

**Users' voices:  
experiences and  
perceptions of  
European drug users**

EMCDDA thematic paper  
See page 15

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## New Minister of State with responsibility for the National Drugs Strategy

Labour TD Mr Alex White succeeded Ms Róisín Shortall TD as Minister of State with responsibility for the National Drugs Strategy in September 2012.

In December Minister White announced the conclusions of a review of drugs task forces by the Department of Health. (See [www.drugsandalcohol.ie/19054](http://www.drugsandalcohol.ie/19054))

The review recommends a series of reforms to better equip the task forces to respond to the current pattern of substance misuse. The key changes include:

- Drugs task forces to be renamed 'Drug and Alcohol Task Forces';
- A national co-ordinating committee to be established to guide the work of the task forces and drive implementation of the National Drugs Strategy;



- Clearer terms of reference and corporate governance guidelines for the task forces;
- Measures to encourage more public representative involvement in the work of the task forces; and
- Review of the number and boundaries of drugs task forces, mainly in Dublin.

## Use of sedatives or tranquillisers and anti-depressants in Ireland



The National Advisory Committee on Drugs (NACD) recently published Bulletin 6 in the series of reports on the 2010/11 general population survey on drug use in Ireland and Northern Ireland.<sup>1</sup> The bulletin reports the prevalence of sedative or tranquilliser and anti-depressant use among adults aged 15–64 years.

This article summarises, in separate sections, the 2010/11 survey findings on sedative or tranquilliser use and on anti-depressant use in terms of lifetime (ever), last-year (recent) and last month (current) use, and compares them with the 2006/7 survey results.

- EMCDDA report on drug trends in Europe
- Prevalence of alcohol consumption in Ireland
- Alcohol excise duties examined
- Talking therapies for drug users with alcohol problems
- The role of alcohol in rape cases
- What makes for a 'good' drugs policy
- SRDTF annual report 2011
- Census of homeless persons
- Research on young people leaving state care
- NESC report commends policing initiative
- Roadside drug testing
- MQI annual review 2011

## contents

- 1 Labour TD Alex White appointed new Minister of State for Primary Care
- 1 Use of sedatives or tranquillisers and anti-depressants in Ireland
- 4 Monitoring centre report reveals latest drug trends in Europe
- 6 Prevalence of alcohol consumption and alcohol-related harm in Ireland
- 7 Report of Alcohol Action Ireland conference 'Time Please... For Change'
- 7 Alcohol: increasing price can reduce harm and contribute to revenue collection
- 9 Which talking therapies (counselling) work for drug users with alcohol problems?
- 10 The role of alcohol in rape cases in Ireland
- 11 What makes for a 'good' drugs policy?
- 14 Southern Regional Drugs Task Force stresses 'humanistic' approach
- 15 'Drug problems are too complex and dynamic for single magic bullet solutions'
- 16 HSE publishes hepatitis C strategy
- 18 The first census of homeless persons in Ireland
- 19 Mental health among homeless male hostel residents in Dublin
- 19 Research on young people leaving state care in North Dublin
- 20 Probation Service annual report 2011
- 21 NESC report commends city policing initiative
- 21 Roadside drug testing
- 22 MQI annual review 2011
- 23 Taoiseach officially opens Riverbank Centre
- 24 From *Drugnet Europe*
- 25 In brief
- 26 Recent publications
- 28 Upcoming events

## Use of sedatives or tranquillisers and anti-depressants (continued)

### Sedatives or tranquillisers

'Sedatives' and 'tranquillisers' are commonly used terms for a group of medicines which depress brain and central nervous system activity.<sup>2</sup> Benzodiazepines are the most common type of drug in this group; the 'Z-drugs', such as zolpidem and zopiclone, are also included in this group and have the same effect. Medically, sedatives or tranquillisers are often referred to as hypnotics (which treat insomnia) or anxiolytics (which relieve anxiety). The same drug can be used as a hypnotic or as an anti-anxiety agent depending on the dosage used and on the time of day that it is consumed.

### Key findings: sedatives or tranquillisers

- Prevalence rates were 14% for lifetime use, 7% for last-year use and 3% for last-month use. There were statistically significant increases in the lifetime rate (up by 32%) and the last-year rate (up by 38%) since the last survey.
- The prevalence rates for women were somewhat higher than those for men on all three measures: lifetime use (16% vs 12%), last-year use (7% vs 6%) and last-month use (3% vs 2%).
- The lifetime prevalence rate for men increased by 55% since the last survey, while the rate for women increased by 17%. The last-year prevalence rate for men increased by 54%, while the rate for women increased by 28%. Overall, the gap between men and women in terms of lifetime and last-year rates has narrowed.
- Prevalence rates were higher among older adults (aged 35–64) than younger adults (aged 15–34) on all three measures: lifetime use (17% vs 10%), last-year use (8% vs 5%) and last-month use (4% vs 1%). Lifetime and last-year rates increased in both age groups since the last survey, but the increases were substantially larger for the younger adult group. Lifetime rates for young adults increased by 71%, compared to 16% for older adults; last-year rates increased by 92%, compared to 20% for older adults. As a consequence, the gap between the older and younger age groups in terms of lifetime and last-year use has narrowed.
- The median age at first use was 30 years, and was lower among men (28 years) than women (30 years).
- More than half (53%) of current users of sedatives or tranquillisers had taken them on 20 or more of the 30 days prior to the survey. Almost all (95%) said they had got the medicines on prescription from a doctor.
- Rates of use of sedatives or tranquillisers were highest at both ends of the social spectrum (among professionals and managers and among those who were dependent on long-term social assistance).

- Prevalence rates were higher among people who were separated, divorced or widowed than among married or co-habiting people.

### Discussion: sedatives or tranquillisers

The misuse of certain prescribed medicines, including sedatives or tranquillisers, is of increasing concern in Europe,<sup>3</sup> and is reported as a growing health problem globally.<sup>4</sup> Such medicines can be more easily obtained than illicit drugs, and the potential for their misuse is widespread. In Ireland, these medicines are legally and appropriately prescribed to patients to treat medical conditions, including some mental health illnesses (such as anxiety, depression and other mood disorders). Their use for short periods of time is recommended to allow doctors or other health professionals and patients deal with or stabilise an underlying condition.

The NACD survey is an important source of information to establish the extent and nature of use of these prescription medicines in the general population in Ireland and to identify which population groups are more likely to be prescribed such drugs. The 2010/11 NACD survey highlights several issues for attention.

The results show that the proportion of people using sedatives or tranquillisers has grown in recent years in Ireland. The reasons for this are not clear. Prevalence rates increased among the groups traditionally associated with these medicines (that is, women and the older population). However, the largest increases were in the rates of use by men and by young people. It is important to continue monitoring use of these drugs and to develop a better understanding of the patterns of use in sub-populations.<sup>5</sup>

The survey also raises questions about the safety of the pattern of sedative or tranquilliser use in the general population. Clinical guidelines<sup>6,7</sup> recommend that, particularly with regard to anxiety-related conditions, many of these medicines should be prescribed for short-term (2–4 weeks) relief and taken for the shortest duration of time, with the least frequency possible, so as to avoid tolerance, drug dependence and the adverse effects of long-term use. However, the survey shows that over half (53%) of all current users reported daily or almost daily use; the proportion rose to 63% in the older adult group. It is important to note that current users in Ireland are engaging in this frequency of use for periods of longer than one month and many may be at risk of experiencing a range of side effects, including dependence. Clinicians can play a critical role in identifying patients who may be at risk of overuse.

The NACD surveys show that social class plays a role in sedative or tranquilliser use. Key indicators of socio-economic deprivation, such as being unemployed, having low educational attainment or fewer years in education, and living in social housing, were associated with

## Use of sedatives or tranquillisers and anti-depressants (continued)

higher prevalence for sedative use in the 2002/3 and 2006/7 surveys. Results from the 2010/11 survey, however, show a departure from this general pattern in that prevalence rates are now highest among those who are unemployed/without employment, followed by those in managerial or professional occupations. An explanation offered for this new pattern is that it reflects a response to the stress of deteriorating economic conditions in Ireland. However, the fall-out from the recession will have impacted all occupational groups and it is difficult to see why managers and higher professionals would have resorted to sedatives or tranquillisers more than other social groups.

General practitioners everywhere need to be aware that the medicine they prescribe may be over used or diverted from the intended patient and fall into the wrong hands.<sup>4</sup> A more considered approach by health care professionals to alternative (and complementary) treatments where appropriate, as well as efforts to inform the general population on the safe and effective use of sedatives or tranquillisers and on the viability of other treatments, may be effective in reducing their use in the future.

Alex White TD, Minister of State at the Department of Health with responsibility for primary care, is considering imposing additional controls on the main sedatives and tranquillisers, such as benzodiazepines and 'Z-drugs'. The legislative amendments being considered include the introduction of an offence of unauthorised possession, as well as controls on the import and export, of such drugs.<sup>8</sup> It is also proposed to tighten the prescribing and dispensing rules applying to these drugs. One of the main challenges in formulating policy to reduce the misuse or over-use of these medicines is doing so in a way that does not interfere with appropriate use.

### Anti-depressants

An anti-depressant is a prescribed medicine used to alleviate medical conditions known as mood disorders (which include major depression, chronic depression and anxiety disorders). Two examples of anti-depressants are serotonin re-uptake inhibitors (SSRIs) and serotonin and noradrenaline re-uptake inhibitors (SNRIs). The former are used as a first-line treatment for depression, while the latter are used to treat patients who do not respond to first-line treatment.

#### Key findings: anti-depressants

- In 2010/11 the prevalence rates among adults (aged 15–64 years) were 10% for lifetime use, 5% for last-year use and 4% for last-month use. The rate for last-month use increased by 29% since the 2006/7 survey.
- Prevalence rates for women were higher than those for men on all three measures: lifetime use (13% vs 8%), last-year use (6% vs 4%) and last-month use (5% vs 2%).
- The lifetime rate for men increased by 41% since the last survey, while the rate for women was unchanged. The last-year prevalence rate for men increased by 33%, and the rate for women was unchanged. Overall, the gap between men and women in terms of lifetime and last-year rates has narrowed.
- Lifetime rates for older adults increased by 21%, from 11% in 2006/7 to 13% in 2010/11. No statistically significant changes were found over time among young adults.
- The median age at first use was 30 years, two years earlier than the median age reported in 2006/7, and was lower for women (30 years) than for men (34 years).

- The vast majority (92%) of current users reported taking anti-depressants on 20 or more days in the month before the survey, and 99% reported getting the medicine on prescription from a doctor.
- Prevalence rates were highest for those who were dependent long-term on social assistance, and lowest for professionals and managers.
- Prevalence rates were higher for people who were separated, divorced or widowed than for married or co-habiting people.

(Justine Horgan, NACD, and Jean Long)

1. NACD and PHIRB (2012) *Drug use in Ireland and Northern Ireland. 2010/11 Drug Prevalence Survey: sedatives or tranquillisers and anti-depressants results*. Bulletin 6. Dublin: NACD & PHIRB. [www.drugsandalcohol.ie/18660](http://www.drugsandalcohol.ie/18660)
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# Monitoring centre report reveals latest drug trends in Europe

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published its annual report 2012 on the drugs situation in Europe in November.<sup>1</sup> According to the report, we may be entering a new era in which heroin will no longer play such a central role in Europe's drugs problems. The number of new heroin users is declining in several countries, while access to substitution treatment for opioid (mostly heroin) users has risen. There is a wide range of new psychoactive substances available and the drugs market is changing rapidly. The stimulant market is particularly complex. Cocaine, amphetamines and ecstasy are still the most important stimulants but a number of new synthetic drugs, such as cathinones, are becoming more significant. The EMCDDA says: 'It is critical that we better understand the health and social impact of these emerging trends and develop measures to reduce demand. To do this better forensic and toxicological analysis is essential, as is the need to proactively engage with those most at risk.'

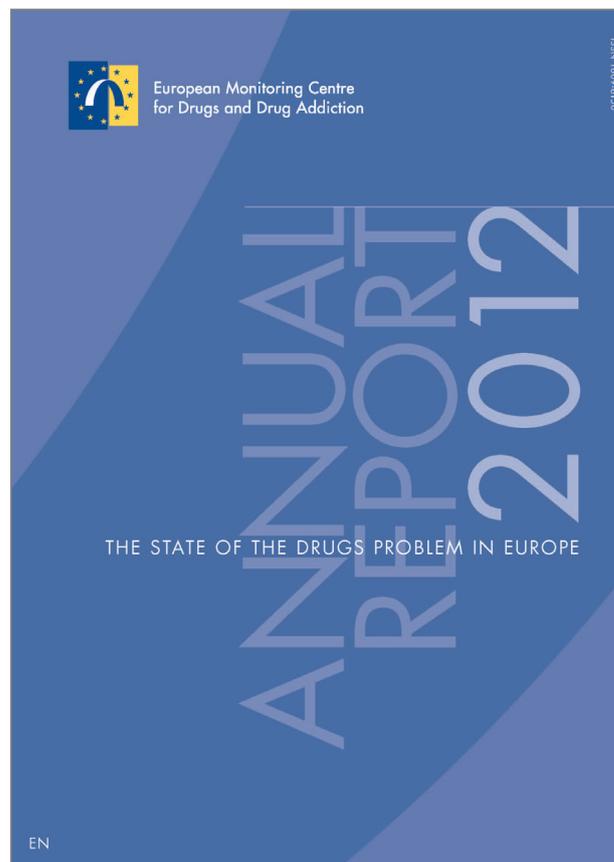
The drugs situation described in the report is presented below under a series of headings.

