

drugnet Ireland

Newsletter of the Drug Misuse Research Division

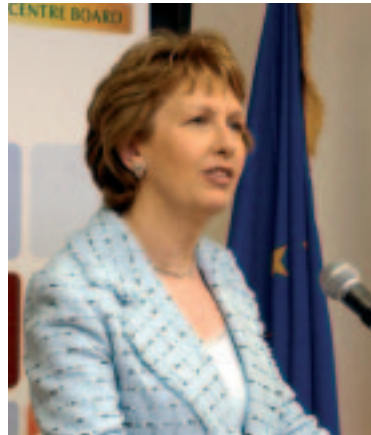
Issue 11, June 2004

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Welcome to Issue 11 of *Drugnet Ireland*, the newsletter of the Drug Misuse Research Division of the Health Research Board. The role of this publication is to disseminate information, news and research findings among those involved in the drugs area in Ireland.

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The Drug Treatment Centre Board celebrates 35 years



President Mary McAleese speaking at the DTCB's 35th anniversary celebrations (Photo: Fennell Photography)

On 18 May last President Mary McAleese attended the 35th anniversary celebrations of the Drug Treatment Centre Board (DTCB) in the centre's premises at Trinity Court, Dublin. The centre is the longest-established treatment service for drug users in Ireland. President McAleese welcomed the opportunity to thank the Board, management and staff for their effort over the last 35 years, and acknowledged the number of lives the centre had helped change: 'Many thousands of individuals and families have cause to be grateful to you for the treatment, counselling, support and hope you have brought to lives skewed out of kilter by addiction and drug abuse.' She noted that the approaches to treatment

ranged from an abstinence-only approach to those including substitution therapy and services to support the families of drug users. She said that this work had strengthened the individual, the family, the community and the country. She commended individuals with problem drug use for their courage in seeking and continuing in treatment.

The National Drug Advisory and Treatment Service, now known as The Drug Treatment Centre Board (DTCB), was established in 1969. The service was originally located at the 'Charitable Infirmary', Jervis Street Hospital, Dublin 1, which was established in 1718 as the first voluntary hospital in Ireland. The current chairman of the DTCB, Mr Denis McCarthy, is from a long line of family members who have held the chair of the Charitable Infirmary (now known as the Charitable Infirmary Charitable Trust) since 1909.

After the closure of Jervis Street Hospital in 1987, the Drug Treatment Centre Board was set up by statutory instrument in 1988 and moved to new premises at Trinity Court, 30-31 Pearse Street, Dublin 2. The centre has undergone considerable change over the last 35 years and now has a staff of 110, including doctors, nurses, psychotherapists, counsellors, family therapists, childcare workers and laboratory staff. The DTCB provides on-site hepatitis C testing and its laboratory is the largest specialist drug-screening facility in Ireland, running in excess of one million tests annually. Inpatient detoxification facilities are located at St Michael's Ward, Beaumont Hospital, Dublin (10-bed unit) and at Cuan Dara, Cherry Orchard Hospital, Dublin (17-bed unit). In 2002 there were circa 98,340 attendances at the DTCB.

President McAleese paid tribute to all those who had worked in the DTCB since its earliest days, and continued, 'I hope that on this day when we look back over those years and see the difficult journey already successfully travelled, you will find the self-confidence and renewed sense of vocation necessary to face the awesome scale of what lies ahead.' She stated that drug misuse has become a part of our society and interventions to tackle this problem would be required into the future.

The Drug Treatment Centre Board provides a national Drug Analysis Laboratory service which supports treatment policy, and monitors trends which supports service planning and best practice in the treatment of drug misuse. (*Damien Walshe*)



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Trends in drug use among young people

Two recently published surveys examine prevalence and patterns of both licit and illicit drug use in post-primary school students in two health board areas. Both surveys are in fact follow-ups to earlier surveys, so they provide a valuable insight into drug use trends among young people. Each survey will be discussed in turn in this article.

North Eastern Health Board survey



In November 2003 the Department of Public Health in the North Eastern Health Board (NEHB) published the results of a survey on smoking, alcohol and drug use among young people in Counties Cavan, Monaghan, Louth and Meath.¹ The survey, which was carried out in 2002, covered post-primary

school students aged 12–19 years. Using a multistage stratified random sampling method, the researchers surveyed a total of 1,426 students from 24 schools. The anonymous questionnaire used in the survey (administered in the classroom setting by a research officer) allowed comparisons with a previous school survey in the NEHB in 1997.

In terms of illicit drug use, the survey found that 41 per cent of students had taken at least one illicit drug² in their lifetime. This was six per cent higher than in the 1997 NEHB survey. In 2002, more girls than boys reported that they had ever taken an illicit drug (boys 41 per cent, girls 42 per cent), compared to 1997 (boys 37 per cent, girls 32 per cent). The large increase in lifetime prevalence of any illicit drug for girls is a cause for concern since it may reflect a growing willingness to experiment with drugs.

Cannabis was the most commonly used illicit drug. Thirty-one per cent of students reported using cannabis at some stage in their lifetime, an increase of over six per cent since the previous survey (see table below). Just under thirteen per cent stated that they had used cannabis in the past month, an increase of over three per cent since 1997.

Cannabis use	NEHB (1997) %	NEHB (2002) %
During lifetime	24.6	31.0
During last month	9.4	12.8

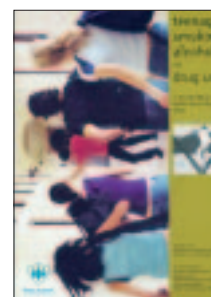
Inhalants (glue, aerosols, etc.) were the second most commonly used drugs in the north east region. Lifetime and last month use of inhalants was higher in 2002 than in 1997 (see table below).

Inhalant use	NEHB (1997) %	NEHB (2002) %
During lifetime	18.9	21.8
During last month	2.0	2.5

Results from the 2002 survey suggest that younger people were being approached with offers of drugs more so than in 1997 and the person offering these drugs was someone that their friends knew or was their best or very good friend. This latter finding highlights the potential influence of peers in the use of drugs and points to the need for strategies aimed at facilitating young people to identify and resist peer influences.

Another notable finding from the survey was the relationship that emerged between smoking, alcohol consumption and illicit drug use. Regular smokers (smoking at least one cigarette per day) were more likely to have been offered illicit drugs or to have taken an illicit drug: they were more than six times more likely to report using an illicit drug in the last month than were non-smokers. The same pattern was also apparent among regular drinkers (consuming one or more alcoholic drinks per week), though not as strong as for regular smokers. The report notes that these findings ‘point to the potency of alcohol and, especially, tobacco in illicit drug use and serve as support for considering these substances as gateway drugs.’ The report goes on to stress that ‘gateway drugs do not necessarily cause young people to use harder drugs, but using these substances may set up patterns of behaviour that may make it easier to progress to using other drugs or may result in young people frequenting places where they can get or be offered illicit drugs’.

Mid-Western Health Board survey



In January 2004 the Department of Public Health in the Mid-Western Health Board (MWHB) published a survey of smoking, alcohol and drug use by teenagers in Counties Clare, Limerick and Tipperary NR.³ The survey, which was carried out in 2002, covered post-primary school students aged 13–19

years. Using a multistage stratified random sampling method, the researchers surveyed a total of 2,297 students from 23 schools. The anonymous questionnaire used in the survey (administered in the classroom setting by the researchers or by teachers) allowed comparisons with a previous school survey in the MWHB in 1988. The report’s findings are based on valid responses from 2,279 students.

In terms of drug use, the survey found that 39 per cent of students had used at least one drug⁴ in their lifetime. This was almost ten per cent higher than in the 1998 MWHB survey. Cannabis was the most commonly used illicit drug: 29 per cent of students reported using cannabis at some stage in their lifetime, again an increase of almost ten per cent since the previous survey (see table below). Fifteen

Results from the 2002 survey suggest that younger people were being approached with offers of drugs more so than in 1997

Trends in drug use among young people (continued)

per cent of students stated that they had used cannabis in the month prior to the survey, an increase of seven per cent since 1998.

Cannabis use	MWHB (1998) %	MWHB (2002) %
During lifetime	19.0	28.6
During last month	8.4	15.4

Inhalants (glue, aerosols, etc.) were the second most commonly used drugs in the mid-west region and both lifetime and last month use increased since 1998 (see table below).

Inhalant use	MWHB (1998) %	MWHB (2002) %
During lifetime	13.6	21.3
During last month	2.7	6.4

Most students in the 2002 survey indicated that cannabis was the first illicit drug they had used, that a friend was the main source of this drug and that 'curiosity' was the main reason why they chose to experiment with drugs. In 1998 the most common reason for experimenting with drugs was 'everyone else does it'. These findings highlight the potential influence of peers in the first use of drugs.

In terms of alcohol use in the MWHB, lifetime prevalence rates for alcohol consumption were higher in the 2002 than in the 1998 survey (90 per cent compared to 82 per cent). However, the current (last month) drinking rate in 2002 was lower than in the previous survey (62 per cent compared to 68 per cent). While the drop in current alcohol consumption is encouraging, it was found that the rates of both lifetime and last month alcohol use were higher among girls than boys. This was a reversal of the pattern found in the 1998 survey and is a cause of concern.

The most popular alcoholic drinks with male students were beer and cider, while females preferred alcopops and spirit-based drinks. When asked about drinking five or more drinks in a row in the past 30 days (binge drinking), 44 per cent of students reported having done so; 23 per cent of students reported indulging in binge drinking on three or more occasions during the past 30 days, which is regarded internationally as 'rather intensive alcohol consumption'.⁵ The frequency of binge drinking increased with age. The report notes that alcohol use by school-going teenagers in the mid-west region is still at 'undesirable levels' particularly in light of the fact that 85 per cent of students were under the legal drinking age. (Hamish Sinclair)

A key performance indicator under the prevention pillar of the National Drugs Strategy 2001 – 2008 is to bring drug misuse by school-goers to below the EU average and, as a first step, to reduce the level of substance misuse reported to the European School Survey Project on Alcohol and Other Drugs (ESPAD) by school-goers by 15 per cent by 2003 and by 25 per cent by 2007 (based on 1999 ESPAD levels). The results of the 2003 ESPAD survey should be available later this year.

The reports, *Teenage smoking, alcohol and drug use in the Mid-Western Health Board region 2002* and *Smoking, alcohol & drug use among young people*, are both available on the National Documentation Centre website at www.hrb.ie/ndc

1. Flanagan E, Bedford D, O'Farrell A and Howell F (2003) *Smoking, alcohol & drug use among young people*. North Eastern Health Board: Department of Public Health.
2. Includes cannabis, inhalants, ecstasy, speed, magic mushrooms, cough syrup, cocaine, LSD, heroin and barbiturates (note: not all these drugs are illicit).
3. Kelleher K, Cowley H and Houghton F (2004) *Teenage smoking, alcohol and drug use in the Mid-Western Health Board region 2002*. Mid-Western Health Board: Department of Public Health.
4. Includes cannabis, inhalants, ecstasy, magic mushrooms, tranquillisers without prescription, amphetamines, crack, cocaine, heroin and LSD.
5. Hibell B *et al.* (2000) *The 1999 ESPAD Report. Alcohol and other drug use among students in 30 European countries*. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN), Co-operation Group to Combat Drug Abuse and illicit Trafficking in Drugs (Pompidou Group) at the Council of Europe.

Young people debate drug and alcohol abuse

In November 2003 the annual Dáil na nÓg,¹ or Irish Youth Parliament, debated drug and alcohol abuse. The delegates concluded:

- We need more facilities, leisure centres, discos, youth clubs and other alcohol-free activities.
- Information and education is too late or not at all – we need campaigns on drugs and alcohol from primary school up.
- We want advertising to highlight the dangers of drug and alcohol abuse.
- We need support to overcome peer-pressure.
- Alcohol is part of our culture – adults need to change too.

The Minister for Children, Brian Lenihan TD, told the delegates that the lack of non-pub entertainment facilities for teenagers was a major national issue and guaranteed delegates that a recreation policy for 12–18-year-olds would be prepared by the National Children's Office (NCO).²

As a preliminary step, the NCO called for proposals for research contributing to the development of a recreation and leisure policy for young people aged 13–17 years. The NCO has also called for research proposals in relation to youth homelessness in Ireland. These calls for research proposals closed on 12 May 2004. (Brigid Pike)

¹ Arising out of the National Children's Strategy and in line with Article 12 (1) of the UN Convention on the Rights of the Child, Dáil na nÓg, the Irish Youth Parliament, was established in 2001 to provide an annual national forum where young people and children can raise and debate issues of concern, under the auspices of the Minister for Children. A report on the outcome of Dáil na nÓg is submitted to the Cabinet Committee on Children, which is chaired by the Taoiseach. For further information see the Dáil na nÓg website at www.dailnanog.ie

² The National Children's Office (NCO) was established in 2001 to improve all aspects of children's lives by leading and supporting the implementation of the National Children's Strategy – Our Children Their Lives. For further information see the NCO website at www.nco.ie

CityWide Drugs Crisis Campaign



In March 2004, CityWide Drugs Crisis Campaign published a report entitled *Cocaine in local communities: survey of community drug projects*.¹ This survey was carried out in response to the growing concern expressed by community groups across Dublin in relation to the emerging cocaine problem in

many parts of the city. The authors surveyed community drug projects to establish whether cocaine users were being treated by local services and, if so, what services were offered to them and what additional services needed to be developed.

