach to substance misuse generally (Department of Health, 2012a; Pike, 2012) ⁽¹⁰⁾. The impact of the steering group's report and, specifically, the implementation of some or all of the recommendations will emerge over time, showing how much these policy areas will have moved towards integration.

A series of drug-related legislative changes took place from 2009 on, with developments addressing new psychoactive substances. The new drugs strategy requested the Department of Health to review existing laws and to close loopholes facilitating the sale of such substances (Department of Community, Rural and Gaeltacht Affairs, 2009). Over 200 substances were controlled under the Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order 2010. Subsequently, the Criminal Justice (Psychoactive Substances) Act was adopted in late 2010, a new 'catch-all' law, making the sale of any psychoactive substance illegal (see the box 'Criminal Justice (Psychoactive Substances) Act 2010'). The Misuse of Drugs (Controlled Drugs) Declaration Order controlled 60 other substances, including cathinones and synthetic cannabinoids, in November 2011 (Reitox National Focal Point, 2011).

⁽¹⁰⁾ Reflecting the style of the 2009 drug policy, a new alcohol policy was structured around pillars covering supply reduction, prevention, treatment and rehabilitation, research and information, and included an action plan, defining concrete actions and the policy actors tasked with undertaking them.

Alcohol and tobacco policies

Since 2011, the Department of Health is responsible for alcohol and illicit drug policies, two areas that have developed in separate ways (Butler, 2002). Recent initiatives to formulate a substance misuse strategy, covering alcohol and drugs, follow earlier policy work on alcohol use by different working groups and committees, such as, the 1996 national alcohol policy (Department of Health, 1996; Hope and Butler, 2010).

The Intoxicating Liquor Acts 2000, 2003 and 2008 are the central legislation governing the control and supply of alcohol (Pike, 2012). The minimum age for the purchase of alcohol (beer, wine, spirits) is 18 in off- and on-license premises. National level restrictions control the hours and days that alcohol can be sold. Ireland's per capita alcohol consumption for adults over 15 years old in 2009 was 11.3 litres, placing it the tenth highest out of 40 OECD countries, the average being 9.1 litres (Department of Health, 2012a).

Tobacco control policy has developed as a distinct area, disconnected from alcohol and illicit drug policy. A national strategy, 'Towards a tobacco free society', was launched in 2000. The National Tobacco Control Office, part of the Health Service Executive, advises the Minister for Health on the implementation of the strategy and legislation (Pike, 2012). Adopted under section 47 of the Public Health (Tobacco) Act 2000, the Tobacco Smoking (Prohibition) Regulations 2003, introduced a ban on workplace smoking, including licensed premises. Ireland was the first country in the world to adopt such legislation covering all places of work targeting environmental tobacco smoke (Fong et al., 2006). Scoring 69/100, Ireland ranked second out of 30 European countries on the tobacco control scale for its combination of tobacco pricing, bans in public places, information campaigns, bans on advertising, health warnings on packaging and the provision of treatment options for dependent smokers (Joossens and Raw, 2011).

In the area of supply reduction, the strategy called for legislation to be kept under continuous review, and this action, alongside ongoing work and other developments in the broader drug policy context, gave rise to new laws. The Criminal Justice (Amendments) Act 2009 and the Criminal Justice (Surveillance) Act 2009 improved existing law's ability to tackle gang-related crime and violence, and made provision for the use of evidence gathered on criminals and terrorists through covert surveillance. The Criminal Justice (Miscellaneous Provisions) Act 2009 established a gun licensing framework (Pike, 2009a). Offences committed inside and outside the state linked to money laundering and the financing of terrorists were targeted, in line with an EU Directive, in the Criminal Justice (Money Laundering and Terrorist Financing) Act 2010. The Communications (Retention of Data) Act 2011 made provision for the providers of fixed and mobile phone and Internet services to disclose data when certain offences, such as customs offences, are being investigated. Public nuisance related to begging near cash machines was addressed through the Criminal Justice (Public Order) Act 2011. The blood alcohol content for drivers was reduced, and provision made for impairment tests to establish if a driver is under the influence

Criminal Justice (Psychoactive Substances) Act 2010

The Criminal Justice (Psychoactive Substances) Act 2010, entered into force in Ireland on 23 August 2010 as a response to a large number of retail outlets, known as ‘head shops’, selling new psychoactive substances not controlled under the Irish Misuse of Drugs Acts, but the effects of which can be similar to those of cannabis or cocaine.