## Cannabis

- Cannabis is still Europe's most commonly consumed illicit drug. One in five adults aged 15–64 have tried cannabis at some point in their lives. Most countries report that cannabis use is stabilising or decreasing. Of the countries which have recorded the highest level of last-year prevalence among young people (aged 15–34) over the past decade, only Italy recorded an increase.
- Around 1% of adults, three-quarters of whom are aged 15–34 use cannabis daily or almost daily. There is increasing awareness that dependency is a possible consequence of cannabis use and the number of individuals seeking help because of their cannabis use is growing in some European countries.
- Cannabis resin seizures declined in 2010 after a steady increase in the previous decade. The amount of cannabis seized continued to decline and the 560 tonnes recorded in 2010 was a new low.
- Europe is now an important producer of cannabis. The overall trend is toward 'import substitution', that is, imported cannabis products being replaced by herbal cannabis grown inside Europe's borders.

## Opiates (mainly heroin)

- More than 200,000 (48%) clients who entered drug treatment in 2010 reported opioids, mainly heroin, as their primary problem drug.
- In some countries clients cited other opioids as their primary drug more often than heroin. These include fentanyl in Estonia, buprenorphine in Finland, and other opioids in Denmark, Latvia and Austria.
- Analysis of data in 24 countries on opioid users entering treatment for the first time in their lives showed a decrease from 61,000 in 2007 to 46,000 in 2010. The average time lag between first opioid use and first treatment entry is about nine years, so recent decreases in the number of heroin users entering treatment for



the first time should at least partly reflect a reduction in heroin incidence that occurred some time ago.

- Most EU countries reported an upward trend in drug-induced deaths between 2003 and 2008, followed by stable numbers in 2009, with provisional data for 2010 pointing to an overall decrease in such deaths.
- Around 36% of those entering treatment for opioid use in 2010 reported injecting. The rate varies greatly between countries, from 7% in the Netherlands to 94% in Latvia, while data from most countries show a steady decrease from 2000. In eastern European countries injection is still the main route of administration.
- While the rate of HIV transmission among drug users continues to decrease, Greece and Romania have reported outbreaks of HIV infection, with a local epidemic among injectors in Athens.
- The EMCDDA estimates that about 1,830 people died of HIV/AIDS attributable to drug use in the EU in 2009, with almost 90% of these deaths occurring in Spain, France, Italy and Portugal.

## Drug trends in Europe (continued)

- An estimated 696,000 opioid users were in receipt of substitution treatment in 2011, the most common type of treatment for opioid dependence in Europe, with medium term trends showing a continuous increase since 2003. About half of all problem opioid users in Europe have access to substitution treatment, but some countries have considerably lower coverage levels: Greece (28%), Lithuania (17%), Slovakia (12%), Poland (8%) and Latvia (2%).
- Latest figures for seizures and drug-law offences point to an overall decrease in heroin supply. Around 55,000 seizures resulted in the interception of 19 tonnes of heroin in 2010, compared with 56,000 seizures and 24 tonnes in 2009.

### Cocaine

- Cocaine remains the second most commonly used illicit drug in Europe, although high levels of cocaine use are observed only in a small number of mostly western European countries.
- Around 15% of drug users entering treatment report cocaine as their main problem drug.
- With the exception of Ireland, where the situation has stabilised, the countries most affected by cocaine use among young adults (aged 15–34) reported a decline in last-year use of this drug by this age group in the last country survey.
- The countries reporting the highest last-month prevalence among young people were Spain, the UK, Cyprus and Italy.
- Some countries reported that the number of cocaine-related hospital emergencies was three times higher in recent years than it had been at the end of the 1990s.
- The number of cocaine seizures fell slightly to around 88,000 in 2010 from 100,000 in 2008.

### Other stimulants and new psychoactive substances

- The European Early Warning System (EWS) identified 24 new psychoactive substances in 2009, 41 in 2010 and 49 in 2011. The EWS has already identified over 50 new substances in 2012, the largest number ever reported in a single year. The two largest drug groups monitored by the EWS are synthetic cannabinoids (such as found in 'Spice') and synthetic cathinones (e.g. mephedrone, MDPV) which mimic the effects of other stimulants (including cocaine).
- While overall last year use of amphetamines among young adults is stable or declining, crystal meth use appears to be increasing. Germany, Estonia, Latvia and Austria are among the countries that have seen significant increases in seizures of the drug between 2009 and 2010.
- Deaths linked to use of the stimulant drug 4-methylamphetamine (4-MA), which is not currently a controlled drug, and reports of seizures in 14 European countries have prompted a risk-assessment exercise by experts from a number of European agencies. 4-MA belongs to the group of synthetic phenethylamine drugs and is sold on the illicit market, usually mixed with amphetamine.

- Use of ecstasy (MDMA) is concentrated among young adults. Of 2.0 million adults who reported using the drug in the past year, 1.5 million were in the 15–34-year age group. The proportion of MDMA in tablets sold as ecstasy had been declining in recent years owing to the success of measures to prevent diversion of precursor chemicals, but MDMA has reappeared and is increasing as manufacturers identify new precursor chemicals.
- The most recent snapshot study (January 2012) identified 693 online shops purportedly selling psychoactive products, with three natural products – kratom, salvia and hallucinogenic mushrooms – the most frequently sold 'legal highs'. There were 170 of these shops in January 2010. The snapshot identified a marked rise in the availability of synthetic cathinones, suggesting that online operators are seeking a replacement for mephedrone, now banned in the EU.

### Responding to drug use in European prisons

It is estimated that around 635,000 people were held in penal institutions in the EU as at September 2010, compared with around 582,000 in 2001. A new EMCDDA report<sup>2</sup> published alongside the annual report examines the provision of drug-related services in European prisons, including counselling, treatment of dependence and the prevention of infectious diseases. Lifetime prevalence levels for heroin use among prisoners in 13 of the 17 countries surveyed were between 15% and 30%; the rate is less than 1% for the general population. Some prisoners initiate drug use or begin to engage in more harmful practices (e.g. sharing injecting equipment) while in prison. Overcrowding, poor hygiene and a lack of healthcare provision affect many prisons, and contribute to the overall poor health status found in inmates.

The report notes that many countries have scaled up the provision of interventions within prisons, particularly of substitution treatment for those who are opioid dependent. However, prisons rarely offer a standard of care equivalent and comparable to that provided to the wider community. 'Penitentiary healthcare has in the past decade increasingly been recognised as part of public health care', says the report. There is a need to improve continuity of care for prisoners on their release when the risk of overdose death is extremely high because of reduced tolerance. The report highlights the need for pre-release counselling and overdose prevention training.

(Brian Galvin)

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2. European Monitoring Centre for Drugs and Drug Addiction (2012) *Prisons and drugs in Europe: the problem and responses*. Luxembourg: Publications Office of the European Union. [www.emcdda.europa.eu/publications/selected-issues/prison](http://www.emcdda.europa.eu/publications/selected-issues/prison)

# Prevalence of alcohol consumption and alcohol-related harm in Ireland



On 24 September 2012, the National Advisory Committee on Drugs (NACD) published the main findings on alcohol consumption and alcohol-related harm among adults in Ireland from the 2010/11 general population drug prevalence survey.<sup>1</sup> This is the first NACD drug prevalence survey to include a comprehensive series of questions on the rates and patterns of alcohol consumption and on alcohol-related harm. The survey involved a representative sample of people aged between 15 and 64 who were interviewed during late 2010 and early 2011. Only those aged 18–64 years (n=4,843) were included in the analysis of the alcohol responses as it is illegal for those aged 15–17 to buy alcohol and it was not feasible to analyse this group separately due to low numbers.

## Frequency and volume of drinking

Eighty-seven per cent of adults aged 18–64 years consumed alcohol in the 12 months prior to the survey; these were classified as current drinkers. The remaining 13% were classified as non-drinkers. Women (15%) were more likely than men (11%) to be non-drinkers and respondents aged 50–64 years (19%) were more likely to be non-drinkers compared with 18–24-year-olds (7%). Previous research has indicated that people in Ireland consume alcohol less frequently than their European counterparts,<sup>2</sup> but that when they do drink they consume more per drinking occasion than Europeans do. In this survey 31% of men and 21% of women consumed alcohol at least twice weekly. Those aged 50–64 years were the most likely to consume alcohol at least twice weekly, with 39% of males and 22% of females in this age group drinking this often. One quarter of respondents (24%) consumed 1–2 standard drinks<sup>3</sup> per drinking occasion, which is classified as being within low-risk daily consumption limits, and this was most common among adults aged 50–64 years (34%). Forty per cent of drinkers in this survey consumed at least five standard drinks per drinking occasion.

## Harmful drinking patterns

The survey examined patterns of harmful drinking using three measures: the World Health Organization's AUDIT-C screening tool, which is used to identify people with harmful

drinking patterns; the frequency of monthly risky single-occasion drinking (RSOD); and the RAPS screening tool, which is used to screen for alcohol dependence. According to the AUDIT-C screening tool, half of the population aged 18–64 years and 58% of current drinkers may be classified as harmful drinkers. Among current drinkers aged 18–24 years, 82% of males and 68% of females scored positive for harmful drinking.

Risky single-occasion drinking (RSOD), commonly described as 'binge drinking', is defined as consuming at least 75g of alcohol on a single drinking occasion; 75g is the equivalent of four pints of beer, or seven pub measures of spirits, or one 750ml bottle of wine. Half (52%) of all current drinkers engaged in RSOD at least once a month in the 12 months prior to the survey.

Based on the RAPS screening of behaviours in the 12 months prior to the survey, 23% of drinkers reported feelings of guilt or remorse after drinking; 24% reported that friends/family told them about things they said/did that they did not remember; 12% reported that they failed to do what was normally expected; 2% reported that they needed a first drink in the morning. Eighteen per cent (22% males; 13% females) of drinkers, had two or more positive scores on the RAPS screening tool. Those aged 18–24 years were most likely to have two positive scores (43%), compared with 7% among those aged 50–64 years.

## Alcohol-related harm

One in five drinkers reported that they had experienced harm, such as harm to health, work, friendship, or being involved in a fight or an accident, in the previous 12 months as a result of their drinking, with men almost twice as likely as women to report such harm, (26% vs. 14%). Harm to health was reported by 13% of drinkers, with 24% of 18–24-year-olds reporting this harm. Over one quarter of respondents (27%) reported that they had experienced harm in the previous year as a result of someone else's drinking; these harms include family problems, being assaulted and being a passenger with a drunk driver. Those who engaged in frequent RSOD were most likely to report alcohol-related harm from both their own and others' drinking.

(Deirdre Morgan)

1. National Advisory Committee on Drugs and Public Health Information and Research Branch (2012) *Drug use in Ireland and Northern Ireland Alcohol Consumption and Alcohol-Related Harm in Ireland 2010/2011 Drug Prevalence Survey: Bulletin 7*. Dublin: National Advisory Committee on Drugs & Public Health Information and Research Branch. [www.drugsandalcohol.ie/18439](http://www.drugsandalcohol.ie/18439)
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3. A standard drink contains 10g of pure alcohol and is the equivalent of a half pint of beer/lager, or one pub measure of spirits, or one small (100ml) glass of wine.

# Report of Alcohol Action Ireland conference 'Time Please... For Change'

Alcohol Action Ireland's conference, 'Time Please... For Change', held on 1 November brought together a number of expert national and international speakers examining key initiatives that could make a difference to Ireland's harmful relationship with alcohol. The conference was launched by Alex White, Minister for State for Primary Care, who said that the National Substance Misuse Strategy would be brought to Cabinet in the coming weeks. Dr Jean Long, Health Research Board, said that surveys have shown that the Irish public supported many of the recommendations in the Strategy, including those on minimum pricing and advertising restrictions.

Prof Frank Murray, chairman of the alcohol policy group at the Royal College of Physicians of Ireland, described how mortality rates for liver cirrhosis in Ireland have doubled in the last 15 years as a result of alcohol consumption. He said that, in order to reduce alcohol consumption and its related harms, it is necessary to increase the price of alcohol and reduce its availability. Marketing lecturer Pat Kenny told the conference that sponsorship was not a type of philanthropy by the alcohol industry, but was part of sophisticated marketing strategies to normalise alcohol consumption.

Dr John Holmes, University of Sheffield, said that alcohol consumption decreased by 3%–8% in Canada following the introduction of minimum pricing and described how similar plans in Scotland would be expected to cut drinking levels by 5.5%. He also stated that minimum pricing has a far greater effect on harmful drinkers than on low-risk

consumers as harmful drinkers consume cheaper products. Dr Evelyn Gillan of Alcohol Focus Scotland said that while it is partly true that drinking is part of the culture in Scotland and Ireland, there has been a huge increase in the availability and affordability of alcohol. She also provided an update on the industry challenge to the Scottish government's minimum pricing legislation introduced in May 2012. The judicial review sought by the industry has been postponed, but Alcohol Focus Scotland remained confident that the government would defeat the legal challenge.

Fiona Ryan, CEO of Alcohol Action Ireland, said the country cannot afford the financial and human costs that arise from alcohol. She said that 27 national charities, community and medical representative organisations, many of which deal with the realities of alcohol-related harm in communities, families, the health system and on the streets, support the call for minimum pricing.

Dr Declan Bedford detailed how implementing evidence-based policy and legislation on drink driving has reduced the harms and costs of alcohol on our roads, and Kathleen O'Meara of the Irish Cancer Society described how policy changes have led to a reduction in tobacco-related harm.

Copies of the presentations can be accessed at <http://alcoholireland.ie/2012/time-please-for-change-the-presentations/>.