Questionnaires were sent to 59 community drug projects requesting information about cocaine use among clients of services and within communities. Although the response rate was low (46 per cent), the projects that participated in the study represented each task force area within Greater Dublin and that of Dun Laoghaire–Rathdown. The non-respondents may manage drug projects where cocaine use is not a problem, and therefore did not complete the questionnaire, leading to a reporting bias.

Twenty-five (93 per cent) of the 27 respondents claimed that some existing clients were using cocaine. Three-quarters of the project participants estimated that between 10 and 50 per cent of their

clients were using cocaine. However, it is unclear from the report whether or not this cocaine use was problematic. All of the project workers who took part in the study said that they were aware of people living in their communities who were using cocaine but not currently seeking treatment at their services. Fifty-eight per cent of the project workers noted that cocaine use was on the increase among young people. Almost one-third of the respondents claimed that cocaine was cheap and easily available, while one in four could identify where cocaine was being sold. Two project participants noted that there was a significant difference in the price of cocaine being sold in different parts of their communities. Three stated that heroin supplies were decreasing in their areas while cocaine was on the increase. One-fifth of the respondents viewed cocaine as a social drug that was being used by people who had not used drugs in the past.

The report outlines the implications cocaine has for the users and their families and for the wider community.

Individuals

- Fifty-two per cent of the project workers reported that cocaine use caused clients to become aggressive and agitated, resulting in difficulties for staff.

CityWide Drugs Crisis Campaign

(continued)

- Almost two-fifths of the respondents reported that the 'high' from cocaine does not last very long; clients therefore use cocaine more frequently, which has cost implications.
- Fifteen per cent of project workers reported that clients were becoming involved in crime in order to cover the costs of their cocaine use.
- Twenty-two per cent of the participants reported that clients presented with mental health problems.
- A number of project workers, particularly those in the south inner city and Ballyfermot, reported that clients injecting cocaine combined with heroin were developing deep vein thrombosis (DVT) and abscesses.

Families

- Thirty per cent claimed that parents of cocaine users were extremely worried and unsure of how to deal with the problem.
- Project respondents in Dublin 8 claimed that families had no option but to leave the area because of cocaine-related debt or anti-social behaviour.
- Some project workers reported an increase in the number of young people forced to leave home because of their cocaine use.
- Respondents reported that cocaine can also have a negative impact on the children of users; for example, in the Dublin 8 area a small number of children had been put into care because of their parents' excessive cocaine use.

Communities (Figure A)

- Fifty-eight per cent of project workers reported increases in petty crime, dealing and other anti-social behaviour within their community,
- Eight per cent of project staff cited recreational cocaine use as causing work-related problems for a number of people living in the area.

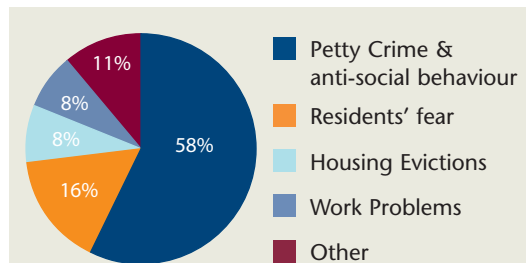


Figure A Negative experiences of cocaine use on local communities reported by project respondents

Source: CityWide Drugs Crisis Campaign March 2004

The lack of services available to cocaine users was of particular concern to those who participated in the study

The lack of services available to cocaine users was of particular concern to those who participated in the study. According to the report, almost one in five respondents said that they had no services for cocaine users; however, the majority of projects did provide some services. These included: acupuncture, yoga, reiki, relaxation methods, Indian massage, and home detoxification through acupuncture and acupressure. Almost 60 per cent of the projects provided counselling, while 45 per cent provided harm reduction services specifically for cocaine users. Fourteen per cent provided practical support, such as laundry, bathing facilities and nursing care. Half of the project workers claimed that they were not aware of any other service available to treat cocaine use in their area. Project workers stated that they would be interested in providing:

- Alternative therapies specifically for cocaine users;
- Cocaine-specific education programmes;
- Respite for cocaine users;
- Detoxification programmes.

However, in order for such services to be developed, project workers felt that they would need additional training and an increase in staffing and funding, and evidence of political will to tackle the issue. The findings of this study support the findings reported by the National Advisory Committee on Drugs in its overview of cocaine use in Ireland.⁵ (Fionnola Kelly)

1. CityWide Drugs Crisis Campaign (2004) *Cocaine in local communities: survey of community drug projects*. Dublin: CityWide Drugs Crisis Campaign.

2. National Advisory Committee on Drugs (2003) *An overview of cocaine use in Ireland*. Dublin: The Stationery Office.

Drug use among marginalised young men

In early 2004 The Katharine Howard Foundation published a report examining the issue of homelessness among young men in the context of the wider issue of marginalisation among men in contemporary Ireland. Entitled *Young men on the margins*, the report was written by researchers from the Social Science Research Centre at University College Dublin, with Anne Cleary as project director. One of the main objectives of the research was to gain an understanding of how and why some men end up and remain homeless.

Using a qualitative approach, the researchers conducted in-depth semi-structured interviews over a period of two months with twenty men aged 18–30 years attending a drop-in centre for homeless men in Dublin. A high prevalence of substance misuse was found in this sample of men. Thirteen participants were, or had been, addicted to heroin, seven were current intravenous (IV) heroin users, six were on methadone maintenance programmes, and one of these was also addicted to alcohol. Two men were described as having alcohol problems. One participant had been addicted to ecstasy, but was now clear, and one young man was a heavy cannabis user. Several participants reported polydrug use, using a mixture of benzodiazepines, sleeping tablets, Valium, alcohol and heroin.

The majority of participants reported engaging in drug use prior to becoming homeless and some reported that this behaviour had caused them to become homeless. Many explained that they were removed from the home by relatives unwilling to endure their anti-social behaviour around drug use and criminal activity. Some criminal activity was directly related to securing money to buy drugs. The experience of homelessness led to more chaotic drug use for some, with progression to heroin use tending to follow their becoming homeless. A consequence of this progression was that drug use now became the main obstacle for most participants wishing to move out of homelessness. In addition, a number of participants had experience of overdosing leading to hospitalisation. However, this did not deter them from using drugs.

Many participants had experience of trying to stop using drugs; 16 men reported undergoing some form of detoxification for their drug use. However, criticism was voiced of existing drug treatment services, long waiting lists and difficulty in securing treatment without a fixed address were cited. These were viewed as major barriers to progression out of homelessness. In addition, some participants expressed concern about substituting methadone maintenance for their heroin addiction, as they had a negative perception of the symptoms of withdrawal from methadone.

A positive message for policy makers and practitioners emerged from the research. Most participants remained orientated towards important social goals. For example, many expressed their need to regain 'normality' in their lives through the restoration of broken relationships with ex-girlfriends and their hopes of becoming fathers. This is an important theme to emerge from this research, for it indicates the value of some form of family unit to marginalised men who are homeless and using drugs. For policy makers and practitioners alike, the restoration of damaged family bonds among marginalised men with drug problems needs to be discussed alongside other social inclusion measures such as accommodation, education/training and employment initiatives.

The current report is a valuable addition to the existing research on drug use among the homeless. For example, Houghton and Hickey² and Halpenny *et al.*,³ looking at homeless families in emergency accommodation, also found that drug misuse was reported to be a major contributory factor to becoming homeless in the first instance. Smith *et al.*⁴ found that homeless women in emergency accommodation reported engaging in a high level of polydrug use, including injecting heroin, during their homeless experience. Although these studies focused on different groups of participants, drug misuse as a major contributor to becoming and remaining homeless is clearly a dominant theme. (Martin Keane)

1. Cleary A, Corbett M, Galvin M and Wall J (2004) *Young men on the margins*. Dublin: Katharine Howard Foundation.
2. Houghton FT and Hickey C (2000) *Focusing on B&Bs: the unacceptable growth of emergency B&B placement in Dublin*. Dublin: Focus Ireland.
3. Halpenny AM, Keogh AF and Gilligan R (2002) *A place for families? Children in families living in emergency accommodation*. Dublin: Homeless Agency.
4. Smith M, McGee H and Shannon W (2001) *One hundred homeless women: health status and health service use of homeless women and their children in Dublin*. Dublin: Royal College of Surgeons in Ireland.

The geographical distribution of drug use in Ireland

On 19 April the National Advisory Committee on Drugs (NACD) and the Department of Health, Social Services and Public Safety (Northern Ireland) published jointly the second bulletin of results from the 2002/2003 all-Ireland general population drug prevalence survey. Bulletin 2 presented drug, alcohol and tobacco use rates for each Health Board in Ireland and Health and Social Services Board in Northern Ireland. Minister of State at the Department of Community, Rural and Gaeltacht Affairs with responsibility for drugs strategy, Mr Noel Ahern TD, launched the findings.

The Irish drug prevalence survey followed best practice guidelines recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The questionnaire, based on the 'European Model Questionnaire', was administered through face-to-face interviews with respondents aged between 15 and 64 years normally resident in households in Ireland and Northern Ireland. The survey was undertaken by MORI MRC during late 2002 and early 2003. The final achieved sample was 4,925 in Ireland and 3,517 in Northern Ireland. This represents a response rate of 70 per cent in Ireland and 63 per cent in Northern Ireland.

One interesting finding from the publication is that the pattern of current cannabis use (used in last 30

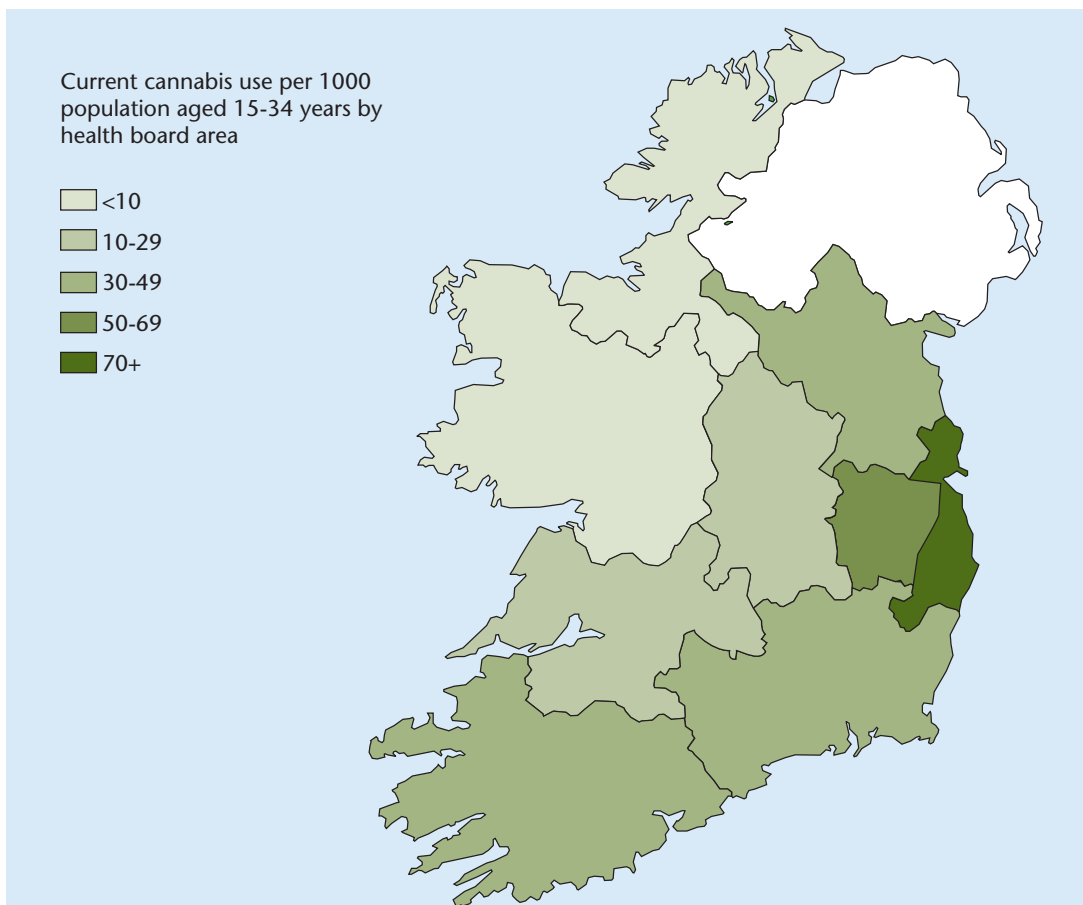
days) among young adults (15–34 years) by health board area in Ireland displays a clear east to west gradient (see map).