The law makes it a criminal offence to advertise, sell or supply, for human consumption, psychoactive substances not specifically controlled under existing legislation. These are legally defined as substances which have the capacity to stimulate or depress the central nervous system, resulting in hallucinations, dependence or significant changes to motor function, thinking or behaviour. Medicinal and food products, animal remedies, intoxicating liquor and tobacco are excluded.

Under the law, high-level police officers can intervene quickly by serving a ‘prohibition notice’ on an offender. If the offender does not comply with it, the courts can issue a ‘prohibition order’. Selling, advertising and non-compliance with a prohibition order are punishable by up to five years in prison. However, no offence or punishment is set out for the users of these substances (Reitox National Focal Point, 2010). Following the adoption of the new law, the number of head shops fell from more than 113 to 19 during 2010, with the remaining outlets no longer selling such substances (Reitox National Focal Point, 2011).

of drugs in the Road Traffic Act 2010, which came fully into force in 2011 (Reitox National Focal Point, 2011).

The delivery and coverage of established treatment and harm reduction services was addressed in the new drugs strategy. A review was sought of the 1998 methadone treatment protocol to maximise treatment availability (Department of Community, Rural and Gaeltacht Affairs, 2009). The external review commissioned by the Health Service Executive recommended altering the protocol to provide for buprenorphine as a treatment and the delivery of level 1 methadone treatment to be part of the criteria for becoming a general practitioner and the number of level 2 doctors — treatment initiators — to be increased alongside the number of patients they can treat, from 35 to 50 (Farrell and Barry, 2010; Reitox National Focal Point, 2011). A call was also made to expand needle and syringe exchange programmes through the establishment of services in 65 locations through community pharmacies (Alcohol and Drug Research Unit, 2009; Department of Community, Rural and Gaeltacht Affairs, 2009).

Mirroring events in the earlier periods of Irish drug policy, a series of changes were made to the drug policy coordination structures. Like the impact of the Strategic Management Initiative in the mid 1990s, these changes were influenced by a 2008 review of the Irish public service by the Organisation for Economic Cooperation and

Development (Alcohol and Drug Research Unit, 2009; OECD, 2008). The Cabinet Committee on Social Inclusion's remit was adjusted and it was renamed the Cabinet Committee on Social Inclusion, Children and Integration. Reflecting the networked organisation model set out by the OECD review, the Drugs Strategy Unit and the National Drugs Strategy Team were combined into a new structure, the Office of the Minister for Drugs, led by the minister of state for drugs policy (Alcohol and Drug Research Unit, 2009; OECD, 2008; Pike, 2008). Designed as an integrated

Drug policy coordination in Ireland

Drug policy is part of the remit of the Cabinet Committee on Social Inclusion, Children and Integration, chaired by the Taoiseach (Prime Minister) and comprised of 14 ministers. Its function is to provide a strategic and integrated approach to social exclusion issues. The minister of state with responsibility for the national drugs strategy and senior civil servants from the Oversight Forum on Drugs attend its meetings.

The Department of Health has overall responsibility for the national drugs strategy. Its Drugs Policy Unit manages the implementation of the strategy and is responsible for the Oversight Forum on Drugs. The Drugs Programme Unit manages and administers the allocation of funds for the Drugs Initiative Programmes undertaken in drugs task force areas and manages the work of the Drugs Advisory Group. The head of the Drugs Policy Unit acts as National Drug Coordinator at the administrative level, while the minister of state with responsibility for the national drugs strategy functions as drug coordinator at the political level.

The Oversight Forum on Drugs operates at the inter-departmental level, with representatives from all departments, agencies, the community and voluntary sectors involved in delivering the national drugs strategy. Meeting four times a year, the Forum reviews the implementation of the strategy and proposes solutions to problems, providing top-level monitoring of the area.