*(Deirdre Mongan)*

## Alcohol: increasing price can reduce harm and contribute to revenue collection

Alcohol is price sensitive – increasing the cost of alcohol reduces its consumption and decreasing the cost of alcohol increases its consumption. Price is therefore often used as a policy lever to reduce alcohol consumption and its related health and social harms. The two main pricing mechanisms that can be used to reduce consumption are taxation and minimum pricing. There are two types of taxes on alcohol in Ireland – excise duties, which vary with the different categories of alcoholic drink, and VAT, a uniform rate currently set at 23%. Excise duties are normally reviewed annually by the Minister for Finance in his Budget.

Excise duty rates for all alcoholic beverages increased greatly in absolute and relative terms between 1950 and 1994; the rate for distilled spirits increased by 660%, while that for beer increased by 2,570%. Rates increased sharply in the 1960s and 1970s but the rate of increase slowed after 1980. While the rate for beer increased by 1,350% between 1960 and 1994, it only increased by 120% between 1980 and 1994.<sup>1</sup> However, since 1994 the rate for beer has actually decreased by 21% and the rate for wine has decreased by 4% (Table 1). In 2010 excise receipts amounted to €826 million.

In general, a reduction in excise duty rates leads to increased alcohol sales, lower excise receipts and higher consumption, while an increase in excise duty rates leads to reduced alcohol sales, higher excise receipts and lower consumption. A recent illustration of the link between tax, price and consumption is provided by Finland, where in 2004 the government reduced alcohol excise duty by an average of 33% in order to reduce the number of cheap imports. The result was an immediate 10% increase in consumption and a 17% increase in alcohol-related mortality, equivalent to approximately eight additional alcohol-related deaths per week.<sup>2</sup>

The impact of recent excise duty rate changes in Ireland is outlined in Table 2. In the December 2009 budget, the excise duty rate was decreased by 20–21% for all alcohol beverages. This led to increased sales for the alcohol industry in 2010 amounting to an additional 2,149,624 litres of pure alcohol (equivalent to 8.1 million 700ml bottles of vodka). However, the decrease in excise duty rates had a detrimental impact both on the exchequer and on public health as the excise receipts decreased by €142 million and overall consumption increased by 6%. In comparison, the 42% increase in excise duty rates on spirits in 2003 led to an increase of €39 million in excise receipts and a decrease of 6% in overall alcohol consumption.

## Alcohol pricing (continued)

**Table 1 Excise duty rates on the main alcoholic beverages sold in Ireland in 1994 and 2010**

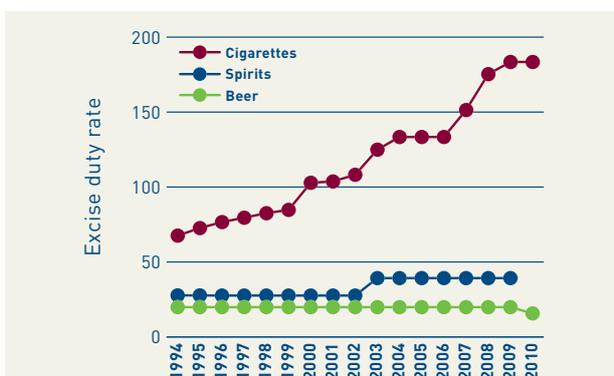
	Beer (per hectolitre per cent of alcohol exceeding 2.8% volume)	Spirits (per litre of alcohol exceeding 5.5% volume)	Wine (per hectolitre 5.5%–15% volume)	Cider (per hectolitre not exceeding 5.5% volume)
1994	€19.87	€27.72	€273.00	€44.48
2010	€15.71	€31.13	€262.24	€65.86
Change	-20.9%	+12.3%	-3.9%	+48.1%

**Table 2 Impact of recent changes in alcohol excise duty rates in Ireland**

Year	Change in excise rate	Impact on alcohol industry	Impact on exchequer	Impact on public health
2010	All alcohol ↓ 20–21%	Litres sold ↑ 2,149,624	↓ €141,599,915	Overall consumption ↑ 6%
2008	Wine ↑ 20%	Litres sold ↓ 334,206	↑ €1,130,436	Wine consumption ↓ 6%
2003	Spirits ↑ 42%	Litres sold ↓ 1,935,707	↑ €38,564,205	Spirits consumption ↓ 21%
2002	Cider ↑ 87%	Litres sold ↓ 418,693	↑ €26,028,516	Cider consumption ↓ 13%

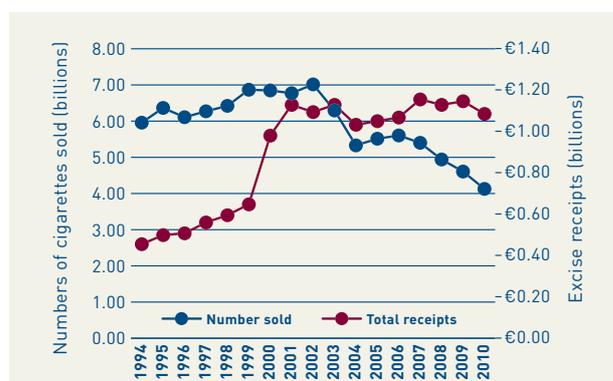
In the European context, Ireland, Denmark, Finland, Sweden and the UK are regarded as having relatively high alcohol taxes. However, the rates in Ireland are declining in real terms and the real burden of alcohol taxation has fallen as prices of other consumer goods have risen. Taxation of alcohol has in the past been a very important source of state revenue. Ireland experienced a clear decrease in alcohol tax revenues relative to total state revenues between 1970, when its share was 16.5%, and 1996, when it was estimated at 5%. A major cause of this decline is that excise duties are commonly set as a fixed amount of the local currency, so that inflation automatically reduces their value, unless there is new legislation to set a new tax level. A solution to the tendency of inflation to reduce the tax rate in real terms is to provide that the tax rate is tied to a cost-of-living index, rising and falling with it, rather than being set at a fixed value. This is the case in Australia, where alcohol excise duty rates are adjusted every six months in line with the Consumer Price Index.<sup>3</sup>

It appears that in Ireland tax is no longer employed as a means of controlling levels of alcohol consumption and its related harm. However, the opposite seems to be the case in relation to cigarette smoking, with the rate of excise duty on cigarettes increasing by 171% between 1994 and 2010 (Figure 1).



**Figure 1 Excise duty rates for cigarettes, beer and spirits 1994–2010**

Coinciding with the excise duty rate increase on cigarettes, the number sold decreased by 31%. In addition to the positive public health benefits arising from a reduction in cigarette smoking, the excise duty receipts increased by 149% and amounted to €1.1 billion in 2010 (Figure 2).



**Figure 2 Number of cigarettes sold and total excise receipts 1994–2010**

### Conclusion

Price regulation is the policy governments most commonly use to reduce alcohol consumption. It has a strong evidence base for reducing alcohol-related harm, although historically it has been used to increase revenue for government, rather than for social or public health reasons. Increasing excise duty rates increases the price of all alcohol regardless of whether it is sold in the on- or off-trade. However, an increase in tax may be absorbed by supermarkets and off-set by increasing the prices of other goods, and if alcohol is sold below cost price the retailer is entitled to a VAT refund on the difference between the cost price and the below-cost sale price, which deprives the state of revenue. Minimum pricing sets a price below which no alcohol beverage can be sold and which therefore cannot be undercut; it predominantly increases the price of the cheaper alcohol sold in supermarkets and mainly impacts harmful and younger drinkers. Excise duty and minimum pricing are not irreconcilable: a restoration of excise duty to the 2009 levels that existed prior to the last government's 20% cut could have earned the government around €170 million in 2011.<sup>4</sup> It is likely that a combination of taxation and minimum pricing will have the most beneficial effect on public health and will also provide increased revenue to the state at a time when harmful use of alcohol is responsible for 88 deaths each month and costs €3.7 billion annually. In 2009 the alcohol industry contributed €2.0 billion in the form of excise duty and VAT,<sup>5</sup> leaving a net cost to the State of €1.7 billion in costs related to alcohol.

## Alcohol pricing (continued)

*In Budget 2013, presented in December 2012, the government increased excise duty on alcohol. It remains to be seen what impact this measure will have across the board.*

(Deirdre Mongan)

1. Osterberg E and Karlsson T (2002) *Alcohol policies in EU member states and Norway. A collection of country reports.* Helsinki: European Commission. [http://ec.europa.eu/health/ph\\_projects/1998/promotion/fp\\_promotion\\_1998\\_a01\\_27\\_en.pdf](http://ec.europa.eu/health/ph_projects/1998/promotion/fp_promotion_1998_a01_27_en.pdf)
2. Mäkelä P and Osterberg E (2009) Weakening of one more alcohol control pillar: a review of the effects of the alcohol tax cuts in Finland in 2004. *Addiction*, 104: 554–63.
3. Babor T, Caetano R, Casswell S, et al. (2010) *Alcohol: No ordinary commodity - research and public policy.* Second Edition. New York: Oxford University Press. pp. 110–112.
4. Alcohol Action Ireland (2012) *Getting the facts right about minimum pricing.* Dublin: Alcohol Action Ireland. <http://alcoholireland.ie/wp-content/uploads/2012/08/minimum-pricing-fact-sheet.pdf>
5. Foley A (2010) *The economic contribution of the drinks industry.* Dublin: Drinks Industry Group of Ireland. <http://www.drugsandalcohol.ie/14139/>

# Which talking therapies (counselling) work for drug users with alcohol problems?

A collaborative team based at the University of Limerick's Graduate-Entry Medical School has recently completed a HRB-funded Cochrane Review of psychosocial interventions for problem alcohol use among problem drug users.<sup>1</sup> The review involved collaboration with the UCD School of Medicine and Medical Science and NUI Galway and was conducted over two years. It describes a gap in the research evidence relating to the important question of whether clinical interventions that are based on behavioural, motivational or social theories of change, and can be effective in treating alcohol problems, are also effective for patients with coexisting addiction issues.

### What is problem alcohol use and what are psychosocial interventions?

Problematic use of alcohol means drinking above the recommended safe drinking limits. It can lead to serious health issues or dependence. Excessive drinking in people who have problems related to use of other drugs is common, and often both exacerbates the substance abuse and leads to serious health challenges. Psychosocial interventions are talking therapies that aim to identify an alcohol problem and motivate an individual to do something about it. They can be performed by staff with training in these approaches, a doctor, nurse, counsellor or psychologist, for example. Talking therapies may help people reduce their drinking, but their influence on people who have problems with other drugs is not known. In undertaking this review, we wanted to see whether talking therapies impact on alcohol problems in drug users. In particular, we wanted to evaluate data from published randomised trials with respect to talking therapies focused on alcohol drinking in adult users of illicit drugs (mainly opiates and stimulants).

### Studies reviewed and conclusions made

We found four relevant studies that involved 594 adults (over the age of 18 years) with drug problems. One study looked at training in cognitive-behavioural coping skills versus 12-step facilitation. One study evaluated

brief intervention versus treatment as usual. Another trial investigated motivational interviewing (group and individual format) versus hepatitis health promotion, while the final paper reported details of brief motivational intervention versus assessment only.

In summary, the studies were so different in their design and implementation that their results could not be combined; it therefore remains uncertain whether talking therapies affect alcohol consumption in people who have problems with other drugs. In essence, this is because of the low quality of the evidence. In addition, it remains uncertain whether talking therapies for drinking affect illicit drug use in people who have problems with other drugs. There was not enough information to compare different types of talking therapies. Many of the studies did not account for possible sources of bias; more high-quality studies, such as randomised controlled trials, are needed to answer this question.

The knowledge gained in this review will now form part of the baseline information for an initiative which develops this topic further – PINTA-lite – a feasibility study integrating addiction treatment and primary care which will develop an evaluation of a psychosocial intervention for polydrug use. This three-year project is led by a team at UL's Graduate-Entry Medical School and involves academic, clinical, and policy experts responsible for planning and delivery of addiction care and primary care, and international experts on problem alcohol use in primary care and on the role of primary care in addressing the needs of vulnerable populations.

(Jan Klimas)

1. Klimas J, Field C-A, Cullen W, O'Gorman CSM, Glynn LG, Keenan E et al. (2012) Psychosocial interventions to reduce alcohol consumption in concurrent problem alcohol and illicit drug users. *Cochrane Database of Systematic Reviews*, 11. Published online 14 November. [www.ncbi.nlm.nih.gov/pubmed/23152270](http://www.ncbi.nlm.nih.gov/pubmed/23152270)

# The role of alcohol in rape cases in Ireland

A Rape Crisis Network Ireland (RCNI)<sup>1</sup> submission to the Joint Oireachtas Committee on Justice, Defence and Equality reported on the issue of 'Gratuitous violence arising from alcohol and substance abuse'.<sup>2</sup> The submission states: 'Whereas there is little evidence to indicate that better recognised drugs, such as Rohypnol and GHB are used with regularity to facilitate rape, the high involvement of alcohol in Irish rape cases, including rape involving victims who were too intoxicated to consent, suggests that alcohol is a very common drug used to facilitate rape' (p.3).

The submission cites *Rape and justice in Ireland (RAJI)*, a study published in 2009 that identified a high level of alcohol involvement in reported and/or prosecuted rape.<sup>3</sup> Acknowledging that alcohol involvement in rape is not unique to Ireland, the submission states that 'the levels of binge drinking [in Ireland] on the occasion of the rape are extraordinarily high compared to European and North American states' (p.3). Data cited from the RAJI study include the following:

- 45% of complainants and 40% of suspects of reported rape between 2000 and 2005 in Ireland had been binge drinking on the occasion of the rape.
- Of those on trial for rape whose alcohol consumption was known, nearly 90% of defendants had been binge drinking.
- As many as 10% of all reported rape cases in Ireland involved a complainant who was incapable of offering consent due to alcohol consumption. (p.3)

According to the submission, young people appear to be particularly at risk, with half of all reported rapes in Ireland between 2000 and 2005 involving a victim under 25, and 33% of those accused of rape in the same period being under 25 (p.3).