Drug prevalence surveys of the general population are important in that they can shed light on the patterns of drug use, both demographically and geographically and, if repeated, can track changes over time. They help to increase our understanding of drug use, and to formulate and evaluate drug policies. They also enable informed international comparisons provided countries conduct surveys in a comparable manner.

The survey was commissioned by the National Advisory Committee on Drugs (NACD) and the Drugs and Alcohol Information and Research Unit (DAIRU) within the Department of Health, Social Services and Public Safety in Northern Ireland. *(Hamish Sinclair)*

Bulletin 2 of the 2002/2003 Drug Prevalence Survey is available on the NACD website at www.nacd.ie

EMCDDA guidelines for drug prevalence surveys are available on the EMCDDA website at www.emcdda.eu.int



Epidemiology of hepatitis C among drug users in Ireland

Brennan and colleagues¹ published a paper entitled 'Epidemiology of Hepatitis C in Ireland' in *EPI-INSIGHT* in May 2004. The authors collated information on hepatitis C from a variety of sources. In Ireland there is no estimate of the prevalence of hepatitis C among the general population. According to the Irish Blood Transfusion Service,¹ the prevalence of hepatitis C among new donors decreased from 0.06 per cent in 1997 to 0.01 per cent in 2004; this decrease reflects changes in eligibility criteria for blood donation rather than a true decrease among the population. The prevalence of HIV and hepatitis B among the general population was three times that among new blood donors living in Dublin. There is no reason not to believe that a similar risk ratio between new blood donors and the general population exists for hepatitis C.

The prevalence estimates among injecting drug users attending community-based drug services range between 52 per cent and 84 per cent (Table 1).²⁻⁶ Hepatitis C is endemic among injectors in prison; the prevalence of hepatitis C antibodies

among injector-inmates and entrants was 81 per cent⁷ and 72 per cent⁸ respectively (Table 1).

Allwright *et al.*⁷ and Long *et al.*⁸ (2001) reported that injecting drug use was the most important risk factor for hepatitis C. Allwright *et al.*⁷ (2000) and Smyth *et al.*⁹ (2003) reported that spending time in prison prior to testing was associated with an increased risk of testing positive for hepatitis C antibodies. Length of time injecting appears to be strongly associated with contracting the infection.^{2,3,4,7} For example, among drug users attending Trinity Court Drug Treatment Centre the prevalence of hepatitis C was 52 per cent among those injecting for less than 25 months, compared to 84 per cent among those injecting for 25 months or more. Also, the prevalence of hepatitis C was 65 per cent among prison inmates injecting for less than 36 months, compared to 85 per cent among those injecting for 36 months or more.² Injecting practices such as injecting frequency and sharing needles were also associated with testing positive for hepatitis C.^{7,8}

Table 1 Review of studies estimating the prevalence of hepatitis C among injecting drug users in Ireland

Year published and authors	Study Design	Study population and sample size	Study Findings	Method to ascertain status
1995 Smyth <i>et al.</i> ²	Old and new attendees registered at Trinity Court Drug Treatment Centre, Dublin, August 1992 to August 1993	272 injectors living in Dublin City	Overall prevalence of anti-HCV ^a was 84%.	Status ascertained from serum
1998 Smyth <i>et al.</i> ³	New attendees registered at Trinity Court Drug Treatment Centre, Dublin between 1992 and 1997	735 injectors living in Dublin City	Overall prevalence of anti-HCV was 61.8%.	Status ascertained from serum
	1993	160	67.6%	
	1994	177	61.0%	
	1995	152	63.2%	
	1996	118	52.5%	
	1997	116	62.1%	
1999 Smith <i>et al.</i> ⁴	Between 1992 and 1997, new attendees registered at Trinity Court Drug Treatment Centre, Dublin	353 injectors living in Dublin and injecting less than 25 months	Prevalence of anti-HCV was 52.1%.	Status ascertained from serum

Taken together, these data suggest hepatitis C is endemic among injecting drug users and it has serious health consequences which can be seen in both morbidity and mortality statistics

Epidemiology of hepatitis C among drug users in Ireland (continued)

Table 1 (continued) Review of studies estimating the prevalence of hepatitis C among injecting drug users in Ireland

Year published and authors	Study Design	Study population and sample size	Study Findings	Method to ascertain status
2000 Cullen <i>et al.</i> ⁵	Review of records of clients attending methadone substitution clinics in a general practice setting	Injectors and non-injectors (78) living in Dublin, Kildare & Wicklow 535 (of whom 372 had their hepatitis C status recorded)	Of those who had hepatitis C status recorded in their clinical notes, 72.6% had a documented hepatitis C positive status. The primary objective of this study was not to assess prevalence of HIV.	Clinical records
2001 Fitzgerald <i>et al.</i> ⁶	Review of client records attending 5 methadone clinics in Dublin	99, including injectors and non-injectors living in Dublin City	Of those who had hepatitis C status recorded in their clinical notes, 79% had a documented anti-HCV positive status.	Status ascertained from laboratory reports or clinical notes
2000 Allwright <i>et al.</i> ⁷	Cross-sectional survey	Prison inmates Of whom 509 were injectors	81.3% tested positive for anti-HCV.	Status ascertained from oral fluid
2001 Long <i>et al.</i> ⁸	Cross-sectional survey	Prison entrants Of whom 173 were injectors	71.7% tested positive for anti-HCV.	Status ascertained from oral fluid

a Following initial infection with hepatitis C, antibodies to this virus develop on average three months after infection but may take up to six months to develop. The presence of hepatitis C antibodies (anti-HCV) indicates either previous or current infection.

Since 1 January 2004 there is a statutory requirement to notify both laboratory and clinical diagnosis of hepatitis C.¹⁰ Up to the end of 2003, there was a statutory requirement to notify clinical cases of viral hepatitis type unspecified (also known as non A and non B) to the public health departments in each health board. Since mid-2000, the type of hepatitis was notified when hepatitis C was the cause of hepatitis and it was observed that the vast majority of cases had this virus type.¹ From 2001 to 2003, just over 80 cases of hepatitis C were notified each year. In 2002, approximately 85 new cases of hepatitis C were reported to public health departments through the clinical notification system, while the National Virus Reference Laboratory reported 1,233 new hepatitis C antibody cases in the same year. This suggests serious under-reporting of clinical cases, which should be rectified under the new statutory instrument. The notification system does not allow us to identify risk factors so it

is unclear how many of these cases were injecting drug users. This indicates the need for an extended notification process for hepatitis C.

Between 1992 and 1998, Smyth *et al.* estimated the incidence of hepatitis C among 100 injecting drug users who had an initial negative test and a repeat test within 24 months.⁹ The authors reported that the incidence of hepatitis C was 66 per 100 person years (95% CI 51 to 84 per 100 person years); this is 30 per cent higher than estimates reported in injecting drug users living in other countries.

There were 6,085 discharges from acute hospitals with hepatitis C as a primary or secondary diagnosis recorded by the Hospital In-Patient Enquiry Scheme.¹ This scheme is an event-based register so cases may be represented more than once.

Epidemiology of hepatitis C among drug users in Ireland (continued)

Of the 6,085 cases:

- 18 per cent had hepatitis C as a primary diagnosis;
- 57 per cent had chronic hepatitis C;
- 21 per cent had a diagnosis of problem opiate use;
- 7 per cent also had a diagnosis of hepatitis B recorded;
- 24 per cent also had a diagnosis of HIV/AIDS recorded;
- 11 per cent had a diagnosis of chronic liver disease or sequelae;
- 0.4 per cent had a diagnosis of liver cancer.

These data suggest the existence of co-morbidity between blood-borne viruses and the damage that hepatitis C can do to the liver.

Brennan and colleagues¹ requested the Central Statistics Office to select cases where the primary cause of death was hepatitis ICD 9 category 070.4, 070.5 or 070.6. This allowed the authors to calculate the number of deaths with a primary diagnosis of hepatitis C using the diagnoses hepatitis 'other specified' or 'unspecified' as proxy diagnoses. Fifty persons died as a result of hepatitis C between 1995 and 2002. Up to 2001, the numbers for each year fluctuated between three and seven cases, with a rise to 15 cases in 2003. The main risk factors for hepatitis C cannot be identified accurately through mortality data held by the Central Statistics Office. This suggests the need for a special register to record the contribution of hepatitis C to premature mortality among injecting drug users.

Taken together, these data suggest hepatitis C is endemic among injecting drug users and it has serious health consequences which can be seen in both morbidity and mortality statistics. (*Jean Long*)

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9. Smyth B, O'Connor JJ, Barry J, Keenan E (2003) Retrospective cohort study examining incidence of HIV and hepatitis C infection among injecting drug users in Dublin. *Journal of Epidemiology and Community Health*, 57: 310-311.
10. Changes to Notification of Infectious Diseases (January 2003) Accessed at: www.ndsc.ie/IDStatistics/ChangestoNotificationofInfectiousDiseases/

The paper 'Epidemiology of Hepatitis C in Ireland' is available on the National Disease Surveillance Centre website at: www.ndsc.ie/Publications/Hepatitis-viral/HepatitisC

Outreach work

Definition

The outreach worker is the link person between drug users and harm minimisation services. The assumption behind outreach work is that individuals are 'out there' using drugs and not in contact with existing harm minimisation or drug treatment services. These include young 'chaotic drug users', homeless drug users and drug users involved in the sex industry. Outreach work targeting individuals engaging with illicit drug use has tended to focus on these 'hard-to-reach' and 'hidden' populations of drug users. When outreach

work was first introduced, the rationale underpinning this work was that users, once reached, could be persuaded to engage with treatment services. Over time, it became obvious that 'the abstinence approach to treatment' was not always feasible for individuals as a first treatment option. Currently, outreach workers place a strong emphasis on 'a harm minimisation approach to drug use'. According to Korf *et al.* (1999)¹

Outreach work in the drug field is a proactive method used by professionals and trained volunteers or peers to contact drug users. Its

Outreach work (continued)

aims are to inform them about the risks associated with drug taking, to support them in reducing or eliminating such risks, and/or to help them improve their physical and psychosocial circumstances through individual or collective means. (p.85)

Evaluation of outreach work in Ireland

There have been two formal reviews of outreach work with drug users in Ireland. Each review examined different but complementary aspects of outreach services. Between June and December 2002, Bunning² examined the policy, planning and organisation of the services; between December 2000 and October 2001, Corr,³ in partnership with outreach workers, reviewed outreach activities and investigated the immediate effects of these activities on drug-users' practice. The Eastern Regional Health Authority (ERHA) commissioned the evaluation done by Bunning in response to Action 64 of the National Drugs Strategy, while Corr at Merchants Quay Ireland (MQI) completed an internal evaluation.

The main objective of Bunning's review was to examine the role and functioning of outreach services in the drugs and AIDS services in the eastern region. This involved reviewing the outreach service with respect to strategic aims and objectives, general management, service provision, quality control and monitoring systems. The reviewer contacted: clients (20), outreach workers (20), senior outreach workers (4), representatives from community projects (10), and persons employed by the area health boards (21) whose work had links with outreach services. The review was carried out using the following methods:

- Observation of outreach workers during their day-to-day activities, which included home visits, street work, and community-based projects;
- Group interviews with management of the addiction services, health professionals and community groups;
- Individual interviews with outreach workers and clients;
- Focus groups with senior outreach workers;
- Feedback sessions with steering committee.

The reviewer found that there was good commitment from staff across the addiction services to participating in the review. Outreach workers conceptualised their activities as:

Initiating and maintaining contact with those who are not in contact with services, relating to them in an open manner and observing what is going on in the drug scene within different local communities (Bunning 2003: 10)

The reviewer reported that, due to the unprecedented expansion in drug treatment services in the ERHA over the last four years, a lack of strategic planning for outreach had resulted. This meant that outreach work was out of focus and that outreach workers carried out a broad range of tasks that were often based on personal preferences and skills, rather than on clear policy choices or guidelines.

The recommendations for the future development of outreach services within the eastern region include:

- Define a clear mission statement;
- Prioritise primary and secondary tasks based on an allocation of time;
- Develop wider needle-exchange networks that include options such as pharmacies and vending machines;
- Develop clear links between clinical staff, outreach workers and clients;
- Formalise the role of outreach workers as advocates for the clients;
- Organise seminars to stimulate peer education, knowledge transfer and up-skilling;
- Set up an outreach association that will work towards the professional development of outreach staff;
- Provide management training to senior outreach workers;
- Develop a monitoring system that includes quantitative and qualitative indicators;
- Create a steering group to explore innovative approaches to outreach.