The Drugs Advisory Group is tasked with advising the minister of state with responsibility for the national drugs strategy on policy and operational issues. Comprised of statutory, community and voluntary sector representatives, it supports the work of the drugs task forces.

The National Advisory Committee on Drugs, attached to the Department of Health, is a non-statutory body tasked with conducting, commissioning and analysing research and advising government on policy developments.

Fourteen local and ten regional drugs task forces are involved in the creation of strategies and service development and delivery at the local level. They include members from the statutory, community and voluntary sectors (Alcohol and Drug Research Unit, 2007; Pike, 2011; Reitox National Focal Point, 2011). In 2012, a review of the task forces and the national structures governing them was completed. It recommended that they be renamed 'drug and alcohol task forces', to reflect their role in addressing both drug and alcohol problems, and the Drugs Advisory Group be reconstituted as the National Coordinating Committee for Drug and Alcohol Task Forces (Department of Health, 2012b).

coordination system, the Office was made responsible for overall coordination, policy development and management of the drugs task forces (Department of Community, Rural and Gaeltacht Affairs, 2009; Pike, 2008). It was supported in its work by the Drugs Advisory Group, including members from the community and voluntary sectors, to advise on drug strategy operational and policy matters. The new strategy also triggered change in the Inter-Departmental Group on Drugs, which was remodelled as the Oversight Forum on Drugs and designed to support an integrated approach to coordination (Alcohol and Drug Research Unit, 2009; Connolly et al., 2009; Department of Community, Rural and Gaeltacht Affairs, 2009; Pike, 2009b).

March 2011 saw further changes to drug policy coordination, following a change of government. Drugs policy was transferred back to the Department of Health, where it was until the mid 1990s before responsibility for the area was moved to other departments that dealt with local and community development (Pike, 2012). The Office for the Minister of Drugs was closed, while two new structures, the Drugs Policy Unit and the Drugs Programme Unit assumed its functions for drug policy and operational issues. Other structures — the Oversight Forum on Drugs, the Drugs Advisory Group, the local and regional drugs task forces and the National Advisory Committee on Drugs — were retained (Connolly et al., 2012; Reitox National Focal Point, 2011) (see the box ‘Drug policy coordination in Ireland’).

Conclusions

While there are many differences in how national drug policies have developed in Europe, the Irish example provides a timeline that reflects some of the broad changes that have taken place in this field. Until the late 1960s, in contrast to the comprehensive policies that are common today, national drug policies in Europe were often more of a compilation of laws and a few measures, coupled with sporadic mental health initiatives. Following an increase in drug-related problems in the late 1960s and throughout the 1970s, modern policies began to emerge in the form of dedicated laws reflecting UN drug conventions and of more specific drug services, which were typically abstinence-orientated residential facilities. This first modern drug policy model came under strong pressure with escalating heroin problems and the spread of HIV among injecting drug users during the 1980s. Consensus among policymakers and other stakeholders on the direction of the action taken in supply reduction appears to have resulted in the development of specialised police forces and new laws to fight organised crime. Drug-demand reduction interventions, however, especially the more controversial harm reduction measures, have often arisen from initiatives at the local level, only becoming endorsed and institutionalised at national level many years later. The achievement of a balance, where supply and demand reduction (including harm reduction) have, at least symbolically, similar weight, took time to develop and to form the national drug strategies that emerged in Europe in the 1990s and 2000s. The public health impetus that drove some of these changes in drugs policy will also, nowadays, raise the question of how drug and alcohol policies can be better linked. Additionally, the development of the 'legal highs' phenomenon triggers new legislative developments, which often focus on those who sell these substances and not on those who use them.