The submission argues that the widespread societal acceptance of alcohol consumption in Ireland diminishes recognition of alcohol as a potential date-rape drug. The submission cites one study where mock jurors normalised the use of alcohol in socio-sexual interaction, even where alcohol was administered surreptitiously. However, the same study found that when alcohol was replaced with a more commonly recognised date-rape drug such as GHB or Rohypnol, such behaviour elicited a 'strong recognition of rape from participants' (p.4).

Applying the lessons from this research to the Irish context, the RCNI submission suggests that in Ireland the tolerance for the use of alcohol to facilitate sexual interaction diminishes the perceived 'seriousness of sexual violence

facilitated by alcohol and the culpability of perpetrators of sexual assaults and rapes against intoxicated victims' (p.4). Although there is no research in Ireland on jury deliberation in rape cases, citing the findings of international research that juries are more likely to assign blame to intoxicated victims of rape, the submission suggests that 'it is possible that victim alcohol consumption is a contributing factor in the low rate of rape conviction' in Ireland (p.4).

The RAJI study found that victims who had consumed alcohol at the time of the rape were likely to self-blame and that they were also likely not to report the rape, or to withdraw their complaint 'due to expected negative reactions from services' (p.5).

The RCNI submission makes a number of recommendations, including the following;

- Alcohol marketing should be controlled through legislation 'in particular where it is targeted at young people and/or presents alcohol consumption as linked to sexual success'.
- Broad educational campaigns should target and dispel inaccurate alcohol expectancies in order to reduce aggressive sexual behaviour in men and facilitate better recognition of sexual disinterest and refusal. Such education programmes should also affirm that 'alcohol consumption is never a justification for coercing or forcing sex on an unwilling partner'.
- 'There is a need for mock-jury studies in Ireland to establish the extent to which victim-blaming attitudes influence jury decision making.' (p.6)

The submission also strongly endorses the recommendations of the National Substance Misuse Strategy with regard to reducing the supply of alcohol to young people.<sup>4</sup>

(Johnny Connolly)

1. The RCNI is the representative, umbrella body for Rape Crisis Centres, which provide free advice, counselling and support for survivors of sexual abuse in Ireland. See [www.rcni.ie](http://www.rcni.ie)
2. Rape Crisis Network Ireland (2012) *RCNI submission to the Joint Oireachtas Committee on Justice, Defence and Equality, on the issue of gratuitous violence arising from alcohol and substance abuse*. Galway: Rape Crisis Network Ireland. [www.rcni.ie/rcni-submissions.aspx](http://www.rcni.ie/rcni-submissions.aspx)
3. Hanly C, Healy D and Scriver S (2009) *Rape and justice in Ireland: a national study of survivor, prosecutor and court responses to rape*. Dublin: The Liffey Press.
4. Department of Health (2012) *Steering Group report on a National Substance Misuse Strategy*. Dublin: Department of Health. [www.drugsandalcohol.ie/16908](http://www.drugsandalcohol.ie/16908)

# What makes for a ‘good’ drugs policy?

In recent months a slew of documents outlining what makes for a ‘good’ drugs policy have appeared. Two sets of guidelines have emanated from the NGO sector, at EU and international level, and two from governmental sources – the Council of Europe and the US government. A study of the principles and criteria as summarised in the table below highlights the differing perspectives and priorities of the different entities.

Just two principles are explicitly mentioned in all four guidelines – the need both to recognise human rights and to focus on public health. Two other principles are referred to either explicitly or implicitly in all four documents – the need for a co-ordinated or integrated response, and the need for evidence-based policy. However, the interpretation of these terms varies. For example, the EU’s Civil Society Forum on Drugs (CSFD) emphasises the ‘right to health care’ of all EU citizens, while the US government policy guidelines foreground the need to protect the ‘human rights of all citizens’, including children and drug users.

The omission of certain principles from various guidelines is also instructive. All guideline documents, except for those published by the White House’s Office of National Drug Control Policy (ONDCP), highlight the need to focus on vulnerable groups and to promote their social inclusion, as a preventive measure. Both sets of guidelines published by governmental sources call for compliance with international treaties, while neither set of guidelines issued by NGO

bodies refer to international policy instruments. Both sets of NGO policy guidelines call for a full role for civil society in developing and implementing drug policy. On the other hand, the Council of Europe’s policy guidelines recommend a limited role for civil society – consultation in order to tap into the experience, and dialogue as a means of containing conflict; the US government’s policy guidelines do not identify any role for civil society.

Finally, principles put forward by one organisation and not mentioned by others tend to emphasise that organisation’s priorities. Thus:

- International Drug Policy Consortium: the principle of harm reduction to be applied not only when addressing drug use but also when tackling drug markets;
- Office of National Drug Control Policy: ensuring access to medication-assisted therapies, protecting citizens from drugs and disrupting drug trafficking reflect the US government’s twin emphases on public health and public safety; and
- Pompidou Group: coherence between policies on illegal and legal psychoactive substances, and other forms of addiction and dependency, reflect a recognition of growing polydrug use and findings from addiction research and neurobiology, which indicate that substance abuse and other addictions are inter-related.

*(Brigid Pike)*

## Summary of principles or criteria for a ‘good’ drugs policy\*

Principles/Criteria	CSFD (EU-based NGOs)	IDPC (International NGO)	ONDCP (USA)	Pompidou Group (Council of Europe)
Human rights	Human rights must be fully respected in drug policies and practices, particularly Europeans’ right to health care.	Drug policies and strategies need to be fully compliant with international human rights standards.	Protect human rights – of all citizens including children and drug-involved offenders.	An approach based on human rights
Public health focus	Drug policies and practices must be focused on public health.	New or revised drug laws need to be carefully drafted to support, instead of undermine, health and social programmes. They should authorise and encourage public-health and harm reduction interventions.	Integrate prevention, treatment, and recovery support services into public health systems.	The public health angle
Co-ordination/Integration	Drug policies and practices must be integrated.	√	Address the drug problem as a shared responsibility (i.e. international co-operation).	Transversality Creating structures for co-operation and co-ordination
Evidence-based	Drug policies and practices must be evidence-based.	Drug policies and strategies need to be based on an objective assessment of priorities and evidence.	√	Evidence-informed policy approaches

## What makes for a 'good' drugs policy? (continued)

Principles/Criteria	CSFD (EU-based NGOs)	IDPC (International NGO)	ONDCP (USA)	Pompidou Group (Council of Europe)
<b>Balance</b>	Drug policies and practices must be balanced, reflecting the multi-disciplinary nature of the drugs issue.		Ensure balanced, compassionate, and humane drug policies.	Balanced approach between demand reduction and supply reduction.
<b>Focus on vulnerable groups</b>	Drug policies should refocus their attention on the needs of vulnerable groups.	Drug policies and strategies need to seek to promote the social inclusion of marginalised groups.		Targeting vulnerable groups
<b>A role for civil society</b>	Civil society should be meaningfully involved, and funded and supported to participate, in national and EU drug policy planning, implementation, monitoring and evaluation.	Drug policies and strategies need to work to build open and constructive relationships between governments and civil society.		Consultation with civil society is a source of ideas, innovative proposals and potential support, and dialogue can be a means of dealing with conflicts emerging in course of policy implementation.
<b>Evaluation</b>	An essential element of effective drug policy	√		Monitoring and evaluation
<b>Criminal justice system and drug users</b>	Focus on drug-related services within criminal justice system, e.g. diversion, alternatives to custody, continuity of care.		Reform criminal justice systems to support both public health and public safety	
<b>Demand reduction</b>	Renew focus on evidence-based demand reduction, including prevention, early intervention, treatment, harm reduction, rehabilitation and social reintegration.		Reduce drug use to reduce drug consequences	
<b>International instruments</b>			Support the UN drug conventions	Taking into account international instruments
<b>Policy planning and implementation</b>		Description of the activities that the government will pursue and support to meet these objectives; Clear identification of the role of departments or agencies responsible for these activities and coordination between them; Amount of resources made available by the government to support these activities; Articulation of the scope and timescale of the strategy, and evaluation of progress.		Building institutional support Efficiency and effectiveness Creating structures for co-operation and co-ordination Initiating and managing change

## What makes for a 'good' drugs policy? (continued)

Principles/Criteria	CSFD (EU-based NGOs)	IDPC (International NGO)	ONDCP (USA)	Pompidou Group (Council of Europe)
Ensuring quality	EU minimum quality standards for drug demand reduction measures.			Ensuring quality
Consistency between policy and practice	√			Taking into account international best practice
Learning and knowledge sharing across local, national, EU and international levels	√			√
Medication-assisted therapies			Support and expand access to medication-assisted therapies.	
Drugs are illegal because their use is dangerous			Protect citizens from drugs.	
Supply reduction			Disrupt drug trafficking.	
Combine policies on all psychoactive substances				Coherence between policies on licit and illicit drugs
Harm reduction		All drug policies and strategies need to be focused on reducing the harmful consequences of drug use and markets.		

**\*Key:**

√ = principle/criteria implicit in the document

Absence of tick symbol = principle/criteria neither specified nor implied in the document

**Sources:**

CSFD (Civil Society Forum on Drugs) (April 2012) 'General principles for drug policies' in *Proposal to the EU member states and the European Commission for inclusion in the new EU drugs strategy and action plan*. Available at [www.drugsandalcohol.ie/18220](http://www.drugsandalcohol.ie/18220)

IDPC (International Drug Policy Consortium) (March 2012) 'Chapter 1: Core principles for developing effective drug policy', in *Drug policy guide*. 2nd edition. Accessed 25 May 2012 at [www.idpc.net](http://www.idpc.net)

ONDCP (Office of National Drug Control Policy) (May 2012) 'Principles of modern drug policy'. Accessed 25 May 2012 at [www.whitehouse.gov/ondcp/policy-and-research/principles-of-modern-drug-policy](http://www.whitehouse.gov/ondcp/policy-and-research/principles-of-modern-drug-policy).

Pompidou Group (December 2011) *Policy paper providing guidance to policy makers for developing coherent policies for licit and illicit drugs*. Strasbourg: Council of Europe Publishing. [www.coe.int/T/DG3/Pompidou/Source/Documents/PolicyPaper\\_en.pdf](http://www.coe.int/T/DG3/Pompidou/Source/Documents/PolicyPaper_en.pdf)

# Southern Regional Drugs Task Force stresses 'humanistic' approach



As well as reporting on drug use in counties Cork and Kerry during 2011 and detailing the projects funded, together with the outputs and outcomes, the co-ordinator and chair of the Southern Regional Drugs Task Force (SRDTF) have used their 2011 annual report as a vehicle for setting out their vision of how the individual should be at the centre of a task force's responses to the illicit drugs problem.<sup>1</sup>

## Innovation and development

Co-ordinator Christ Black reports that, as well as focusing on its funded projects, the SRDTF has been involved in innovative development work that draws on international sources. He suggests this is 'setting the seeds for a more user friendly, person centred and health based approach to drugs policy and drugs support'. Initiatives include:

- **Developing an effective service user involvement (SUI) strategy** by sending development workers from the SRDTF and the South East RDTF to attend training in Scotland, provided by 'Involving Expertise', which is funded by the Scottish Government to create a culture of innovation and continuous improvement in service user involvement across all organisations in Scotland. These development workers are now rolling out training to treatment centres in their task force areas.
- **Engaging with third-level students and raising awareness of perceived high levels of drinking** through use of an online, evidence-based resource called e-Pub (Electronic Personal Use Barometer), developed in San Diego, which allows an individual to assess their drinking habits, and incorporates a brief intervention.

- **A new style of policing that embraces human rights and harm reduction** is the subject of a proposal being developed by the SRDTF in conjunction with the International Drug Policy Consortium (IDPC). The proposal encompasses work that the SRDTF has been progressing, such as an arrest referral process, and 'a vision that drug users be viewed as having a health issue and in need of support, rather than being seen as criminals within the criminal justice system'.

## Care and nurturing

In a personal introduction to the report, the chair of the SRDTF, Peadar King,<sup>2</sup> reflects on what the SRDTF does and what it should be doing. He contrasts the 'harsh and unsympathetic response to drug producers and consumers' adopted generally around the world following the ratification of the 1961 UN convention and its concomitant treaties, with the response of civil society, health activists and field workers who foreground citizens' human rights and promote harm reduction strategies. King is concerned that this focus on human rights and the reduction of harm may be undermined by the new wave of managerialism, the effects of which he likens to the destructive impact of the original UN Convention. He writes:

As with other Task Forces in the country, these types of [harm reduction] interventions as well as prevention, education, treatment and aftercare are core to the work of the Southern Regional Task Force. But it is also the case that the emphasis on the bureaucratic management of these interventions has increased exponentially and this has become a feature of the three years of my involvement with this Task Force. This new managerialism or what has become known as New Public Service Management is not just a feature of drugs policy but increasingly is affecting all areas of human interaction. This new managerialism has spawned a new lexicon, 'organizational outputs, performance indicators, service users, clients', terms that President Michael D. Higgins described at the start of 2012 as inappropriate as he urged people to use the 'language of the heart'.

(Brigid Pike)

1. Black C (2012) *Southern Regional Drugs Task Force: annual report 2011*. Cork: Southern Regional Drugs Task Force. [www.drugsandalcohol.ie/18470](http://www.drugsandalcohol.ie/18470)
2. Peadar King is author of *The politics of drugs: from production to consumption*, Liffey Press, Dublin, 2003. [www.drugsandalcohol.ie/3690](http://www.drugsandalcohol.ie/3690)

# 'Drug problems are too complex and dynamic for single magic bullet solutions'

That is the conclusion of a paper published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in October 2012.<sup>1</sup> Entitled *Users' voices*, the paper contains a collection of narratives from substance users in Europe about their attempts to control or reduce their consumption.