The second evaluation was conducted by Corr of the outreach service within Merchants Quay Ireland (MQI). The outreach service was established in the late nineties to reduce the levels of drug-related public nuisance in the immediate locality. MQI is located in the south-west inner city of Dublin. The outreach service targets chaotic drug users in the locality and seeks to change their behaviour in the community through one-to-one interactions. The outreach teams work in pairs to ensure workers' and clients' safety. In order to minimise danger, the outreach workers carry mobile phones and identity cards. The majority of the outreach work is done on the streets. The team works on building rapport with clients and providing information on health issues and accommodation. The team uses motivational interviewing techniques to promote safer drug-using practices among clients. The ERHA and Dublin City Council fund the service jointly.

A combination of quantitative and qualitative methods was used to evaluate the MQI service. Between December 2000 and October 2001, outreach workers completed 'contact sheets' on all

The data presented in this document indicate that outreach workers were successful in contacting hard-to-reach drug users

Outreach work (continued)

clients met each day. In order to place the quantitative data collected in context with the day-to-day realities of outreach work, two outreach workers participated in in-depth interviews. During the 10-month evaluation period, a total of 262 clients were contacted at least once. In total, there were 587 separate contacts with clients; 163 (62%) were contacted once only and 99 (38%) were re-contacted an average of four times. Of those contacted, 31 per cent were female, 52 per cent were aged 24 years or under and 27 per cent were first-time contacts. Three-quarters were homeless at some point during the year. Overall, 88 per cent reported using drugs (other than alcohol) and 96 per cent reported the streets as their most popular location for taking drugs. Of those using drugs, 79 per cent were using heroin. During the 10-month period, the outreach workers collected and disposed of 2,741 needles. The outreach workers reported that among the 99 clients who were met more than once, almost one-fifth had changed to safer drug-using practices and half had adopted less safe practices. In addition, the team reported that approximately fifteen per cent of clients contacted were referred to other drug treatment services. The data presented in this document indicate that outreach workers were successful in contacting hard-to-reach drug users as a large proportion were homeless and half had never been in contact with drug treatment services.

Taken together, these evaluations highlight the need to develop the capacity of outreach staff and enhance the general management of the services. At the same time, the documents present the essential role of outreach workers and the positive outcomes of their work, such as success in locating hard-to-reach populations, an increase in numbers using safer injecting practices and modest numbers referred into treatment. However, it may be useful to explore why 50 per cent of those participating in the Merchants Quay Ireland study developed additional unsafe injecting practices despite receiving safe injecting information. (*Jean Long and Martin Keane*)

1. Korf D, Riper H, Freeman M, Lewis R, Grant I, Jacob E, Mouglin M and Nilson M (1999) *Outreach work among drug users in Europe: concepts, practice and terminology*. Lisbon: EMCDDA.
2. Bunning E (2003) *Outreach in Focus: review of outreach services in the Drugs/AIDS service in the eastern region*. Dublin: ERHA unpublished report.
3. Corr C (2004) 'Engaging the hard-to-reach: an evaluation of an outreach service'. In *Pieces of the jigsaw*. Dublin: Merchants Quay Ireland.

Pieces of the jigsaw is available from Merchants Quay Ireland (see 'Recent Publications' section for details).

Drug consumption rooms

In March 2004, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published a review of the evidence base for the introduction of consumption rooms as part of a harm reduction strategy.

Definition

Consumption rooms are protected places for the hygienic consumption of pre-obtained drugs in a non-judgemental environment and under the supervision of trained health and social care staff. They comprise a highly specialised drugs service within a wider network of services for drug users. Consumption rooms are official services, funded from local or regional budgets or by voluntary organisations. They are distinct from illegal 'shooting galleries', which are run for profit by drug dealers, as well as from consumption facilities provided within the framework of drug prescription programmes, where drugs are supplied to users.

Rationale and objective

Dagmar Hedrich¹ at the EMCDDA reviewed the available literature on consumption rooms. She reviewed 143 articles, written in several European languages, from published and grey literature. The overall rationale for consumption rooms is to reach

and address the problems of specific, high-risk populations of drug users, especially injectors and those who consume in public. These groups have important healthcare needs that are often not met by other services, and pose problems for local communities that have not been solved through other responses by drug services, social services or law enforcement.

According to Hedrich's review, the *specific objectives* of consumption rooms are:

- to establish contact with difficult to reach populations;
- to provide a safe and hygienic environment for drug consumption, and injecting drug use in particular;
- to reduce mortality and morbidity associated with drug use including overdose, as well as transmission of HIV, hepatitis, and bacterial infections;
- to promote other social, health and drug treatment services;
- to reduce public drug use and associated nuisance.

Drug consumption rooms (continued)

Availability and house rules

The author reported that in Europe there are 62 consumption rooms located in 36 cities in four countries, namely, Switzerland, the Netherlands, Germany and Spain. The first consumption room was opened in Berne, Switzerland in 1986. In the early nineties, the first consumption rooms were opened in the Netherlands and Germany, while in 2000 the first was opened in Spain. There are no consumption rooms in Ireland.

In a consumption room, the use of drugs is supervised by staff, who also give advice on risks, educate clients about safer drug use techniques and provide emergency help in case of overdose or other adverse reactions.

General admission criteria are that clients are regular or dependent users of heroin or cocaine and over 18 years old. Occasional or first-time users are excluded. Access controls to consumption rooms are strict, and in many services personalised user cards are issued after formal registration. In some cases, the number of cards is limited to prevent overcrowding. Use of a facility is sometimes restricted to local residents to limit the influx of drug users from other cities.

House rules prohibit drug dealing and specify basic hygiene requirements and safety procedures. Consumption rooms do not advertise, and staff do not help clients inject.

On entry, staff ensure that potential service users meet the admission criteria and make them familiar with house rules. After receiving sterile equipment, clients can use the facility, usually for about 30 minutes (this period applies to facilities that are predominantly used by heroin injectors; cocaine injectors usually require less time). Inside the supervised consumption area, a staff member makes clients aware of health risks and dangerous modes of consumption, observes during consumption and provides safer use advice, for example, on injecting techniques. Other staff are available to provide immediate help in case of an emergency. As most consumption rooms are integrated into wider drugs services, many clients also use other services available on site.

Risks and benefits

According to the author, the expected benefits of consumption rooms are:

- decreased high-risk drug use;
- decreased morbidity and mortality among the target population;
- increased uptake of health and social care including drug treatment;
- reductions in public drug use and neighbourhood nuisance.

Because consumption rooms target those who are not ready for treatment, a major function is to offer other survival-oriented services, including basic medical care, food, drinks, clothes and shelter. The rationale underlying this function is that drug users, as long as they cannot or do not want to stop drug use, should be enabled to survive in the hope that they may at some later stage be able to give up drug use.

The possible risks of these facilities are that their presence:

- encourages increased drug use;
- initiates new users;
- makes drug use more acceptable and comfortable thus delaying initiation to treatment;
- increases public order problems by attracting drug users and drug dealers from other areas.

Effectiveness

Several studies have examined the positive and negative effects of this intervention. Hedrich reviewed the available literature on the effectiveness of consumption rooms and her summary findings are presented in order of the specific objectives of consumption rooms.

Objective 1: Attract difficult to reach drug users

Consumption rooms reach their defined target population, including street users and older, long-term users who have never been in treatment. There is no evidence that they recruit drug users into injecting.

In order to achieve adequate coverage and high rates of regular use, it is necessary to provide sufficient capacity relative to the estimated size of the target population, to locate rooms on sites that are easily accessible and to ensure that opening hours are long enough to meet demand, especially in the evening. Rooms set up to facilitate drug-using sex workers also need to be appropriately situated and remain open in the evening and night.

Given the nature of the target population, it is vital that the 'house style' encourages rather than deters potential clients. This implies that staff need to be sympathetic and non-judgemental towards problematic, marginalised and sometimes difficult clients, yet at the same time be clear and consistent about admission criteria and house rules.

Consumption rooms clearly increase access to drug services and health and social care. In so doing, they promote the social inclusion of a group of extremely marginalised problem drug users

Drug consumption rooms (continued)

Objective 2: Provide a safer injecting environment

Consumption rooms achieve the immediate objective of providing a safe place for lower risk, more hygienic drug consumption without increasing the levels of drug use or risky patterns of consumption.

Health education at consumption rooms encourages sustainable changes in risk-taking behaviour by some clients and contributes to reducing drug-related health damage among a difficult to reach target group.

Objective 3: Decrease the incidence of infection associated with drug use

No conclusions can be drawn about the direct impact on infectious disease incidence owing to a lack of studies and methodological problems associated with isolating the effect of consumption rooms.

Objective 4: Decrease the incidence of drug-related deaths

Where coverage is adequate, consumption rooms may make a contribution to reducing drug-related deaths at a city level.

Objective 5: Increase access to social, health and drug treatment services

Consumption rooms clearly increase access to drug services and health and social care. In so doing, they promote the social inclusion of a group of extremely marginalised problem drug users.

Besides supervision of drug consumption, a range of other services is usually delivered on site. Low-threshold medical care and psychosocial counselling services are especially well used and contribute to the stabilisation of and improvement in the somatic and psychological health of service users.

Consumption rooms make referrals to further services, including drug treatment. For frequent attenders, in particular, the rooms act as a link to the wider system of care. Only a small proportion of clients use the facilities for drug consumption purposes only. The majority at some point make use of other medical, counselling and treatment services.

It is possible that some clients become partly dependent on the services provided through consumption rooms. This is a fairly common observation in many services dealing with marginalised and problematic client groups. There is, however, little evidence to suggest that consumption rooms delay treatment seeking for problem drug use by clients through making drug use more 'comfortable'.

The question of whether consumption rooms conflict with treatment goals, in particular whether they should allow clients in oral methadone treatment to use the rooms for injection, is dealt with in different ways. For example, in Germany, methadone clients are excluded from most consumption rooms; on the other hand, Switzerland takes the pragmatic view that if methadone clients are going to inject anyway it is better that they do so in safe and hygienic circumstances.

Objective 6: Reduce public drug use and associated nuisance

Consumption rooms can reduce the level of drug use in public. The extent to which this is achieved depends on their accessibility, opening hours and capacity to accommodate drug consumption that would otherwise occur in public.

The location of consumption rooms needs to be compatible with the needs of drug users, but also to take account of the needs and expectations of local residents. A reduction in the number of public consumptions can contribute to improvements in the neighbourhood by helping to reduce public nuisance associated with open drug scenes. However, facilities near illicit drug markets are not able to solve wider nuisance problems that result from these markets.

Police actions against drug markets and drug scenes in other neighbourhoods may sometimes increase public order problems near consumption rooms. This implies that, if rooms are to contribute to reducing public nuisance rather than be blamed for aggravating it, there needs to be consultation not only with local residents but also with police, so that action to discourage open drug scenes does not at the same time deter drug users from making use of the facilities.

Consumption rooms have greater impact where there is a political consensus that they are part of a comprehensive local strategy to respond to drug-use-related problems that acknowledges public and individual health objectives as well as the need to maintain an acceptable situation with regard to order and safety in the community.

There is no evidence that the operation of consumption rooms leads to more acquisitive crime.

There is small-scale drug dealing in the vicinity of many services, which is not surprising given their location.

Conclusions

According to the author, the evidence suggests that the benefits of consumption rooms can outweigh the risks. It is important to set this in the wider context of problem drug use and of responses to it,

Drug consumption rooms (continued)

and to be modest in claiming what consumption rooms can or cannot achieve. In particular, it is unrealistic to expect that they can:

- prevent all public drug use;
- persuade all clients to reduce risky drug use or enter treatment;
- in themselves be the major factor in reducing morbidity and mortality;
- solve wider problems of drug markets and drug dealing.

The author states that the evidence suggests that consumption rooms can only be effective, if they are:

- established within the wider framework of a public policy and network of services that aim to reduce individual and social harms arising from problem drug use;
- based on consensus and active co-operation between key local actors, especially health

workers, police, local authorities and local communities;

- seen for what they are – specific services aiming to reduce problems of health and social harm involving specific high-risk populations of problematic drug users and addressing needs that other responses have failed to meet.

This article provides a basic overview of the evidence in relation to the provision of consumption rooms. It is recommended, as a first step, that individuals or organisations considering introducing such facilities read the complete review-document. (*Jean Long*)

- 1. Hedrich D (2004) *European report on consumption rooms*. Lisbon: EMCDDA.

This report is available on the EMCDDA website at: www.emcdda.eu.int

Legal issues in relation to consumption rooms

The International Narcotics Control Board (INCB) is responsible for reviewing whether drug policies adopted by countries bound by the three international drug control conventions, comply with those agreements. The relevant treaties are the 1961 United Nations Single Convention on Narcotic Drugs, the 1971 UN Convention on Psychotropic Substances and the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

Citing Article 4 of the 1961 Convention, which obliges states to ensure that the 'trade in, use and possession of drugs'¹ is limited exclusively to medical and scientific purposes, the INCB states in its annual report for 2003 that facilities 'where injecting drug abusers can inject drugs that they have acquired illicitly' are, 'from a legal point of view'² in violation of the international drug control conventions.