Ireland's drug policy has, however, many distinctive features. One of them is the drug problem itself, which grew rapidly from the early 1980s on, was mainly located in poor areas of the capital city and, at times, linked with violence and public demonstrations. This situation contributed to the impetus for government action in the drugs sphere, which developed at the local level before being fully endorsed, following some delay, in a national policy document. The policy shift that occurred in 1996, and was consolidated in 2001, was a combination of many factors, some of which were outside the realm of drug policy. These included the adoption of the Strategic Management Initiative (i.e. New Public Management) agenda and a partnership approach to public policy aimed at increased stakeholder involvement. The former gave a new expression to drug policy (clear objectives and the use of indicators), while the latter facilitated the involvement of stakeholders with different views in implementing the policy. In addition, the influence of drug policy at the EU

Ireland's drug situation

The Irish drug situation is characterised by a level of drug use in the general population that is often close to the European average. For example, last-year cannabis use among young adults (aged 15–34) was 10.3 % in 2010/11, below the current European average of 12.4 %. The Irish figure for last-year cocaine use among 15- to 34-year-olds was 2.8 % in 2010/11, compared to an estimated current average of 2.1 % for the European Union and Norway. In terms of trends, general population surveys show a stable situation regarding both cannabis and cocaine use among adults in Ireland. However, among 15- to 16-year-old school students, the number reporting having ever used cannabis decreased from 39 % in 2003 to 18 % in 2011 (EMCDDA, 2012a).

The most recent (2006) estimate of the number of problem opioid users in Ireland had a central value of 20 790, which represents 7.2 cases per thousand population aged 15–64 and is above the estimated European average of 4.2 cases per thousand. The latest estimate of the number of drug-induced deaths (overdoses) in Ireland was 203 cases in 2009, and represents about 65 cases per million population aged 15–64, with a European average rate of about 20 cases. The number of newly diagnosed HIV cases among drug users (4.9 per million population in 2010) is also above the European average (2.54 cases per million), but it has been showing a downward trend in recent years.

Every year, Irish law enforcement bodies confiscate large quantities of cannabis products, with, in 2010, the quantity of herbal cannabis seized (913 kg) exceeding that of cannabis resin (748 kg). Seizures of cocaine and heroin fluctuate from about 5 kg to 330 kg a year for each of the substances, with the exception of 2007, when almost 2 tonnes (1 752 kg) of cocaine was seized.

See EMCDDA (2012b) for further information.

and UN levels also played a role in shaping the expression of drug policy in national strategies (Pike, 2008).

Like many European countries, drug policy coordination has been developed at three broad levels in Ireland: the inter-departmental (or inter-ministry), the operational, and the regional or local. Several phases of structural change in these mechanisms have taken place. At times, this has been linked to changes in government and how drug policy's relationship with other policy areas, such as community development and social inclusion, was framed (Pike, 2008). Despite these shifts, the underlying approach to working with different sectors and maintaining three levels of coordination has remained relatively stable, with structures initially at the local and later the regional levels taking on increased importance from the mid 1990s onwards. The Irish model of drug treatment also evolved in a pragmatic and comprehensive way towards the end of the 1990s. This is evident from its expansion through the development of prescribing guidelines for methadone maintenance, coupled with increased utilisation of the established primary care network — family

doctors and community pharmacists — to deliver drug treatment. Importantly, this system has been consistently complemented by community and voluntary sector service provision, particularly in terms of harm reduction and low-threshold services.

Today's Irish drugs policy may be viewed as balanced, with strong supply and demand reduction features, expressed in a managerial style that seeks to generate a high level of consensus through stakeholder involvement, building on internationally established best practices. Changes in the drug situation, which have seen the drug problem spread across the country during the 2000s, within a climate of national and international economic difficulties have created a context in which this policy model and the problems it responds to may undergo further changes. One of them may be establishing a national substance misuse strategy, covering illicit drugs and alcohol. However, the merits and feasibility of this approach are still being reviewed.

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The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is one of the European Union's decentralised agencies. Established in 1993 and based in Lisbon, it is the central source of comprehensive information on drugs and drug addiction in Europe. The EMCDDA collects, analyses and disseminates factual, objective, reliable and comparable information on drugs and drug addiction. In doing so, it provides its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA Drug policy profiles aim to describe some of the main characteristics of national drug policies in Europe and beyond. The profiles do not attempt to assess these policies, but instead outline their development and main features. The objective is to help readers — from researchers to policymakers — gain a better understanding of the way in which countries control drugs and respond to drug-related security, social and health problems.



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