Evidence shows that the power of psychoactive drugs is heavily influenced by users' norms, values, practices and circumstances. Yet, says the paper, there is still a tendency 'to overestimate the pharmacological properties of psychoactive substances and underestimate the influences of social, psychological and cultural aspects on drug use and on individuals' efforts to control it'.

The purpose of the paper is to provide a channel of expression for the 'enormous heterogeneity' in the experiences of substance users and what helps or hinders them as they attempt to manage their cravings.

The review presents quotations gleaned from interviews with substance users in 16 countries, including Ireland, between 1993 and 2012. While some quotations are from chronic, long-term and marginalised drug users, others are from individuals who have managed to limit their consumption or do not fulfil common medical criteria for dependence or problem use. The authors identify three key issues, which are outlined below. The shaded boxes contain quotations from Irish sources used in the report to illustrate the issues.

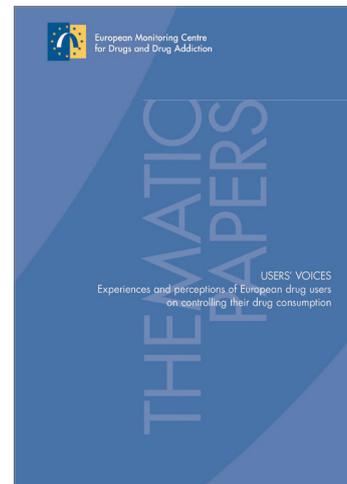
## Triggers prompting an individual to reduce or stop consumption and/or to seek help

According to the authors, 'help-seeking behaviour by substance users remains poorly understood. There are no clear, universally applicable, causal explanations of how or why some people manage to limit their use of psychoactive substances and others do not. Nor can researchers accurately explain why certain individuals seek help and others do not or predict when they will do so, although accessible services clearly play a major part. ... The quotations collected for this paper lend support to findings of a unique study by Patrick Biernacki that compared heroin addicts who recovered through treatment facilities with those who overcame their addiction without treatment.<sup>2</sup> He described three main ways in which people resolve to stop using drugs':

- stopping or limiting use without making a firm decision to do so,
- realising the need to change behaviour, often after an accumulation of negative experiences, and
- hitting rock bottom or experiencing an existential crisis.

## Positive experiences gained from interventions and support

Specialist drug treatment services are important for users trying to reduce or stop their substance use, as are the support and encouragement of family and friends. Problem users who have maintained good relationships with family and friends not involved in the world of addiction are more



able to realise their new identities than those who have not. Objective and timely information about risks of substance use and the range of available services is also cited as a valued resource.

*I'm happy that I did it that way [counselling]. I'm not dependent on anything now. I don't need any medication, I don't need any doctor. I need to go to counselling and I go to counselling.*

(McDonnell A and Van Hout MC [2010] Maze and minefield – a grounded theory of opiate self-detoxification in rural Ireland. *Drugs and Alcohol Today*, 10(2): 24–31)

*Recovery is an individual thing. Recovery isn't just coming off methadone, it's a hell of a lot more than that: it's about occupying time, trying to get back into society, trying to get back to the normal things... it's filling the void that the heroin and everything that comes with the heroin use, the friends, parties.*

(Van Hout MC and Bingham T [2011] *Holding pattern: an exploratory study of the lived experiences of those on methadone maintenance in Dublin North East*. Dublin: Dublin North East Drugs Task Force Publications.)

## Obstacles that hinder individuals trying to change their behaviour

In addition to gaps in provision and support, the stigmatising attitudes of others can have a profound impact on the lives of people with substance use problems, leading to feelings of low self-worth and avoidance of contact with non-users. Since the 1960s, researchers have been highlighting the barrier effects of social stigma on recovery from addiction.<sup>3</sup> A large body of research also describes how people with the least stake in conventional, mainstream life are generally at the highest risk of long-term problematic substance use, compelled to remain outside or on the margins.<sup>4</sup>

## Drug problems are too complex... (continued)

*When you're in the chemist, you're ducking and diving watching to see anyone you know. There is a stigma there; people do look down their noses.*

(Van Hout and Bingham, *Holding pattern*.)

In recent years there has been increased recognition of how environmental factors promote consumption behaviours.<sup>5</sup> The most commonly cited is 'bumping into' friends who use psychoactive substances and living in a social environment where such substances are easily available. Another obstacle is inaccurate, misleading or subjective information.

*We were told that it [methadone] wasn't addictive...they were just giving it out to people, the doctors were just writing scripts for money.*

(Van Hout and Bingham, *Holding pattern*.)

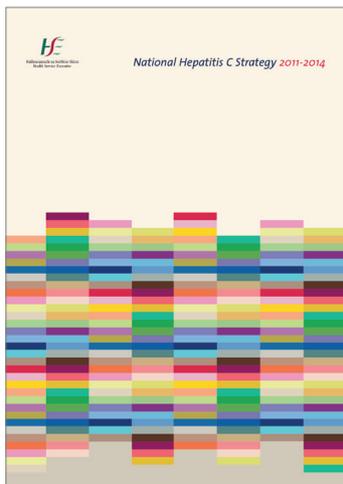
The authors point out that the testimonies gathered present a challenge to developing a stock of effective interventions and signal how complex 'giving up' can be. They stress that the statements do not represent the situation of all those attempting to control

or reduce their consumption, but the statements do make an important and universal point about the importance of choice and the need for diverse interventions that are sensitive and adapted to individual circumstances.

(Brigid Pike)

1. Olszewski D, Hedrich D and Montanari L (2012) *Users' voices: experiences and perceptions of European drug users on controlling their drug consumption*. Lisbon: EMCDDA. [www.drugsandalcohol.ie/18490](http://www.drugsandalcohol.ie/18490)
2. Biernacki P (1986) *Pathways from heroin addiction: recovery without treatment*. Philadelphia: Temple University Press.
3. Goffman E (1963) *Stigma: notes on the management of spoiled identity*. New Jersey: Prentice-Hall.
4. Lloyd C (2010) *Sinning and sinned against: the stigmatisation of problem drug users*. London: UK Drug Policy Commission. Online at: [www.ukdpc.org.uk/publications](http://www.ukdpc.org.uk/publications)
5. Prinzleve M, Haasen C, Zurhold H *et al.* (2004) Cocaine use in Europe – a multi-centre study: patterns of use in different groups. *European Addiction Research*, 10(4): 147–55.

## HSE publishes hepatitis C strategy



The Health Service Executive published the hepatitis C strategy in September 2012.<sup>1</sup> The strategy contains updated epidemiological information on hepatitis C and details of new direct-acting antivirals.

The Hepatitis C Strategy Working Group summarised the epidemiology of hepatitis C, which is a disease of the liver caused by a virus identified in 1989. This viral disease is spread from person to person through contact with infected blood or other body fluids. Unsterile injection equipment and infected blood or blood products are the major risk factors for the transmission of the virus. There are usually no symptoms associated with the acute and early chronic stages of hepatitis C disease. Chronic infection occurs in 70%–80% of adults who are infected with the virus. Symptoms of chronic infection may include: ongoing flu-like symptoms, joint pains, abdominal pain, loss of appetite, altered bowel habit, mood swings and/or an inability to sleep. Complications of chronic hepatitis C include liver cirrhosis, liver failure and liver cancer. There are six genotypes for hepatitis C; treatment outcomes are dependent on genotype and other factors. In Ireland injecting drug users are likely to have genotypes 1 or 3.<sup>2</sup> Certain factors have been identified as increasing the severity of the disease and these are alcohol intake, co-infection with HIV or hepatitis B, super-infection with hepatitis A and older age at infection.

The working group reviewed the effectiveness of treatment and reported that hepatitis C can be treated with a combination of two or three anti-viral agents. The medication used to treat this disease includes pegylated interferon, ribavirin and more recently (in the USA) the addition of telaprevir or boceprevir. The addition of either telaprevir or boceprevir to the existing treatment (pegylated interferon and ribavirin) increases the success of the treatment for those with genotype 1. When treated with a combination of the three anti-viral agents, 80% of the hepatitis C genotype 1 patients are likely to experience sustained viral clearance, compared to 50% when only the two drugs (pegylated interferon and ribavirin) were used. There are contra-indications to hepatitis C treatment which include pregnancy; severe depression or other mental illness; renal disease; autoimmune disease; and end-stage liver cirrhosis.

The working group reported that the prevalence of hepatitis C among those infected through injecting drug use or the administration of blood and blood products was high. For injecting drug users the prevalence was between 62% and 81% prior to 2003 while 1,700 people were infected through blood and blood products. The prevalence in the general population is unknown but was 0.02% among blood donors between 2007 and 2010 and was 1% among attendees at antenatal clinics. There are only two historic studies that examined the incidence of hepatitis C among drug users. One study estimated the incidence of hepatitis C among 100 injecting drug users attending treatment in Dublin between 1992 and 1998 who had an initial negative test and a repeat test within nine months.<sup>3</sup> The authors reported that the incidence of hepatitis C was 66 per 100 person years. A later study reported an incidence of 24.5 per 100 person years among a sample (358) of opiate users (including some non-injectors) attending treatment in the former South Western Area Health Board in 2001/2002.<sup>4</sup> Comparisons between these studies are difficult as it is not possible to ascertain the proportion of non-injectors in the sample surveyed in the later study. Studies in Ireland identify homeless people, prisoners and asylum seekers as being high-risk populations for hepatitis C, largely because a high proportion of prisoners and homeless people inject drugs. The working group reports that asylum seekers often come from countries where hepatitis C is endemic.

## HSE hepatitis C strategy (continued)

There were 2,800 discharges from acute hospitals with a principal diagnosis of chronic viral hepatitis C between 2005 and 2010 and there were 1,193 discharges with a principal diagnosis of primary liver cancer. There were 703 cases of hepatocellular carcinoma registered by the National Cancer Register Ireland between 1994 and 2010. The NCRI estimates that 30% of hepatocellular carcinoma cases were hepatitis C positive. The liver transplant unit at St Vincent's University Hospital reported that 42 (13.5%) of 311 liver transplant cases between 2000 and 2006 had hepatitis C.

The new national hepatitis C strategy makes 36 recommendations: 8 covering surveillance; 14 on education, prevention and communication (through 6 overarching themes); 6 on screening and testing; and 8 on treatment (through 7 overarching themes).

The recommendations for ensuring accurate surveillance are:

- Ensure laboratory requests for hepatitis C serology contain patient identifiers and clinician details.
- Encourage clinicians to notify newly diagnosed cases of hepatitis C and provide relevant information where possible.
- Commence enhanced surveillance (including the collection of risk factors) for newly diagnosed cases of hepatitis C
- Establish a national register of patients diagnosed with hepatitis C
- Commence appropriate public health follow-up on newly notified cases of hepatitis C
- Estimate the prevalence of hepatitis C and identify risk factors among the general population
- Complete a modelling exercise to estimate future disease burden and aid service planning
- Conduct follow-up studies amongst injecting drug users to identify seroconverters so as to measure incidence rate.

The recommendations for maximising prevention and ensuring clear and accurate information are:

- Treat existing drug addiction among injecting drug users.
- Prevent transition from smoking heroin to injecting heroin and encourage current injectors to move to treatment or harm-reduction approaches.
- Improve provision of harm-reduction materials through nationwide access to and uptake of comprehensive set of materials and appropriate communications with respect to language, literacy and accuracy.
- Ensure staff and peer-educators are recruited to pre-agreed standards and have appropriate training and materials to provide accessible and accurate information.
- Plan and implement a campaign to raise awareness amongst those who may previously have been diagnosed with hepatitis C or who may have been at risk of infection in order that they consider accessing new treatment options.
- Regulate services that provide body-piercing, tattooing and permanent make-up.

The recommendations for ensuring screening and diagnosis are available to the appropriate risk populations in a timely manner are:

- Improve availability of and access to facilities for screening, testing and diagnosis available in primary and community care services with adequate and timely laboratory facilities.
- Enhance prison-based services with respect to risk assessment, screening and follow up.
- Offer and promote screening for hepatitis C and other blood-borne diseases to those who attend services such as needle-exchange programmes and other harm-reduction services.
- Continue targeted antenatal screening for those with risk factors for hepatitis C infection and consider the evidence for introduction of universal screening at regular intervals.
- Ensure the NVRL provide previous tests results to medical practitioners who ascertained the patient's consent.
- Establish guidelines on hepatitis C screening for individuals from endemic countries or new entrants to the Irish healthcare system.

The recommendations for ensuring that evidence-based hepatitis C treatment and other supports are available to patients in a timely manner are:

- Ensure governance, evidence-based protocols and review is available to diagnose people with hepatitis C and treat if required.
- Develop, implement and evaluate a treatment model appropriate to the prison setting on a national basis.
- Establish a postgraduate diploma in hepatitis C management for physicians and nursing staff.
- Undertake a formal assessment of the needs of individuals infected with hepatitis C, other than through contaminated blood and blood products, through an increased number of clinical nurse specialist posts and subsequent needs assessments.
- Develop a role for general practitioners (with special qualifications) to monitor hepatitis C treatment in primary and community care in consultation with other appropriate medical specialists.
- Provide patients, particularly those with chaotic lifestyles and other social problems, with practical supports to enable them to attend for and adhere to treatment.
- Provide interventions to assess and if necessary reduce alcohol intake in patients with hepatitis C.