In Ireland, the Misuse of Drugs Act (MDA) 1977 and 1984 and the Regulations made thereunder ensure Ireland's compliance with its obligations under international law. Section 3 of the original Act renders it a criminal offence to be in possession of a controlled drug. Section 16 prohibits the smoking or other use of prepared opium³ or the frequenting of a place used for the purpose of smoking or otherwise using prepared opium,⁴ while section 19 prohibits a person from knowingly allowing another to possess illicit drugs on premises under his or her control.⁵ Despite a number of provisions within the legislation for the Minister to grant exemptions to the law regarding

possession in certain circumstances,⁶ as things currently stand, drug consumption rooms, where drug users could consume drugs obtained illicitly, would be in direct contravention of Irish domestic law.

Despite criticism from the INCB, a number of other state signatories to the UN conventions have adopted various legal measures to facilitate the establishment of drug consumption rooms. In doing so, they have tested the application of international law in this area.

In Switzerland, following the establishment of a number of state-controlled consumption rooms, a legal opinion commissioned by the Swiss Federal Office for Public Health (FOPH) concluded that such facilities did not violate Swiss law 'as long as the rooms improve the hygienic conditions under which consumption takes place and provide medical supervision and no drug dealing takes place'.⁷ A further opinion commissioned by the FOPH considered the legality of such facilities in relation to the three relevant international treaties. This opinion, carried out by the Swiss Institute of Comparative Law, concluded that, in the absence of any clear guidance in the treaties on the utility of 'public injecting rooms' with regard to the 'rehabilitation and social reintegration of drug addicts in the short term and to the reduction of human suffering and the elimination of financial incentives for illicit traffic in the long term', it must be concluded that 'state parties retain the freedom to make their own policy choices on the tolerance of Fixer-Stubli (public injecting rooms)'.

Legal issues in relation to consumption rooms (continued)

Furthermore, it was argued, 'State parties are not obliged by the conventions to prosecute and punish the possession and consumption of drugs (other than those psychotropic substances listed in Schedule 1 to the 1971 convention.)'

In this respect, Switzerland may be seen to be relying on what is referred to as the 'expediency principle'.⁸ This arises under Article 3, paragraph 2 of the UN Convention of 1988 whereby each party is obliged to establish drug possession for personal consumption as a criminal offence 'subject to its constitutional principles and the basic concepts of its legal system'. This principle is used by some countries to discourage prosecution of certain crimes, such as possession of cannabis for personal use for example.

In a legal opinion commissioned by the Strasbourg-based think tank, the Pompidou Group, Professor Dr Brice De Ruyver argues that 'there is no clear guidance in relation to the compatibility of injecting rooms with international law' and that countries may apply the 'expediency principle' when establishing drug consumption rooms 'in order to avoid violating international laws'. He adds however, 'that governments are not allowed to invoke this expediency principle whenever they would like to deviate from the international provisions'. De Ruyver concludes that 'inasmuch as injecting rooms are extreme forms of risk reduction, some doubts can appear about the fidelity to the convention obligations' which require a 'loyal enforcement'.⁹

In Germany in 1993, an assessment of the legal implications of supervised injecting facilities commissioned by the health authorities of the city of Frankfurt concluded that 'the operation of such facilities was not a punishable offence either under any German laws or according to UN conventions, provided that the sale, acquisition or passing on of drugs/narcotic substances are not tolerated and that hygienic, stress-free and risk-reduced drug consumption is ensured through adequate care and control'.⁷ The issue remained controversial in other parts of Germany however. Consequently, in April 2000, the German parliament introduced an amendment to the narcotics legislation which now leaves it to the discretion of individual states whether or not to issue such facilities with a licence. Licences, where they are granted, are generally contingent on compliance with a range of minimum standards defined by law. These standards relate to such measures as, for example, adequate medical standards, the availability of abstinence-oriented follow-up counselling, measures to prevent criminal offences other than possession of drugs for personal use from occurring in or surrounding such premises, restrictions on the age, type of drug and level of addiction of the user attending the facilities.

In the Netherlands, legal guidelines issued in 1996 clarified that the possession of drugs in consumption rooms is tolerated 'provided the facilities fit into the local policy framework defined by the local triumvirate of mayor, police and public prosecutor'.⁷ In Spain, supervised injecting rooms operate on the basis of local public health regulations.

In Sydney, Australia, and in Canada since 2003, supervised injecting rooms operate on the basis of scientific trials or pilot programmes which must comply with ongoing evaluations and specific licensing conditions in order to continue in operation.

It has been argued that, as harm reduction strategies, including drug consumption rooms, become an increasing element of policy in a number of states, so they have the potential to become increasingly acceptable under the UN treaties. Following a recent review of the UN drug conventions regime and alternatives for reform, Andenas and Spivak concluded that 'the preferred approach is one that is premised on collective action by a group of countries with a shared reform agenda. Such collective action paves the way for various legal techniques which provide potentially wide scope for modifying the drugs Conventions'.¹⁰ However, with regard to drug consumption rooms, the preconditions established in specific countries will determine whether these strategies qualify as legitimate harm reduction practices. A difficulty which arises here however, is that, at present, there is no clear consensus between states on what precisely 'harm reduction' is. As the INCB highlights in its recent report: 'The conventions do not contain, refer to or define 'harm reduction.'¹¹

(Johnny Connolly)

1. Article 4, subparagraph 1 (c), *United Nations Single Convention on Narcotic Drugs* 1961.
2. International Narcotics Control Board (2004) *Report 2003*. United Nations Publications.
3. Section 16 (1) (a) *Misuse of Drugs Act* (1977)
4. Section 16 (1) (b) *Misuse of Drugs Act* (1977)
5. Section 19 (1) (i) *Misuse of Drugs Act* (1977)
6. Part III *Misuse of Drugs Regulations* (1988)
7. This discussion of legal approaches taken in countries where drug consumption rooms are in operation is derived from Hedrich D (2004) *European Report on drug consumption rooms*. Lisbon: EMCDDA pp.15-19.
8. De Ruyver B (2000) *Legal (Pre) Conditions and control mechanisms with regard to risk reduction*. Strasbourg, Pompidou Group P-PG/MIN/CONF (2000) 2.
9. Ibid p.14.
10. Andenas M and Spivak D (2003) *The UN Drug Conventions Regime and Policy Reform*. Legal opinion prepared by the British Institute of International and Comparative Law (BIICL).
11. International Narcotics Control Board (2004) *Report 2003*. United Nations Publications p.36.

A difficulty which arises here however, is that, at present, there is no clear consensus between states on what precisely 'harm reduction' is

National Drugs Strategy – Critical Implementation Path published¹

In early 2004 the Department of Community, Rural and Gaeltacht Affairs published a Critical Implementation Path (CIP), containing the critical implementation paths for all government departments and agencies responsible for completing the 100 actions contained in the National Drugs Strategy. The document maps out how each of the 100 actions is to be delivered.

Government departments and state agencies have identified a wide array of tasks needed to complete the actions, including reviewing current policies, undertaking gap analyses, consulting on issues, establishing best practice, developing guidelines, producing policy frameworks and identifying resource needs. No less than 17 working or review groups are to be established to progress the work. The CIP also records the obstacles that departments and agencies have identified as they have moved forward.

According to the target timeframes set out in the CIP, 43 actions should have been completed, or completed and ongoing, by the end of 2003; 35 actions are due for completion during 2004; and 22 actions are due for completion during the remainder of the period covered by the strategy. However, as the CIP is a plan, rather than a progress report, it is difficult to confirm how many actions have been completed or where slippage has occurred. In the introduction to the document, the authors note that the projections are dependent on resources being available to deliver the actions.

The need for 'each agency to prepare and publish a critical implementation path for each of the actions relevant to their remit by end 2001' is identified in the National Drugs Strategy as a key performance indicator (KPI), contributing to the achievement of 'an efficient and effective framework for implementing the National Drugs Strategy'. An associated KPI is the completion of 'an independent evaluation of the effectiveness of the overall framework by end 2004'. This evaluation is scheduled to be completed in two stages:

- an Annual Report, reporting on the nature and extent of the drug problem in Ireland and on progress in achieving the objectives set in the Strategy, due by mid-2004; and
- a Mid-Term Evaluation, measuring the Strategy's impact and effectiveness, due by the end of 2004.

It is expected that the CIP will feed into the evaluation process. The Minister of State with responsibility for the National Drugs Strategy, Noel Ahern TD, stated in his foreword to the document: 'Through the CIP, we can gain important insights into the strengths and obstacles within the Strategy and refocus our efforts, if necessary. ... the Strategy must be flexible enough to tackle any new challenges facing it.' (*Brigid Pike*)

¹ Department of Community, Rural and Gaeltacht Affairs (2004) *National Drugs Strategy 2001-2008: Critical Implementation Path*. Dublin: The Stationery Office.

National Drugs Strategy Mid-Term Review – submissions invited

The Minister of State at the Department of Community, Rural and Gaeltacht Affairs with responsibility for the National Drugs Strategy, Noel Ahern TD, has called for submissions from interested individuals and groups as part of the mid-term review of the National Drugs Strategy. The mid-term review will enable priorities for future actions to be identified and a refocusing of the Strategy, if necessary, for the remaining period up to 2008.

Submissions should reach the Department of Community, Rural and Gaeltacht Affairs by close of business on Tuesday 17 August 2004 and be addressed to:

Email: drugsstrategy@pobail.ie

Fax: 01 667 0824

Post: Drugs Strategy Unit,
Department of Community, Rural and Gaeltacht Affairs,
43–49 Mespil Road,
Dublin 2.

Guidelines and further information are also available at email drugsstrategy@pobail.ie or on www.pobail.ie

Note: All submissions received are liable to be made publicly available and, in any event, will be accessible under Freedom of Information legislation.

The Pompidou Group advocates better use of drug treatment data

In May 2004, the Pompidou Group of the Council of Europe published a report on a European Project that sought, through the use of advanced statistical techniques, to enhance the interpretation of drug treatment demand data.¹ The results of such statistical analysis increase the relevance of treatment data to policy and practice. The project was carried out between 2001 and 2003 and involved 14 cities across Europe. Statistical consultancy was provided by Carla Rossi (Rome) and Colin Taylor (London) and the project was co-ordinated by Michael Stauffacher (Zurich).

Descriptive analysis is the first step in obtaining a thorough understanding of data and is a prerequisite for advanced statistical analysis. During the course of the project, guidelines were prepared to facilitate the participants in applying the advanced statistical techniques. These statistical techniques permitted the identification of the independent contribution of each factor associated with injecting drug use, and the calculation of the incidence of heroin misuse for all those who seek treatment within a specific time period. The report provides an example of each of these analyses.

During the project, the participants learnt some important lessons. These include:

- The **quality of the data** collected and entered is the key to the validity of the reporting system. If questions on the forms are incorrectly or incompletely answered, then the accuracy of the analysis is reduced. The authors report that this requires repeated contact with service providers, proactive training, protocols for completing the form and prompt analysis of data.
- The full **analytic capability** of treatment data and its potential to inform policy and practice

has never been realised. Since a large amount of resources are invested in the collection of treatment data, there is an onus on those responsible for these reporting systems to provide regular and comprehensive analysis of data.

- Data that are analysed **promptly and comprehensively** are more useful to policy makers and service providers.
- The comprehensive interpretation of treatment demand data cannot be done without considering the **other indicators** of the drug use in a region or country and the responses to it.

The Pompidou Group has advocated the collection of drug treatment data using comparable procedures and criteria for the last decade or so. Since 2000, the Pompidou Group's focus in terms of drug treatment data evolved from one of data collection to one of data analysis and interpretation. Now, under the new work programme of the Pompidou Group for 2004–2006, emphasis is placed on how such data can be used to help develop evidence-based policies and practices. A Pompidou Group project to examine the impact of treatment demand data on policy and practice in Europe is currently under way and is co-ordinated by Drug Misuse Research Division of the Health Research Board. The project is funded by the Irish Department of Health and Children. (*Hamish Sinclair and Jean Long*)

1. Stauffacher M, Arpa S and Vassilev M (2004) *Follow-up project on treatment demand: tracking long-term trends*. Final report. Strasbourg: Council of Europe, Pompidou Group.

Occasional Paper 10: Twice as many are treated for problem alcohol use than for problem drug use

In April 2004, the DMRD, in collaboration with the South Eastern and Southern Health Boards, published an occasional paper entitled *Treatment demand for problem alcohol use in the South Eastern and Southern Health Board areas, 2000-2002*.¹ It is the first publication that documents treatment demand for problem alcohol use in community settings and special residential services and complements the data published in the annual reports from the National Psychiatric Inpatient Reporting System.