(Jean Long)

1. Hepatitis C Strategy Working Group or HSE National Social Inclusion. (2012) *National Hepatitis C Strategy 2011–2014*. Dublin: Health Service Executive. [www.drugsandalcohol.ie/18325](http://www.drugsandalcohol.ie/18325)
2. Conroy A, Coughlan S, Dooley S and Hall WW (2003) Prevalence of hepatitis C genotypes in Ireland. *Irish Journal of Medical Science*, 172(2, Supplement 1): 15.
3. Smyth B, O'Connor JJ, Barry J and 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(4): 310–311.
4. Grogan L, Tiernan M, Geoghegan N, Smyth B and Keenan E (2005) Bloodborne virus infections among drug users in Ireland: a retrospective cross-sectional survey of screening, prevalence, incidence and hepatitis B immunisation uptake. *Irish Journal of Medical Science*, 174(2): 14–20.

# The first census of homeless persons in Ireland

The Central Statistics Office (CSO) has published for the first time a comprehensive profile of the homeless population, as enumerated in the 2011 census of the population of Ireland.<sup>1</sup> This article presents a descriptive account of a selection of data contained in the report.

A comprehensive approach to measuring homelessness was adopted as part of the census undertaken on 10 April 2011. Homeless persons were identified based on where they were located on census night. Of the 4,588,252 persons counted in the state, 3,808 were either counted in accommodation providing shelter for homeless persons or were identified sleeping rough (Table 1).

**Table 1 Persons counted in accommodation for the homeless and sleeping rough, by sex**

Category	Male	Female	Total
Persons in accommodation	2,481	1,263	3,744
Persons sleeping rough	58	6	64
Total	2,539	1,269	3,808

Source: Central Statistics Office (2012)

## Accommodation type

- Over 40% (n=1,648) of homeless persons were counted in emergency accommodation: 1,117 males and 531 females.
- 555 were counted in transitional accommodation: 397 males and 158 females.
- 992 were counted in long-term accommodation: 578 males and 414 females.
- 344 were counted in mixed accommodation: 250 males and 94 females.
- 206 were counted in what was reported as 'unknown' accommodation: 139 males and 66 females.

## Persons sleeping rough

The Dublin Regional Homeless Executive (DRHE) on behalf of the CSO undertook a count of persons sleeping rough in the Dublin area on census night. The count took place between 3.30 am and 6.00 am through a process of 'discovery', that is, direct observation of the number of persons physically present and sleeping rough in Dublin on that night. Of the 64 persons counted sleeping rough, 58 were male and 59 were counted in Dublin.

## Age profile

Almost three quarters of homeless persons (n=2,781) were in the 20–59-year age group; 641 were in the 0–19-year age group, including 457 children aged 0–14.

## Marital status and the family unit

Among 3,351 homeless persons aged 15 or over, two thirds were single, compared to 42% in the general population. Just under 6% (n=189) were married or re-married, compared to 48% in the general population. Almost 17% (n=561) were separated or divorced, compared to 6% in the general population.

The family unit was defined as a couple with or without children or a lone parent with at least one child. There were 296 family units comprising 905 persons, of whom 498 were children.

## Economic and education status

Of the 3,351 homeless persons aged 15 or over, 1,287 were unemployed and 99 were looking for their first job. Twenty-two per cent (n=752) were unable to work due to permanent sickness or disability, compared to 4% in the general population. 274 homeless persons were in work, 218 were students, and 186 were retired.

Forty-nine per cent (n=1,439) of homeless persons aged 15 to 59 did not have an educational qualification beyond lower second-level, compared to 25% in the general population.

## General health and disabilities

Just over 60% (n=2,298) of the homeless population indicated that their general health was 'good' or 'very good', compared to 89% in the general population. Almost 70% of homeless females indicated that their health was 'good' or 'very good', compared to 56% of homeless males.

Almost a third (n=1,179) of the homeless population indicated that their general health was 'fair', 'bad' or 'very bad', compared to 10% in the general population. Forty-two per cent (n= 1,581) of homeless persons had a disability, compared to 13% in the general population. The most common disability was a psychological or emotional condition (n=740).

(Martin Keane)

1. Central Statistics Office (2012) *Homeless persons in Ireland: a special census report*. Cork: Central Statistics Office. [www.drugsandalcohol.ie/18334](http://www.drugsandalcohol.ie/18334)

## Mental health among homeless male hostel residents in Dublin

Recently published research aimed to determine the prevalence of mental illness among residents of a homeless hostel in inner-city Dublin.<sup>1</sup> The Structured Clinical Interview for DSM-IV Axis 1 Disorders (SCID-1) Clinical Version was used to collect data from study participants over an eight-week period in June–August 2010. Of 97 men considered as ‘residents’ for the purpose of the study, 38 agreed to be interviewed, representing a response rate of 39.2%.

Of the 38 participants:

- 47.4% were in the 40–54-year age group, 31.6% in the 26–39-year age group and 21% were aged 55 or over.
- Over half (57.9%) had never married.
- 68.4% had children.
- 73.7% reached secondary level education without graduating.
- 92% were unemployed.

A total of 81.6% had a current (last 30 days) Axis 1 diagnosis; the rate increased to 89.5% for lifetime prevalence, when current and past Axis 1 diagnoses were combined. Regarding lifetime diagnoses, the rates were as follows: 42% depressive disorder, 78.9% substance use disorder, 18.4% anxiety/adjustment disorder and 5.3% psychotic disorder. The most common current and past diagnosis was alcohol dependence, with 52.6% of participants meeting the criteria for dependence. The most common disorders during the past 30 days were alcohol dependence 23.7%, opioid dependence and

major depressive disorder both 18.4% and opioid abuse and alcohol-induced depression both 7.9%. According to the authors ‘there was considerable comorbidity between disorders, with a significant number of residents experiencing both mental illness and substance use problems’ (p. 25).

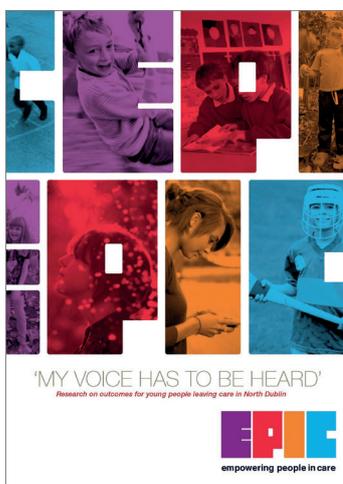
Of those interviewed, 31.6% had been admitted to a psychiatric hospital at least once during their lifetime and only 23.7% were currently attending an outpatient psychiatric or addiction service. The authors note that ‘the low number of residents attending services is cause for concern’ (p. 25).

The authors acknowledge the relatively low response rate to the study, and report that information provided to the research team by the specialist support worker at the hostel suggested that some of the 59 men who did not agree to be interviewed may have had experience of mental illness. They also acknowledge the possibility of selection bias, given that the specialist mental health worker at the hostel encouraged the men who had mental health problems to be interviewed for the study. However, the authors also note that, to the best of their knowledge, this was the first study undertaken in Ireland to assess the complete spectrum of Axis 1 disorders.

(Martin Keane)

1. Prinsloo B, Parr C and Fenton J (2012) Mental illness among the homeless: prevalence study in a Dublin homeless hostel. *Irish Journal of Psychological Medicine*, 29(1): 22–26. [www.drugsandalcohol.ie/18235](http://www.drugsandalcohol.ie/18235)

## Research on young people leaving state care in North Dublin



Recently published research examined the issues facing young people leaving state care in North Dublin.<sup>1</sup> The research was commissioned by the independent association, Empowering People in Care (EPIC). Currently there is no statutory obligation to provide aftercare services to people

leaving state care when they reach age 18, however, the Health Service Executive (HSE) provides a discretionary package of supports and services to some young people who are deemed to be in need. These provisions are made under Section 45 of the Child Care Act 1991, which states: ‘Aftercare services may be provided to young care leavers up to the age of 21 or when they finish education.’

The bulk of data in this report comes from surveys completed by eight aftercare workers on the circumstances of 65 young people, including 33 females, who were receiving aftercare support in North Dublin. Data were collected in two rounds: in May/June 2010 when all 65 young people were aged 17–18, and again in December 2010/January 2011 when 34 of the young people were aged 19.

It was reported that 42 of the young people were first placed in care because of their parents’ inability to cope or their parents’ alcohol and drug problems; 27 were first placed in care owing to abuse and neglect. Eleven of the young people were first placed in care because of their own alcohol and drug use and behavioural difficulties. Seventeen were first placed in care when aged five or under.

## Young people leaving state care (*continued*)

Twenty-five of the young people had spent more than 10 years in care; 22 had spent 1–5 years. Thirty-three spent their final placement in foster care, 18 with a relative and 15 in general foster care; 18 spent their final placement in residential care. Twenty-four spent more than five years in their final placement, 30 spent 1–5 years and 17 less than one year. Twenty-four young people had one care placement and 11 had two placements during their time in care; eight had more than five placements. Spending time in foster care was associated with one placement; in contrast, spending time in residential care was associated with more than one placement. Females were more likely than males to experience multiple placements. Reducing the number of different placements was reported by aftercare workers to promote stability and positive outcomes for young people.

At Round 2 of data collection, it was reported that 23 of the young people had no accommodation moves in the previous 20 months, 14 had two moves and 20 have moved three or more times. Movement between different accommodations was associated with multiple care placements. It was reported at Round 1 of data collection that 18 of the young people had experienced homelessness at least once in their lives.

It was reported that 25 of the young people had completed their education at junior certificate level, 17 had reached leaving certificate level and a further 13 were currently attending college, most of whom were studying a post-leaving certificate course; eight young people had no formal educational qualifications. There were reductions in the numbers of young people in education and training between Rounds 1 and 2 of data collection, and an increase in unemployment among the young people.

At Round 1 of data collection 29 young people were regular smokers and 27 were regular consumers of alcohol; at Round 2 these numbers increased to 35 regular smokers and 40 regular users of alcohol. In contrast, there was a reported reduction in the use of illegal drugs, from 27 reported users at Round 1 to 23 at Round 2. Aftercare workers reported an increase from 20 to 25 in the number of young people with mental health needs between the two rounds of data collection.

Analysis of the data gathered in Round 2 helped define 'positive outcomes' in terms of seven key aspects of a young person's circumstances while in care and on leaving care (p. 51):

- no accommodation moves since Round 1;
- not being homeless at any time;

- being engaged in further education or training beyond secondary school;
- having sat leaving certificate or equivalent;
- having contact with at least one member of birth family after leaving care;
- not engaging in risky behaviour; and
- having overall good physical and mental health and not using illicit drugs.

It was reported that 29 of the young people in this study had achieved 2–4 of the seven outcomes, 24 had achieved 5–7 and 12 had achieved 0 or 1 outcome. Further analysis of the data suggested that when young people remain in the same care placement, typically foster care, they experience positive outcomes to assist in their transition from state care to adulthood.

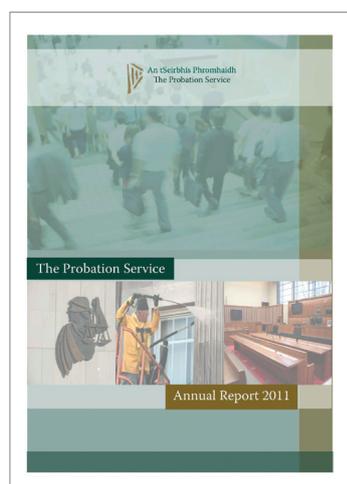
Data were collected through interviews with eight of the young people. The main issues identified through thematic analysis of the data were that the young people were concerned with multiple accommodation moves and with their mental health needs after leaving care. They identified social support as their greatest need and expressed disquiet at the speed of transition from care to the community, preferring more step-down supported accommodation to aid a gradual transition. Overall, they spoke positively about the aftercare support they were receiving but had concerns about not having access to their support workers during out-of-office hours and with the challenges they experienced with budgeting.

The report acknowledges the potential limitation of relying on data collected through surveys with aftercare workers, whose records may have been incomplete and whose perceptions of young people's circumstances may not have been a true representation of their situation. The author acknowledges that it would have been preferable to survey the young people but that this had been ruled out as it would have required a time consuming exercise gaining informed consent from a number of agencies that were involved in the lives of young people.

(Martin Keane)

1. Daly F (2012) *'My voice has to be heard': research on outcomes for young people leaving state care in North Dublin*. Dublin: EPIC. [www.drugsandalcohol.ie/18294](http://www.drugsandalcohol.ie/18294)

## Probation Service annual report 2011



The 2011 annual report of the Probation Service was published in August 2012.<sup>1</sup> The introduction to the report describes the role of the service as follows:

The Probation Service is an agency within the Department of Justice and Equality. The Service works closely with the Courts Service, the Irish Prison Service (IPS), An Garda Síochána, the Irish Youth Justice Service (IYJS), the Parole Board and many organisations in the community. ...

We generally become involved in the criminal justice process between the trial and sanction phases, often in cases where a court requires a pre-sanction assessment to assist in deciding on an appropriate sanction. In some cases, the court may be considering placing an offender on probation supervision or community service. (p.6)

In 2011, the Service dealt with 14,845 offenders in the community. The statistical data provided in the annual report does not provide a breakdown of offenders or interventions by offence type.

(Johnny Connolly)

1. The Probation Service (2012) *The Probation Service annual report 2011*. Navan: Probation Service. [www.drugsandalcohol.ie/18249](http://www.drugsandalcohol.ie/18249)

# NESC report commends city policing initiative



A report published by the National Economic and Social Council (NESC) as part of its quality and standards in human services in Ireland series reviews the various police oversight and consultative bodies established by the Garda Síochána Act 2005.<sup>1</sup> The new regulatory institutions established by the Act include the Garda Síochána Ombudsman Commission, the Garda Síochána Inspectorate, Joint Policing Committees and Local Policing Fora.

Many of these oversight bodies emerged as a response to ‘revelations about abuse of powers by individual officers’, with the net result being a much greater oversight of police activity (p.2). However, the report queries their overall impact, on both the level and quality of policing and ‘the potentially egregious abuses of power’ (p.2). The report suggests that ‘these bodies have yet to institutionalise procedures that would embed and sustain reform over time’ (p.ix). It also poses the more fundamental question as to whether the kind of oversight offered by these bodies is sufficiently ‘diagnostic’ to uncover the causes of the various complaints and problems they were established to address, so as to prevent their recurrence.

The report suggests that a more promising route towards the improvement of policing standards may be through

a structured liaison process between gardaí and local communities, citing an example of how this has been accomplished as part of a local community policing initiative established in Dublin’s north inner city. The North Inner City Community Policing Forum (CPF) was established in 1999 to facilitate a co-ordinated strategy in response to drug dealing and drug-related anti-social behaviour in the north inner city.<sup>2</sup> The CPF brings together the local community and representatives of the Garda Síochána and Dublin City Council. The NESC report concludes that the CPF has been a ‘relatively successful model of engagement with citizens at a local level’ and that it has fostered a ‘greater culture of transparency’ between the community and the gardaí involved (p.33). The community, according to the report ‘now have a more responsive police service and the gardaí have been able to tap into confidential information derived from the community’ (p.34).

Although highlighting the positive achievements of the CPF, the NESC report concludes that, when approaching all forms of policing service delivery in Ireland, there is a need for a more rigorous process of learning and analysis so as to encourage continuous improvement. It advocates a process referred to as ‘triple-loop learning’, described as a ‘need for learning to take place at a number of levels that reinforce each other: the level at which the service is delivered; at corporate level; and at the level of regulator or at national level’ (p.5). According to the NESC report, because of the policing reforms introduced by the Garda Síochána Act 2005, ‘Ireland has all the “parts” necessary for a well-functioning system of quality policing... . But these parts have yet to be co-opted into a common regime of learning that is conducive to greater quality in policing’ (pp.ix–x).

(Johnny Connolly)

1. National Economic and Social Council (2012) *Quality and standards in human services in Ireland: policing and the search for continuous improvement*. Dublin: National Economic and Social Council. [www.drugsandalcohol.ie/18406](http://www.drugsandalcohol.ie/18406)
2. For a detailed account of the CPF see Connolly J (2002) *Community policing and drugs in Dublin: the North Inner City Community Policing Forum*. Dublin: North Inner City Drugs Task Force.

## Roadside drug testing

The Medical Bureau of Road Safety (MBRS) published its Report on roadside drug testing and equipment and related matters in October 2012.<sup>1</sup> Speaking at the launch, Professor Denis Cusack, director of MBRS, said ‘this report provides a detailed analysis of all aspects of roadside drug testing’.

‘Unlike alcohol, there is no legal limit for drugs. Under current road traffic law, the Gardaí must be satisfied that a driver is under the influence to such an extent as to be incapable of having proper control of a vehicle. This means that the Garda has to prove the driver impairment to the satisfaction of the Court and this can cause difficulties in successfully prosecuting such offences’, Professor Cusack said.

This report will inform the Road Traffic Bill which is currently at draft stage. The Bill will include new roadside impairment testing for drug use by motorists. Research is currently under way to identify a suitable device for detecting drugs at the roadside, similar to that used for detecting alcohol.

The National Drug-Related Deaths Index (NDRDI) at the Health Research Board made a substantial contribution to the MBRS report by providing a complete census of fatal road traffic collisions (RTCs) where the deceased person was the driver of the vehicle and had a positive toxicology report for an illicit substance. Currently the NDRDI is the only data source able to provide comprehensive data on the presence of illicit drugs in post-mortem toxicology. In the future the

## Roadside drug testing (continued)

NDRDI will be able to monitor trends in drug-related deaths and evaluate the effects the new Road Safety Strategy will have on preventing these deaths.

The following analysis presents NDRDI data for the period 2004 to 2009 on RTC deaths among vehicle drivers in Ireland where the individual had a positive toxicology for one or more illicit drugs at the time of death. In this six-year period there were 93 of these deaths recorded by the NDRDI.

Cannabis (38.7%) was the most common illicit drug found in the toxicology reports on these 93 individuals, followed by cocaine (23.7%) and MDMA (18.3%) (Figure 1).

(Simone Walsh)

1. Cusack D A, Leavy P and Maguire R (2012) *Report on roadside drug testing and equipment and related matters*. Dublin: Medical Bureau of Road Safety. [www.drugsandalcohol.ie/18630](http://www.drugsandalcohol.ie/18630)

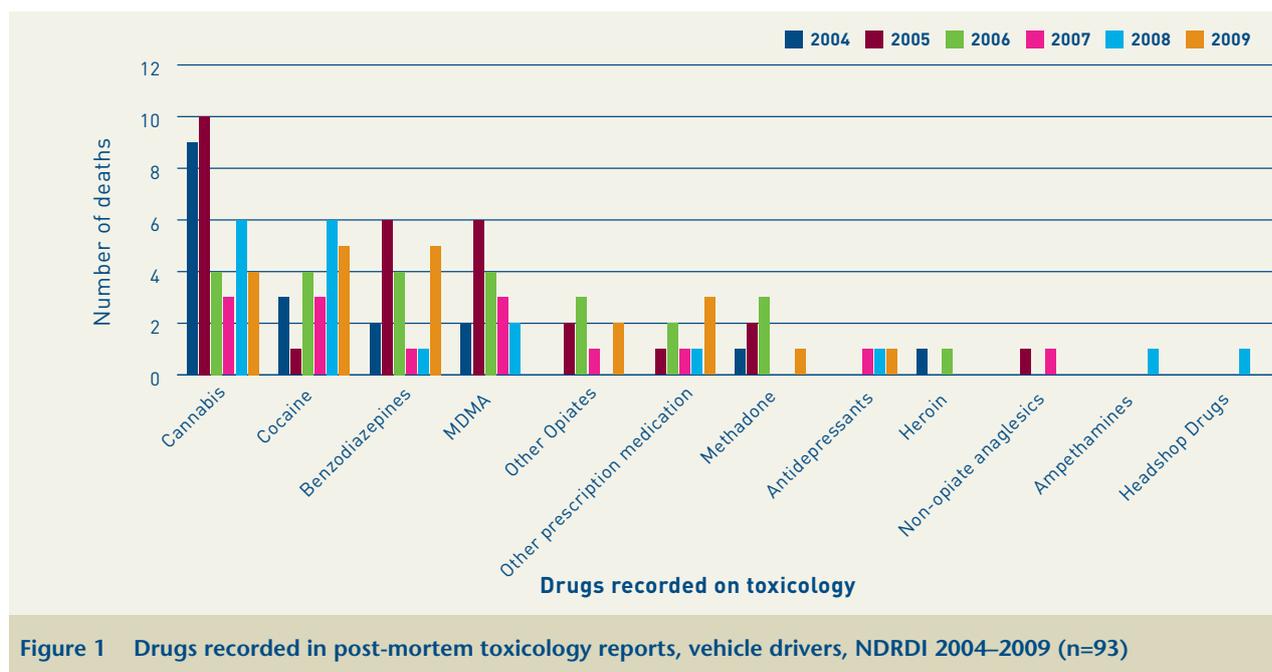


Figure 1 Drugs recorded in post-mortem toxicology reports, vehicle drivers, NDRDI 2004–2009 (n=93)

## MQI annual review 2011



The Merchants Quay Ireland (MQI) annual review for 2011 was launched on 14 September 2012 by journalist and broadcaster Miriam O’Callaghan.<sup>1</sup>

Important new initiatives at MQI in 2011 included the Athlone Open Door Centre, the new 10-bed unit at St Francis Farm Detox facility (opened in November 2011) and

the commencement of renovation works at the Riverbank Centre. (This new Centre was officially opened by An Taoiseach Enda Kenny in November 2012 – see opposite.)

The outreach worker for the New Communities Support Service provided one-to-one support to 112 service users, 53% of whom were from Poland. The Easy Access Education for Homeless People programme engaged with 45 clients during 2011: 34 male and 11 female.

MQI’s needle-exchange service recorded approximately 21,819 client visits in 2011. The report highlights a continuing high level of demand for homeless services: 58,858 meals were provided, with an additional 29,000 meals provided by the Extended Day Service in association with Focus Ireland. The Primary Health Care Services provided 3,331 interventions in 2011.

MQI continued to provide the national prison-based addiction counselling service to 12 prisons in 2011: 10,293 individual counselling sessions and 2,830 group attendances were recorded during the year. This service is provided by 26 counsellors. The service also co-ordinates an eight-week inter-agency programme at the medical unit in Mountjoy for groups of nine clients at a time. Seven groups, totalling 63 clients, participated in 2011, of whom only four did not complete the programme.

MQI in association with the Midland Regional Drugs Task Force and the HSE administer the Midlands Family Support and Community Harm Reduction Service, providing outreach and working with families of those actively using drugs in that task force region. The family support service provided 140 group sessions and 505 individual sessions, in addition to 723 supportive phone calls. The harm reduction service provided needle-exchange services and engaged in 4,000 one-to-one client interventions during 2011.

## MIQ annual review 2011 (continued)

The Midlands Traveller-Specific Drugs Project worked with 38 clients and engaged in 1,187 support sessions. Athlone Open Door Centre, for which MQI assumed operational responsibility in January 2011, recorded 1,415 visits and provided 400 meals, with an average of 44 clients per month.

The services offered by MQI and the numbers of people accessing them in 2011 are shown below.

(Vivion McGuire and Ita Condrón)

1. Merchants Quay Ireland (2012) *Annual review 2011*. Dublin: MQI. [www.drugsandalcohol.ie/18372](http://www.drugsandalcohol.ie/18372)

Service	Type of intervention	Activity in 2011
Needle-exchange and health-promotion services	Promotes safer injecting techniques HIV and hepatitis prevention Safe sex advice Information on overdose Early referral to drug treatment services	4,051 used needle-exchange services, of whom 492 were new clients 1,220 safer injecting workshops
Stabilisation services	Methadone substitution Gateway programme	18 service users 795 service visits
Integration programmes	Access to transitional accommodation Ballymount House Leixlip House with Respond Housing Association	3 residents (annual average) 9 admissions, with an average of 5 clients in the house for an average tenancy of 5 months
Training and work programmes	FÁS Community Employment scheme	86 participants Of the 35 who completed FÁS placements at MQI, 2 secured permanent employment, 7 moved to further education
High Park	17-week, drug-free residential programme including individual counselling, group therapy, educational groups, work assignments and recreational activities	50 participants (of whom 4 were admitted for detoxification) 3 clients completed detox 24 clients completed the full programme
St Francis Farm	Residential programme – reduced from a 6-month to a 14-week programme in October 2011, in conjunction with a new 4–6-week detox facility on site	40 participants 15 clients completed three months or more 23 clients part-completed the programme

## Taoiseach officially opens Riverbank Centre



Taoiseach Enda Kenny preformed the official opening of MQI's new Riverbank Centre at 13 Merchants Quay, Dublin 8, on 21 November.

The Riverbank Open Access Centre offers three free meals a day in a respectful non-judgemental atmosphere. Additional services provided include a

primary care centre offering medical and dental facilities, as well as help with the practicalities of ending homelessness and addiction.

Tony Geoghegan, MQI director, said he was 'not surprised' that the new centre, which has almost double the capacity of the old centre, has seen demand increase to fill it up almost immediately. 'We have known from experience there is a social cost to the recession', he said, 'it was the same in the 1980s.'

Mark Kennedy, head of day services, said the new primary care services are a great asset. Many foreign nationals experience difficulty in accessing HSE services, he said, and the project was particularly grateful to a dentist who offered his services for free.

(Vivion McGuire)

## From Drugnet Europe

### Selected issues 2012

Cited from *Drugnet Europe*, No. 80, October–December 2012

#### **Prisons and drugs in Europe**

In a new review published alongside the *Annual report*, the EMCDDA provides insight into drug use in the prison population and the efforts made at European and national level to improve prisoners' rights and health. While many countries have scaled up the provision of interventions within prisons (e.g. substitution treatment), these institutions still do not offer a standard of care equivalent or comparable to that provided to the wider community. The report presents progress now being made in several countries towards promoting 'equivalence of care' and closing this 'treatment gap'.

#### **Pregnancy, childcare and the family**

Families and the related issue of drug users with parental responsibility are analysed in this new study. The report finds that, although those with drug problems do not necessarily make bad parents, they are likely to require additional support. The report concludes that treatment services, in particular, must be sensitive to the needs of these individuals, as worries about childcare or child protection can act as a barrier to seeking help.  
[www.emcdda.europa.eu/publications/selected-issues](http://www.emcdda.europa.eu/publications/selected-issues)

### Resources

Reviews by Isabelle Giraudon and Julián Vicente in *Drugnet Europe*, No. 80, October–December 2012

#### **Preventing opioid overdoses in Europe: a critical assessment of known risk factors and preventative measures**

This study focuses on the individual, situational and organisational risk factors linked to overdoses and how they can be modified to reduce fatal outcomes. Key risk and protective factors were categorised for the study and their efficacy plus the factors facilitating or impeding overdose prevention were critically discussed by an expert panel. The review evidenced that many interventions may reduce overdose, particularly in settings where the drug user is in contact with treatment or emergency services. It also shows that specific interventions are proven to be effective (e.g. pharmacological treatment). At the population level, where many drug users are not in contact with services, overdose reduction depends on behavioural change (e.g. avoiding the mixture of opiates and depressant drugs). The study concludes that overdose prevention involves personal and societal issues which call for multifaceted interventions.