The number of treated cases reporting alcohol as their main problem substance is at least double that reporting all other drugs combined in the South Eastern and Southern Health Board areas (Table 1), suggesting that alcohol is the most common substance of abuse in Ireland.

In both health board areas, 40 per cent of those reporting problem alcohol use had been treated previously, indicating that this is a chronic health problem.

Occasional Paper 10: Twice as many are treated for problem alcohol use than for problem drug use (continued)

Table 1 Numbers (%) reporting problem substance use that attended treatment in the South Eastern Health Board (SEHB) and Southern Health Board areas (SHB), 2000 to 2002

Main problem substance	2000		2001		2002	
	Number (%)					
	SEHB	SHB	SEHB	SHB	SEHB	SHB
Alcohol	1010 (71.2)	719 (67.3)	1472 (76.7)	852 (61.0)	1498 (71.5)	1160 (64.2)
Drug (licit or illicit)	408 (28.8)	349 (32.7)	447 (23.3)	544 (39.0)	598 (28.5)	647 (35.8)
Total	1418	1068	1919	1396	2096	1807

In 2001 and 2002, one-fifth of treated cases in both health board areas reported use of drugs along with alcohol. Cannabis was the most common drug used alongside alcohol. Previously treated cases were more likely to use benzodiazepines with alcohol than were their newly treated counterparts.

There was an increase in the proportion of new female cases seeking treatment for problem alcohol use in both areas, though the increase was higher in the Southern Health Board area.

The rate of new cases (incidence) seeking treatment for problem alcohol use varied throughout the seven counties included in the study and merely reflected the level of service provision in the area and participation in the reporting system.

This analysis demonstrates that it is possible to collect reliable data on problem alcohol use through the National Drug Treatment Reporting System, and highlights that the exclusion of alcohol from reporting systems leads to an underestimation of problem substance use and the workload of addiction services.

The benefit of information on persons with problem alcohol use is that it will permit planners to rank problem alcohol use alongside other public health priorities in the population and to allocate appropriate resources to its management.

There is momentum gathering that responses to alcohol and illicit drug use should be integrated. This is an issue that is being discussed by the ten Regional Drugs Task Forces, which have been set up over the last year. These data identify a clear overlap between problem alcohol and drug use and point to the need for an integrated approach to the management of substance misuse. *(Jean Long)*

1. Long J, Jackson T, Kidd M, Kelleher T and Sinclair H (2004) *Treatment demand for problem alcohol use in the South Eastern and Southern Health Board areas, 2000 to 2002*. Occasional Paper 10. Dublin: Health Research Board.

This report is available on the Health Research Board website at www.hrb.ie

Tracy Kelleher

In April Tracy Kelleher left the Drug Misuse Research Division after five years to take up a new position with the National Cancer Registry of Ireland in Cork. Tracy worked as a researcher on the National Drug Treatment Reporting System (NDTRS) and was the main link between the NDTRS and the providers of drug treatment services throughout Ireland. During her time with us, Tracy co-authored many publications and was the lead author on an occasional paper *Trends in treated problem cannabis use in the seven health boards areas outside the Eastern Regional Health Authority, 1998 to 2002*, which will be published in the autumn. Tracy will be remembered as a warm, positive and committed colleague and we want to wish her every success and happiness in the future.

EDDRA Column

Welcome to the eighth EDDRA (Exchange on Drug Demand Reduction Action) column. The aim of this column is to inform people about the EDDRA online database, which exists to provide information to policy makers and practitioners on drug demand reduction actions across Europe and to promote the role of evaluation in drug demand reduction action. The database is co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

In this issue we focus on the St Aengus Stay-In-School Youth Project, which operates in Tallaght in West Dublin. The project was included on the EDDRA database in 2002 as representing good practice in drug prevention in Ireland. Recent developments suggest that the project is now accepted as a model of good practice internationally.

The project was set up in 1998 to maintain 'at risk' young people, aged 10-15 years, from St Aengus parish in Tallaght in mainstream education. The underlying assumption of the project is that when 'at risk' children are maintained in mainstream education, there is a reduced risk of their engaging in substance misuse. The association between early school leaving and drug use has been highlighted in research, both in Ireland and the UK. Comiskey¹ found among 112 early school-leavers in Ireland that 51.1 per cent had used drugs prior to leaving school, with 46.5 per cent of these reporting that their drug use had affected them at least sometimes while attending school. Research from the Youth Lifestyles Survey in the UK showed higher rates of drug use for truants and those excluded from school, compared with those routinely attending school.²

The St Aengus project, along with two other European projects (one each from Portugal and Austria), has recently been used in training seminars on drug prevention and evaluation held throughout Portugal. The three projects were used as examples of good practice because of their clear design and interesting evaluation. Over 150 Portuguese professionals in the field of prevention attended the seminars, which were organized by the Institute for Drugs and Drug Addiction. The seminar participants worked actively with the three

project examples in group discussions, improving on their design, learning how to apply concepts of operational versus specific objectives, discussing the use of relevant evaluation instruments, reflecting on the variables and instruments for a good project description and evaluation.

An evaluation of the St Aengus project in 2000³ found that all those who had participated in the project over the previous two years were still in mainstream education. Project activities were extremely well received by participants, reflected in attendance rates of over 90 per cent at all activities. The project's annual report for 2001 showed an increase in the number of parents attending parents' sessions and in those expressing satisfaction with the projects activities.⁴ In addition, the number of volunteers giving time to the project had also increased. (Martin Keane)

1. Comiskey CM and Miller RTH (2000) *Young people, drug use and early school leaving*. A report submitted to the Research and Development Committee, Department of Education and Science.
2. Goulden C and Sondhi A (2001) *At the margins: drug use by vulnerable young people in the 1998/99 Youth Lifestyles Survey*. Home Office Research Study 228. London: Home Office Research, Development and Statistics Directorate.
3. Rourke S (2000) *St Aengus Stay-In-School Youth Project: a process evaluation*. Dublin: Tallaght Local Drugs Task Force.
4. St Aengus Stay-In-School Youth Project. *Annual Report 2001*.

More information on the St Aengus project and other Irish projects in the EDDRA database can be obtained from the EDDRA website at <http://eddra.emcdda.eu.int>

Alternatively, you can contact the EDDRA Manager for Ireland, Martin Keane, at the Drug Misuse Research Division, Health Research Board, Holbrook House, Holles Street, Dublin 2. Tel: 01 676 1176 Ext. 169; Email: mkeane@hrb.ie

If you wish to contribute to the knowledge base of good practice interventions by adding your own particular project to the database, please contact the EDDRA Manager for Ireland at the above address.

National Documentation Centre on Drug Use

The National Documentation Centre on Drug Use (NDC) has continued the development of its electronic library of research and policy documents and is working on a range of new information resources. Currently the NDC makes the following resources available to users of its website and special library:

- An electronic library containing more than 500 full text research reports, journal articles, conference papers and other documentation relating to drugs in Ireland. These can be read or searched by visitors to the NDC website at www.hrb.ie/ndc;

National Documentation Centre on Drug Use (continued)

- More than 2,500 books and reports and an extensive collection of specialist journals which are available to library visitors;
- A range of excellent online bibliographical databases which can be searched by visitors with the assistance of NDC staff;
- A diverse and speedy system of inter-library lending so that visitors can identify, order and receive the documents most relevant to their area of research all within a few days.

The number of visitors to the NDC website and the volume of queries dealt with by documentation centre staff have increased steadily since the end of last year. More queries were made and more people visited the website during March 2004 than in any previous month. The documentation centre is currently developing a number of new information resources which will be available at the end of the summer. These include:

- An electronic book with table of contents which will make a major update on the drugs situation in Ireland available to website visitors;
- A directory of researchers in the drug field in Ireland and a database of ongoing research and evaluation in this area;
- A revised News section will make news, new publications and information on policy development almost immediately available through the website's front page;
- A simplified search option, by which visitors to the web site can carry out database searches simply by selecting from a list of subject headings.

In developing its collections, the documentation centre has worked very closely with staff of the Drug Misuse Research Division. The DMRD's

extensive collection of Irish research documentation formed the basis of the NDC library collection. This original collection has now been catalogued and is available to visitors to both the website and the NDC library.

The DMRD's monitoring of the drugs situation in Ireland and its extensive international connections have been of considerable help to the NDC in the identification and acquisition of appropriate local and international material.

Current Research and Evaluation Database

The National Documentation Centre will shortly begin to compile a database of ongoing research and evaluation in the drugs area in Ireland. This database will be a valuable information resource for both researchers and those commissioning research and evaluation work. The documentation centre is also creating a directory of researchers and evaluators which will contain details of research interests and projects which the researcher or evaluator is currently involved in.

In order to ensure that the information on the database and directory is accurate and comprehensive, online forms which researchers and evaluators can use to provide details of their work will shortly be available on the NDC website. These forms are short, easy to complete, and will allow researchers and evaluators to create a thorough and informative record of their work. The database compiled from information provided in these forms will be made available on the website later this year. *(Brian Galvin)*

For further information on these information resources contact the National Documentation Centre on Drug Use, Health Research Board, Holbrook House, Holles Street, Dublin 2. Tel: 01 676 1176; Email: ndc@hrb.ie or visit the website at www.hrb.ie/ndc

From Drugnet Europe

Four new synthetic drugs under EU control Cited from Alain Wallon and Roumen Sedefov, Drugnet Europe No. 45, January–March, 2004

The Council of the European Union has adopted a Decision defining four new synthetic drugs as substances to be placed under control measures and criminal penalties in the EU Member States. ... All four drugs, 2C-1, 2C-T-2, 2C-T-7 and TMA-2, are amphetamine derivatives and have hallucinogenic and stimulant properties. Although there have been no reported cases within the EU of death or poisoning due to these drugs, they are believed to carry similar risks to other

hallucinogenic drugs that are already listed under Schedules I or II of the 1971 UN Convention on psychotropic substances.

Following the publication of the decision in the Official Journal of the European Union, and in line with their national laws, EU Member States have up to three months to introduce measures to control the four drugs, in compliance with their obligations under the 1971 UN Convention on psychotropic substances.

From *Drugnet Europe* (continued)

Progress in the key indicator 'drug-related deaths'

Cited from Julián Vicente, *Drugnet Europe* No. 45, January–March 2004

The EMCDDA expert group on population statistics on drug-related deaths held its most recent annual meeting on 11 and 12 December last year. The aim of the meeting was to consolidate the implementation of this key indicator by reviewing progress in each country, assessing the quality of the annual summary data (Reitox tables) and developing technical training for full application of the drug-related death protocol for a forthcoming detailed data collection. ...

The forthcoming data collection (detailed aggregated data) builds on previous projects and aims to validate the key figures reported annually by countries, to analyse national application of ICD classifications and to allow further analysis at national and EU level.

Prevalence estimation: cutting-edge work needs further investment

Cited from Luke Wiessing, Ludwig Kraus and Carla Rossi, *Drugnet Europe* No. 45, January–March 2004

The latest EU-wide expert meeting on estimation of the prevalence and incidence of problem drug use ... concentrated on (1) how to further refine the current EMCDDA definition of problem drug use,

which is a relatively wide 'umbrella definition' that includes several subgroups of problem users; (2) how to obtain more and better estimates of the prevalence and incidence of problematic stimulant use; and (3) the urgent need for more and repeated local estimates as a necessary ingredient of improved national estimates. It was acknowledged that the multivariate indicator method (MIM) can provide powerful syntheses at national level but cannot be used in the absence of multiple high-quality local estimates (preferably obtained by capture-recapture based on three or more data sets). New incidence estimates from Austria, Italy and Spain presented at the meeting suggest that there is important variation over time in the initiation rates of new opiate users, providing further evidence for the epidemic nature of problem drug use.

Drugnet Europe is a newsletter published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The newsletter is published four times a year in Spanish, German, English, French and Portuguese. An electronic version of *Drugnet Europe* is available from the EMCDDA website at www.emcdda.eu.int

If you would like to receive a hard copy of the current or future issues of *Drugnet Europe*, please contact Mary Dunne, Drug Misuse Research Division, Health Research Board, Holbrook House, Holles Street, Dublin 2, Tel: 01 676 1176 Ext. 127; Email: mdunne@hrb.ie

Drugs in Focus - Policy Briefings

No. 12: Evaluation of the European Union's strategy and action plan (2000–2004)

The EMCDDA's twelfth *Drugs in Focus* policy briefing was launched in May at the Dublin EU drugs strategy conference, which started the ball rolling for an EU strategy and action plan against drugs post 2004. The final evaluation of the EU drug strategy and action plan 2000–2004, to be conducted by the European Commission with technical assistance from the EMCDDA and Europol, will be a key input into the development of the new strategy and action plan. The EMCDDA's briefing paper on the evaluation process highlights six points.

1. Importance of evaluation

Evaluation is essential for the 'transparency and legitimacy of public action', helping to hold the state accountable to its citizens for 'what it does, how it does it and the results it achieves'. Evaluation also helps identify needs, improve selection, planning and implementation of responses and ensure a more rational allocation of resources.

2. Approach to evaluation

The evaluation will look at the extent to which actions laid down in the strategy are implemented, the extent to which implementation of the plan meets the objectives of the strategy, and the effects of the strategy on the drug phenomenon.

3. Innovative evaluation tool

Evaluating the effects of a particular policy on the drug problem is both technically and scientifically challenging. To rise to this challenge, the EMCDDA and Europol have developed an information baseline or 'snapshot' offering an overview of the drug situation and policy measures at the outset of the current action plan (1999). This will be compared with a similar 'snapshot' at the close of the plan (2004), enabling trends between the two dates to be traced.

4. Evaluation at national level

Most actions having an impact on the drug situation are the sole competence of the EU member states. Evaluation of the EU drug strategy and action plan will only be fully effective if it draws on evaluations carried out nationally. The briefing urges member states to 'develop their own evaluation capacities' with 'appropriate resources'.

Drugs in Focus - Policy Briefings (continued)

5. Political dimension of evaluation

There is more to evaluation than observation and monitoring. It also involves a value judgement, which presupposes prior agreement on the underlying evaluation criteria and their respective weighting. The briefing paper observes: 'the findings of evaluations are not always exhaustive, do not remove all ambiguities and include a large measure of uncertainty. Frequently they open the door to several possible rational scenarios. An intervention can be optimal from an economic point of view, but costly from a social point of view. Who should be the judge? Certainly not just the scientists or evaluators.'

6. The next EU drugs strategy and action plan

When European legislators set the objectives and targets for the new strategy and action plan they will have to take into account the results of the evaluation exercise and monitor the priorities

adopted by means of a device providing adequate indicators. They will also have to take into account the change in perspective linked to European Union enlargement. (*Brigid Pike*)

Drugs in Focus is a series of policy briefings published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The briefings are published three times a year in the 20 official languages of the European Union plus Norwegian. An electronic version of Drugs in Focus is available from the EMCDDA website at www.emcdda.eu.int

If you would like to receive a hard copy of the current or future issues of Drugs in Focus, please contact Mary Dunne, Drug Misuse Research Division, Health Research Board, Holbrook House, Holles Street, Dublin 2, Tel: 01 676 1176 Ext. 127; Email: mdunne@hrb.ie

Connecting research, policy and practice

On 6–7 April 2004 the Pompidou Group of the Council of Europe held an international conference in Strasbourg entitled 'Connecting research, policy and practice: lessons learned and challenges ahead'. The conference provided policy-makers, researchers and practitioners in the field of drug prevention, treatment and criminal justice an opportunity to reflect on the role of research in policy and practice. For some twenty years now the Pompidou Group has been active in the area of drug epidemiology, developing and promoting a range of drug indicators and methodological approaches to examine the drug problem. However, the work programme of the Pompidou Group for 2004–2006 envisages a new role, that of stimulating dialogue between researchers, policy-makers and practitioners and acting as a catalyst for evidence-based innovative approaches to drug policy and practice. The conference was a first attempt by the Pompidou Group towards the development of strategic thinking on the connection between research, policy and practice.

Prior to the conference, the Pompidou Group commissioned Richard Hartnoll, in his capacity as a former consultant in epidemiology for the Pompidou Group and as the former head of the epidemiology department of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), to prepare a background paper. This

pre-conference paper reviewed what had been achieved over the past twenty years in the area of drug epidemiology, the current gaps in our knowledge, and the opportunities available to strengthen policy- and practice-relevant research. The paper served as the basis for discussion by a panel of international experts and participants at the conference.

One of the main conclusions from the conference was that there was a need for a strengthening of policy-relevant research on drugs in Europe by investment in a long-term strategy on research. More emphasis on programme- rather than project-based approaches was required and more priority should be given to secondary analysis and synthesis of existing data before embarking on new data collection. There was also need for 'think tanks' of experienced researchers, policy-makers and practitioners to offer detached reflection and critical questioning. (*Hamish Sinclair*)

It is expected that Richard Hartnoll's pre-conference paper will be published by the Pompidou Group before summer 2004. Copies will be available in the National Documentation Centre on Drug Use, Health Research Board, Holbrook House, Holles Street, Dublin 2. Tel: 01 6761176 ext. 175; Email: ndc@hrb.ie

International conference on the future EU Drugs Strategy

On 10 May 2004 the Minister for Justice, Equality and Law Reform and President of the Justice Affairs Council, Mr Michael McDowell, opened an international two-day conference in Dublin to discuss the future EU strategy on drugs. The conference, entitled 'EU Strategy on Drugs—The Way Forward', was organised by the Irish Presidency in partnership with the Netherlands, Luxembourg and United Kingdom forthcoming Presidencies. More than 200 experts in the field of drugs from the 25 EU member states, the three candidate countries, all relevant EU institutions, as well as other international bodies and organisations, attended the conference. Addressing the conference were speakers from the European Commission, EUROPOL, the European Monitoring Centre for Drugs and Drug Addiction and other experts in specific drug-related fields.

The conference aimed to facilitate an exchange of ideas between all participants and to agree conclusions and recommendations on the main elements of a future Strategy. The current EU Drugs Strategy, for the period 2000–2004, will soon come to the end of its term and the Justice and Home Affairs Council will be invited to approve a new Strategy for 2005 onwards. To facilitate discussion, workshops were organised under the thematic fields of demand reduction, supply reduction, international co-operation, and information and evaluation. In each workshop, four strategy priorities proposed by the organising committee

were discussed with a view to reaching a consensus on the main priorities for the new Strategy.

It was generally agreed that the new Drugs Strategy should be based on a balanced and multidisciplinary approach, on scientific evidence, on respect for the principles of subsidiarity and proportionality, and on providing added value in relation to activities that are undertaken at national level. Furthermore, the future Action Plan resulting from the new Strategy should contain measurable targets, and specific time-bound actions that can be monitored and evaluated.

The Dublin conference was one of a number of inputs to the preparation of the new Drugs Strategy. Another will be the final evaluation of the current EU Drugs Strategy 2000–2004 and its Action Plan. The aim of the final evaluation, under way at the European Commission, is to assess how far the activities identified in the Action Plan have been achieved, and how far that achievement has met the objectives of the underlying Drugs Strategy. It also aims to assess the impact of both on the drug situation in the EU. The final evaluation is expected by the end of October 2004.

At its meeting on 8 June 2004, the EU Council for Justice and Home Affairs welcomed a report by the Irish Presidency on the main elements discussed at the Dublin Conference. (*Hamish Sinclair*)

Crack Cocaine, Epidemiology, Services and Treatment Conference

On 10 May 2004, a crack cocaine conference was held by the North West Wales NHS Trust in the historic town of Caernarfon on the Welsh coast. The conference was held in response to the increasing number of crack cocaine users entering treatment throughout the United Kingdom and the perceived lack of services available to them. The conference provided an opportunity for service providers, project workers, researchers and other people working with drug users to increase their understanding of the issues surrounding the use of crack cocaine. The speakers at the conference shared their broad range of experiences with attendees.

The conference was divided into three sessions.

Session one began by outlining the physiology of crack cocaine use.

- Dr Chris Thorpe, a physician from the North West Wales NHS Trust, spoke about the feelings of euphoria, excitement and increased motor

activity experienced by an individual when using crack cocaine;

- Dr Jim O'Toole, the Director of Substance Misuse North West Wales NHS Trust, went on to report on the risk behaviours associated with crack cocaine, such as having unprotected sex and sharing both injecting and smoking equipment.

The afternoon session focused on patterns of cocaine use from a criminal justice perspective.

- Sgt Dewi Roberts, from the North Wales Police force, stated that there are between 15,000 and 45,000 crack cocaine users in the United Kingdom. Forty to fifty tonne of cocaine powder is imported annually and police and customs seize approximately one-fifth of it;
- Nino Maddalena, the Criminal Justice Manager of the National Treatment Agency (NTA), described the growing crack problem in the

Crack Cocaine, Epidemiology, Services and Treatment Conference (continued)

United Kingdom and said that the incidence of crack use is generally under-reported.

The evening session concentrated on service provision and effective approaches to treatment.

■ Aidan Gray (Advisor to the NTA) and Daniel Taegtmeier (Blenheim Project West London) described methods of developing and delivering services for crack cocaine users and the treatment options available to them. They emphasised that in order to develop appropriate

crack cocaine services it is necessary to: identify the barriers that exist in preventing the establishment of such a service; to ascertain local trends and uses; and to identify effective approaches to tackle the issue.

The topics discussed at this conference will be examined in more detail in *Drugnet Ireland* 12. The research findings, practices and service provision for crack cocaine users in the United Kingdom will be compared with those in Ireland and suggestions will be made on how to improve treatment services for crack cocaine users in Ireland.

Recent Publications

Books

Drug users in society

Neale J Palgrave 2002
ISBN 0 333 91262 4

This book is one of a number of publications resulting from a research project funded by the Health Department of the Scottish Executive to investigate drug users' views and experiences of non-fatal illicit drug overdose. It takes the approach that, ultimately, the problem of drug misuse can never be fully understood without a clear appreciation of the motivations and life circumstances of those individuals who become involved in drug taking. The introductory chapter describes in some detail the research design and methods used. Chapter 1 provides a description of opiates and their effects, considers how opiate misuse has evolved as a social problem, and offers an overview of policy responses in the US and the UK.

The central part of the book is based on data collected from in-depth interviews with 200 opiate users living in Scotland. The respondents included men and women, teenagers and older addicts, novice drug users and those who had been addicted for many years. In addition to discussing their experiences of drug overdose, those interviewed provided accounts of many other aspects of their lives. Drawing extensively on drug users' own words, the book provides a candid insight into what it means to be opiate dependent. By interviewing addicts at different stages of their drug-using careers and by discussing with them a wide range of issues, the processes of obtaining and using drugs are explored within the wider context of personal biographies and daily routines. Key topics considered include childhood experiences; income, employment and educational opportunities; crime and violence; housing and homelessness; family relationships; prison life; health matters; and drug treatments. Drug users' statements are related to policy, service provision, previous research, and theoretical debates in the

hope that this might increase understanding and improve future responses to drug problems.

Pieces of the jigsaw: Six reports addressing homelessness and drug use in Ireland

Merchants Quay Ireland 2003
ISBN 190279 407 9

This book contains six reports of research studies on aspects of homelessness and drug use in Dublin. Five of the six studies were carried out within Merchant Quay Ireland's own programmes; four were concerned with evaluating the services provided by MQI, including methadone prescribing, outreach work, and advice and food centres; one set out to examine the health status of female drug users. The sixth study was more policy focused and reviewed the literature on the impact of drug use on local communities. The research work was carried out and the reports compiled between 1999 and 2002. Contributors to this volume are: Marie Lawless, Caroline Corr and Gemma Cox.

The first chapter in the book reports on a pilot project set up to examine the health status of female drug users and their use of primary health care, and to assess their healthcare needs. The project was funded under the Health Research Board's Project Grants Scheme and ran for eight weeks in 2001 at the MQI Contact Centre. The investigation involved detailed medical assessments and self-reported information.

The next chapter reports on the evaluation of the MQI methadone prescribing service in Dublin city. The aim of this research was to measure the service's levels of effectiveness in terms of client outcomes. Information on clients' self-reported behaviour was obtained by questionnaire at first intervention and at follow-up 18 months later. The research objectives included reviewing international information on methadone maintenance and defining the services provided by the methadone prescribing service.



Recent Publications (continued)

The other MQI services evaluated are the Outreach Service, the Fáilteú Information and Advice Centre, and the Fáilteú Food Service, all with the ultimate goal of identifying their strengths and shortcomings and improving their services to clients.

The literature review is entitled 'Managing Urban Tensions' and examines responses to drug-related anti-social behaviour in Dublin's inner city, and presents an overview of best practice employed in Europe.

Treating alcohol and drug abuse: an evidence based review

Berglund M, Thelander S, Jonsson E (eds) *Wiley-VCH GmbH & Co KgaA 2003*
ISBN 3 527 30682 X

This volume is the result of a project undertaken by the Swedish Council on Technology Assessment in Health Care (the official acronym is SBU) and its editors include two members of the council. The SBU was founded in 1987 to assess the technologies and methods used in providing health services and to identify treatment options that are effective, not only medically, but also in economic, social and ethical terms.

The foreword to the book makes the point that, despite the enormous resources spent on alcohol and drug treatment programmes, there is still no satisfactory evaluation of their effectiveness or of the cost of the different alternatives. The project described here set out to assess the range of scientific literature on alcohol and drug treatment by means of an integrated literature search, a quality rating checklist and meta-analytic techniques. Claimed as the most comprehensive scientific review of its kind, it presents the findings from more than 1,600 studies, including many randomised control trials, on the effectiveness of different treatments. The extensive results are arranged in detailed tables, which may be searched using the accompanying CD-ROM.

The book consists of 10 chapters, and covers a full range of topics in alcohol and drug abuse treatment. It begins with a review of interventions for hazardous drinking, followed by chapters on the psychosocial and pharmacological treatment of alcoholism. A chapter on the long-term course of alcohol and drug dependence introduces a chapter on psychosocial treatments for drug dependence and three chapters on the pharmacological treatment of opioid withdrawal, opioid dependence, and cocaine dependence. A final chapter reviews the literature on substance abuse during pregnancy and the neonatal period. Three appendices provide a list of the contributors and scientific reviewers, the criteria used to rate the quality of the articles reviewed, and the guidelines employed to estimate effect size.

Estimating the social cost of the illicit drugs problem in Poland

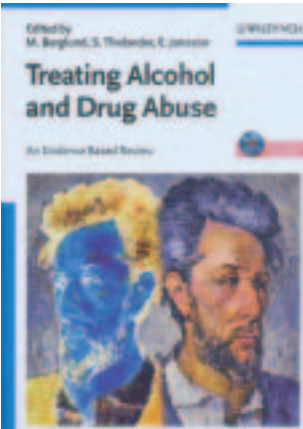
Sieroslowski J and Boguslawa B
Council of Europe 2004

The Pompidou Group recently published this report of a cost estimation study on drug use in Poland. The aim of the study was to verify the method of social-cost calculation for illegal drugs designed by Pierre Kopp and published by the Council of Europe in 2001. Identifying and estimating these economic costs could play an important role in increasing the effectiveness of the social response to the problems of addiction and illegal drug use. Poland was selected for this study because of the relatively extensive epidemiological data available and because of the opportunity it presented to test the feasibility of such a study in the Central and Eastern European region.

There are both private and public economic costs associated with illegal drug use. For this study, public costs were defined as the expenditure of various institutions in response to the drugs problem; private costs referred to spending by drug users and their families and lost productivity due to illness, death or imprisonment. Expenditure was calculated using the attributable risk method, using statistics and epidemiological studies. The method of competent raters was used to estimate the proportion of public expenditure attributable to the drugs problem. The total social costs of illegal drug use were calculated on the basis that all financial resources absorbed in dealing with the drugs problem could be used elsewhere if the problem did not exist. Lack of data meant that certain specific costs, including those relating to treating illnesses associated with drug use and injury resulting from criminal behaviour, were not included in the study.

The study was based on a survey of 153 drugs users in three rehabilitation centres in Warsaw and Krakow in 2001. The total cost of illicit drug use in Poland was estimated at €98.1 million, about 0.06% of Poland's GDP, or €2.5 per capita. The state budget bears three quarters of this total cost. Both this public cost and the private costs, estimated at €47.5 million in total, are lower than in other countries. The findings of the study show that expenditure on supply reduction and expenditure on demand reduction are roughly equal. The authors recommend that the balance should be shifted in favour of harm reduction.

The results of the study have been presented widely both to the international research community and to Polish policy makers.



Recent Publications (continued)

Articles

The following are brief summaries of a selection of articles published in international journals during 2004 relating to the drugs situation in Ireland or written by Irish authors.

Prisoners' views of injecting drug use and harm reduction in Irish prisons

Long J, Allwright S and Begley C
International Journal of Drug Policy 2004 April; 15(2): 139–149

Drug misuse and hepatitis C are known to be endemic in Irish prisons. Using a grounded theory approach, this qualitative study sought to examine prisoners' views of drug injecting practices and harm reduction interventions in Dublin prisons. Thirty-one male prisoners were interviewed (16 injecting drug users and 15 non-injectors). Two themes relevant to drug use practices emerged. Respondents described increased health risks related to injecting drug use during detention and associated with a prison environment. These included: the low availability of heroin which encouraged a shift from smoking to injecting; the scarcity of injecting equipment which fostered sharing networks far wider than outside prison; inadequate injecting equipment cleaning practices; and the rent of needles and syringes in exchange for the drugs. Both non-injectors and injectors interviewed supported harm reduction interventions in prison and felt that the range of drug services available in prison should mirror those

currently available in the community, although half opposed or had reservations about syringe exchange in prison. Prisoners viewed their time in prison as an opportunity to address substance misuse related problems; health professionals should not miss this opportunity.

Children attending addiction treatment services in Dublin, 1990-1999

Smyth BP and O'Brien M
European Addiction Research 2004; 10(2): 68–74

In Europe, adolescent substance misuse increased during the 1990s. Ireland has among the highest rates of substance misuse among schoolchildren in Europe. This study sought to describe the socio-demographic and drug misuse profile of children presenting to addiction treatment services in Dublin during the 1990s. Of the 9,874 individuals who sought addiction treatment, 1,953 (20%) were aged less than 18 years. There was a sharp increase in the number of children after 1993. The main drug of abuse was an opiate in 48 per cent of cases. Compared to adults, the children were more likely to be female and less likely to inject. As the decade progressed the proportion of girls increased, injecting was reported more frequently and there was a dramatic rise in heroin misuse. Child heroin users were more likely to be female and to be homeless, compared to their adult counterparts. This study highlights the need for a dedicated service for child drug users in Dublin.

(Joan Moore, Louise Farragher)

Upcoming Events in 2004 – A Selection

July

5–9 July 2004

AIDS / STD Prevention: Designing Theory-based and Evidence-based interventions

Venue: Maastricht University, The Netherlands

Organised by/Contact:

Registration can be achieved by filling in the registration form. Registration forms can be requested at the course secretariat: Ms Anja Ronken
Tel: +31 (0) 43 38 82 941
Email: anja.ronken@fd.unimaas.nl
www.interventionmapping.nl

Information: The summer course will focus on developing theory-based and evidence-based health education and promotion programmes for Aids prevention. The emphasis of this course will be on applying the Intervention Mapping process to the development of Aids prevention

programmes. Intervention Mapping is a new process for the creation of health education programmes, in which the educators are guided through a series of steps that will assist them in theory-based and evidence-based intervention development.

12–14 July 2004

12th British Prison Drug Workers' Conference

Venue: Edinburgh, Scotland

Organised by/Contact:

Conference Co-ordinator
Tel: +44 (0) 20 8543 8333
Email: smaster@cranstoun.org.uk or skucuk@cranstoun.org.uk

Information: Entitled 'Advancing the Inclusion Agenda', the aim of this conference is to promote debate and facilitate the exchange of information between those working with drug users in prisons, and to provide the opportunity to network and contribute to

influencing policy development within the field.

September

7 September 2004

Seminar: Drug Abuse: A Perspective on Individual and Community Rights

Speaker: Dr John O'Connor

Venue: Drug Treatment Centre Board, Trinity Court, 30–31 Pearse Street, Dublin 2

Seminar Price: €30.00 per Seminar or €120.00 per Series (5 for the price of 4)

All places must be pre-registered, full details available from:

Tel: 01 648 8600 Fax: 01 648 8700

Email: seminars@dtcb.ie
www.addictionireland.ie

Information: Dr John O'Connor is a consultant psychiatrist and clinical director at the Drug Treatment Centre Board, Trinity

Upcoming Events in 2004 – A Selection

Court / Beaumont Hospital and the Rutland Centre. Specialising in substance misuse, Dr O'Connor is widely published in this field.

16 September 2004

Towards a Comprehensive System for Treating Alcohol-Related Problems

Venue: Edmund Burke Theatre, Trinity College Dublin

Organised by / Contact: Fiona Clarke, Addiction Research Centre, Goldsmith Hall, Trinity College, Dublin 2

Tel: 01 608 3647 Fax: 01 608 3790

Email: addiction.research@tcd.ie

21 September 2004

Seminar: Hepatitis C and Drug Users

Speaker: Dr Shay Keating

Venue: Drug Treatment Centre Board, Trinity Court, 30-31 Pearse Street, Dublin 2

Seminar Price: €30.00 per Seminar or €120.00 per Series (5 for the price of 4)

All places must be pre-registered, full details available from:

Tel: 01 648 8600 Fax: 01 648 8700

Email: seminars@dtcb.ie

www.addictionireland.ie

Information: Dr Keating currently works at the Drug Treatment Centre Board as a medical officer and occupational health physician. His particular clinical and research interest is the medical consequences of intravenous drug use, particularly hepatitis C infection. He has completed a pilot study into the on-site treatment of hepatitis C in a specialist drug treatment centre and has recently published a booklet titled Hepatitis C: a guide for drug users and their families. He is also a specialist general practitioner working in the areas of addiction and sexual health, in the Eastern Region Health Authority and in private practice.

24-26 September 2004

Crossing Boundaries: Implications of Advances in Basic Sciences for the Management of Addiction

Venue: Queensland, Australia

Organised by / Contact: Claire Norris
Email: addiction-conference@elsevier.com

www.addiction-conference.elsevier.com

Information: The fifth international conference on addictive behaviours will be a two-day interdisciplinary conference aiming to bring basic and applied scientists together to discuss the opportunities for the management of addictions that are emerging from recent research.

28 September 2004

Alcohol and Drugs in Sexual Assault

Venue: Manchester Conference Centre, Manchester

Organised by / Contact: Iain Mclean

Email: stmarys.sarc@cmmc.nhs.uk

www.stmaryscentre.org

Information: St Mary's Centre announces a conference for forensic physicians and scientists, counsellors, nurses, health and social service providers, the police, and academics and practitioners interested in rape/sexual assault or alcohol/drug use.

October

5 October 2004

Seminar: Drugs and Alcohol: Should we be approaching them so differently?

Speaker: Dr Joseph Barry

Venue: Drug Treatment Centre Board, Trinity Court, 30-31 Pearse Street, Dublin 2

Seminar Price: €30.00 per Seminar or €120.00 per Series (5 for the price of 4)

All places must be pre-registered, full details available from:

Tel: 01 648 8600 Fax: 01 648 8700

Email: seminars@dtcb.ie

www.addictionireland.ie

Information: Dr Joseph Barry is a specialist in public health medicine with the Eastern Regional Health Authority and senior lecturer in public health at the Department of Public Health and Primary Care, Trinity College, Dublin. Dr Barry qualified in medicine from UCC and has worked in Dublin's drug services since 1989. He has been medical advisor to the National Drugs Strategy Team since its establishment in 1996 and was a member of the Drug Treatment Centre Board from 1993 to 2003. He is a member of the National Advisory Committee on Drugs and of the Strategic Task Force on Alcohol. He has published extensively, nationally and internationally, on drug-related issues.

19 October 2004

Seminar: Drug & Alcohol Use by Irish Teenagers: From an Ireland of craic to an island of crack?

Speaker: Dr Bobby Smyth

Venue: Drug Treatment Centre Board, Trinity Court, 30-31 Pearse Street, Dublin 2

Seminar Price: €30.00 per Seminar or €120.00 per Series (5 for the price of 4)

All places must be pre-registered, full details available from:

Tel: 01 648 8600 Fax: 01 648 8700

Email: seminars@dtcb.ie

www.addictionireland.ie

Information: Dr Bobby Smyth is a consultant child and adolescent psychiatrist working full time with adolescents who have addiction problems. Based at the Drug Treatment Centre Board in Trinity Court and also with the South Western Area Health Board, Dr Smyth completed general psychiatry training in St John of God Hospital, Dublin, before undertaking higher specialist training on Merseyside in England. Currently lecturing in Trinity College on addiction, Dr Smyth previously sat on the executive committee of the child psychiatry section of the Royal College of Psychiatrists. Dr Smyth currently is a member of the Department of Health working party examining treatment services for under 18s with serious addiction problems in Ireland. Involved in addiction research for past ten years, Dr Smyth has published a dozen research papers in national and international peer-reviewed journals.

21-23 October 2004

16th ELISAD conference and annual meeting: Problematic Drug Use and Lifestyles: Trends and Social Representations

Venue: Florence, Italy

Organised by / Contact: Mariella Orsi

Tel: +39 055 6263315

Email: mariella.orsi@asf.toscana.it

Information: The theme of the conference will be: Problematic use and lifestyles: trends and social representations. In particular, it will focus on phenomena such as doping, gambling, eating disorders and extreme risk.

If you have information on upcoming conferences or other events, please let us know so that we can include it in future issues of *Drugnet Ireland*.

Send information to Brian Galvin, Drug Misuse Research Division, Health Research Board, Holbrook House, Holles Steet, Dublin 2.
Tel: (01) 676 1176 Ext. 168; Email: bgalvin@hrb.ie.

Drugnet Ireland Mailing List

If you wish to have your name included on the mailing list for future issues of *Drugnet Ireland*, please send your contact details to: Mary Dunne, Drug Misuse Research Division, Health Research Board, Holbrook House, Holles Steet, Dublin 2.
Tel: 01 676 1176 Ext 127; Email: mdunne@hrb.ie

Please indicate if you would also like to be included on the mailing list for *Drugnet Europe* and *Drugs in Focus*.