Available at [www.drugsandalcohol.ie/18701](http://www.drugsandalcohol.ie/18701)

#### **Analysis of the data sources, numbers and characteristics of cocaine-related DRD cases**

Nineteen countries (nine of which submitted data), responded to an EMCDDA survey on cocaine related deaths. The identification and coding of cocaine-related deaths varies across registers and across countries. The study shows that during the 2000s there was an increasing upward trend in the numbers of these deaths, followed by a decline in most countries. By far, most deaths were reported in the UK (2 400 deaths over 1998–2009) and

Spain (1 300 deaths over 2005–09). Most victims were males (7–9 in 10), in their late 20s or early 30s, having often used cocaine with opioids and sometimes with more drugs. Around two-thirds of all reported cases died of an overdose. The report also calls for further examination of deaths indirectly related to cocaine use.

Available at [www.drugsandalcohol.ie/18975](http://www.drugsandalcohol.ie/18975)

#### **Public expenditure profiles**

Cited from *Drugnet Europe*, No. 80, October–December 2012

How much do countries in Europe spend on drug-related activities as a percentage of their GDP? Do national governments allocate specific budgets to drug policy? How has national drug-related public expenditure evolved over time and what can be expected in the future? These are some of the questions which the EMCDDA's new 'Public expenditure profiles' aim to answer. Recently published on the agency's website, the profiles cover 30 countries. For more, see [www.emcdda.europa.eu/countries/public-expenditure](http://www.emcdda.europa.eu/countries/public-expenditure)

*Drugnet Europe* is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). *Drugs in focus* is a series of policy briefings published by the EMCDDA. Both publications are available at [www.emcdda.europa.eu](http://www.emcdda.europa.eu).

If you would like a hard copy of the current or future issues of either publication, please contact:

Health Research Board, Knockmaun House,  
42–47 Lower Mount Street, Dublin 2.  
Tel: 01 2345 148; Email: [drugnet@hrb.ie](mailto:drugnet@hrb.ie)

## In brief

On 24 April 2012 the **UK Drug Policy Commission** published *Charting new waters: delivering drug policy at a time of radical reform and financial austerity*. The study explores the ability of local areas to achieve the ambitions of the UK's national drugs strategy and the future security of investment in drug interventions. The study reveals a broad picture of upheaval and uncertainty. [www.ukdpc.org.uk](http://www.ukdpc.org.uk)

On 29 June 2012 a **British–Irish Council** ministerial meeting on the misuse of drugs was chaired by the then Minister of State Róisín Shortall TD on the island of Jersey. Under the heading 'Young People and Drugs – Breaking the Cycle', issues discussed included evidence of trends in drug use among young people, general and targeted prevention measures, early intervention and broader treatment issues. There was particular focus on the need to support young people whose parents are involved in drug use. The Ministers also discussed issues around the use and misuse of alcohol in their jurisdictions; this arose in the context of proposals for the possible expansion of the work of the misuse of drugs sectoral group to include alcohol. [www.britishirishcouncil.org](http://www.britishirishcouncil.org)

On 17 July 2012 the *Sixth annual report of the independent monitoring group for A Vision for Change* was published. The Independent Monitoring Group (IMG) reports that implementation of A Vision for Change (AVFC) has been slow and inconsistent. The IMG states that as a matter of urgency, specialist mental health services for co-morbid severe mental illness and substance abuse problems, inter alia, need to be fully developed and delivered. In addition, government departments, other than the Department of Health and the Department of the Environment, Community and Local Government, also need to focus on their responsibilities for the implementation of AVFC. According to the IMG, there also needs to be a cultural shift in how mental health services are delivered, moving from professional dominance towards a person-centred, partnership approach, and from a largely medicalised and maintenance approach towards one based on recovery competencies within the biopsychosocial model, as envisaged in AVFC. The IMG notes that the principles and practices of a recovery-oriented service appear to be developing in localised services and this needs to be encouraged and reinforced by a clear national corporate policy implementation framework. [www.dohc.ie](http://www.dohc.ie)

On 24 July 2012 the *Fifth report of the special rapporteur on child protection* was laid before the Houses of the Oireachtas. In reporting on recent child protection developments in the United Kingdom, the special rapporteur, Dr Geoffrey Shannon, describes a pilot Family Drug and Alcohol Court (FDAC) as 'a new approach to care proceedings in cases where parental substance misuse is a key element in the local authority decision to bring proceedings'. Shannon reports that the pilot has shown early signs of success and recommends that such an initiative should be implemented in Ireland. [www.dcyia.ie](http://www.dcyia.ie)

On 25 July 2012 **Harm Reduction International (HRI)** launched *The global state of harm reduction 2012: towards an integrated response*. First published in 2008, this third iteration of the report compiles data on international developments since 2010 in HIV prevention among people who inject drugs, including needle and syringe exchange programmes, opioid substitution therapy and drug consumption rooms. The report finds that even in countries that have programmes in place to prevent HIV via unsafe injecting practices, reach and effectiveness are

severely undermined in many cases by lack of geographical coverage – Ireland is mentioned in this regard. The report also explores key issues for developing an integrated harm reduction response, such as building effective harm reduction services for women who inject drugs, limited access to harm reduction services by young people, drug use among men who have sex with men, and global progress toward drug decriminalisation and sustainability of services in challenging environments. To coincide with the launch of the report, the new Global State of Harm Reduction interactive e-tool has been updated to present the latest information on harm reduction policy and programming around the world. [www.ihra.net](http://www.ihra.net)

On 8 September 2012 **Thomas Szaz**, psychiatrist and critic of psychiatry, died aged 92 years. Famous for his critique of the concept of 'mental illness', arguing that the term 'illness' can only be applied to a body, not a mind, except as a metaphor, Szaz challenged the medicalisation of dysfunctional and illegal forms of behaviour, such as the consumption of illicit drugs, which, he argued, had led to an assumption that individuals, such as drug 'addicts', were not responsible for their actions. He argued that drug use was not an 'addiction', to be treated as an illness, but a 'social habit' to be addressed by the individual as a free agent. Among his 36 books were *Ceremonial chemistry: the ritual persecution of drugs, addicts and pushers* (1974) and *Our right to drugs: the case for a free market* (1992).

On 28 September 2012 a *Communications paper on approaches to promoting and developing an understanding of domestic, sexual and gender-based violence* was published by COSC (The National Office for the Prevention of Domestic, Sexual and Gender-based Violence). The paper provides suggestions and advice for organisations and professionals on developing messages and methods for raising awareness, confronting offending behaviour, and increasing understanding and recognition of domestic, sexual and gender-based violence both in the general population and in two population-specific groupings – the Traveller community and migrant communities. [www.cosc.ie](http://www.cosc.ie)

On 15 October 2012 *A fresh approach to drugs: the final report of the UK Drug Policy Commission* was published. The UKDPC proposes a radical rethink of how responses to drug problems are structured. It provides an analysis of the evidence for how policies and interventions could be improved, with recommendations for policymakers and practitioners to address the new and established challenges associated with drug use. [www.ukdpc.org.uk](http://www.ukdpc.org.uk)

On 16 October 2012 *Putting people first: action programme for effective local government* was published. Incorporating the final report of the Local Government and Local Development Alignment Steering Group,<sup>1</sup> the action programme states, 'Local government will be the main vehicle of governance and public service at local level – leading economic, social and community development, delivering efficient and good value services, and representing citizens and local communities effectively and accountably.' [www.environ.ie](http://www.environ.ie)

(Compiled by Brigid Pike)

1. For a description this Steering Group's interim report, see 'In brief' in the last issue of *Drugnet Ireland* (No 43, Autumn 2012).

# Recent publications

## Journal articles

The following abstracts are cited from recently published articles relating to the drugs and alcohol situation in Ireland.

### Mothers' experiences of their children's detoxification in the home: results from a pilot study

Van Hout MC and Bingham T  
*Community Practitioner*, 2012, 85(7): 30–33  
[www.drugsandalcohol.ie/18241](http://www.drugsandalcohol.ie/18241)

Detoxification from alcohol and/or drugs and the achievement of abstinence without formal treatment is often preferred using community-based supports from local GPs and family. Family members are often involved in the sourcing of information on detoxification and treatment options, user advocacy and provision of remedial supports while detoxifying within the family home. The aim of the research was to describe and explore family experiences of self-detoxification processes from the perspectives of mothers in the Mid West of Ireland. A convenience sample of adult mothers who had experienced their child detoxifying in the home (n=9) were interviewed. The findings illustrated varied personal definitions of detoxification. Addiction stigma and costly experiences of treatment and after care pathways facilitated home detoxification attempts. A lack of GP advice, support and information around safe home detoxification was observed to contribute to information and support seeking from friends, family and community members with home detoxification experience. Self-medication of both licit and illicit substances while detoxifying, and relapse cycles were common. The research highlights the need for inclusive health and social supports provided by GPs, community nurses, RGNs and district nurses for families and individuals detoxifying in the home setting.

### Methadone maintenance and Special Community Employment schemes: a study of Irish participants' views

Van Hout MC and Bingham T  
*Journal of Vocational Rehabilitation*, 2012, 37(1): 63–73  
[www.drugsandalcohol.ie/18303](http://www.drugsandalcohol.ie/18303)

Specialist vocational training for ex-drug users include employment skills training, supported placements and therapeutic work programmes. The research was peer led by Client Forum representatives of five 'Special Community Employment' schemes and aimed to explore participant experiences of Methadone Stabilization; 'Special Community Employment' schemes, and Vocational Outcomes. A Client Forum consultation (n = 11) and Client Forum representative focus groups (n = 2) were used to finalize interview questions. In depth interviews with a convenience sample of participants from 'Special Community Employment' schemes (n = 25) were conducted. Content and thematic analysis of narratives was undertaken with Client Forum (n = 11) interpretative support. The findings are indicative of 'Special Community Employment' schemes offering methadone maintenance participants' the opportunity to commence recovery, engage in vocational training and reintegrate into the community. However, participation in these schemes appeared restrictive and operated primarily as therapeutic medium, with little individual vocational care planning, training or supported work placements. Many participants reported leaving these schemes unqualified, unemployed and experiencing little aftercare. The research underscores the need for extensive revision of 'Special Community Employment' schemes within an interagency approach, so as to provide specific therapeutic supports dependent on individual recovery stage, and client specific vocational training needs, certification, work placement and supportive aftercare.

### Substance use and psychiatric disorders in Irish adolescents: a cross-sectional study of patients attending substance abuse treatment service

James PD, Smyth BP and Apantaku-Olajide T  
*Mental Health and Substance Use*, 2012, 6 July. Early online.  
[www.drugsandalcohol.ie/18305](http://www.drugsandalcohol.ie/18305)

Little information exists on the levels of psychiatric disorders among substance abusing adolescents in Ireland. The aim of the study is examine the pattern of psychiatric disorders and explore for gender differences among adolescents with a substance use disorder (SUD) in Ireland. A cross-sectional descriptive study and retrospective review of medical records on the 144 most recent admissions at the Youth Drug and Alcohol (YoDA) service, Dublin was carried out. Overall, 48% of the patients had a lifetime history of psychiatric disorders. Deliberate self-harm (DSH) was the most common condition (27.1%), followed by attention deficit hyperactivity disorder (20.8%) and depression (10.4%). Conduct disorder and oppositional defiant disorder were infrequently diagnosed. Compared with boys, the girls were more likely to have a lifetime history of psychiatric disorders (odds ratio 3.7; p = 0.005). These findings provide the first prevalence data on psychiatric disorders in a clinically representative sample of Irish adolescents with SUDs. Adolescent addiction services should have the skills to assess and manage co-occurring mental health problems. There is a need for further studies to examine DSH among adolescents with SUDs.

### A national study of the retention of Irish opiate users in methadone substitution treatment

Mullen L, Barry J, Long J *et al.*  
*American Journal of Drug and Alcohol Abuse*, 2012, 2 July. Early online.  
[www.drugsandalcohol.ie/18304](http://www.drugsandalcohol.ie/18304)

**Background:** Retention in treatment is a key indicator of methadone treatment success. This study aims to identify factors that are associated with retention. Objectives: To determine retention in treatment at 12 months for Irish opiate users in methadone substitution treatment and to indicate factors that increase the likelihood of retention. Methods: National cohort study of randomly selected opiate users commencing methadone treatment in 1999, 2001, and 2003 (n = 1269). Results: Sixty-one per cent of patients remained in continuous treatment for more than one year. Retention in treatment at 12 months was associated with age, gender, facility type, and methadone dose. Age and gender were no longer significant when adjusted for other variables in the model. Those who attended a specialist site were twice as likely to leave methadone treatment within 12 months compared with those who attended a primary care physician. The most important predictor of retention in treatment was methadone dose. Those who received <60 mg of methadone were three times more likely to leave treatment. Conclusion: Retention in methadone treatment is high in Ireland in a variety of settings. The main factors influencing retention in methadone treatment was an adequate methadone dose and access to a range of treatment settings including from primary care physicians. Scientific Significance: Providing an adequate dose of methadone during treatment will increase the likelihood of treatment retention. Methadone treatment by the primary care physician is a successful method of retaining opioid users in treatment.

## Recent publications (*continued*)

### Retrospective study of outcomes, for patients admitted to a Drug Treatment Centre Board

Somers CJ and O'Connor JJ  
*Irish Medical Journal*, 2012, 105(9)  
[www.drugsandalcohol.ie/18636/](http://www.drugsandalcohol.ie/18636/)

Retrospective study of urinary heroin outcomes of a cohort (123) of patients commenced on a methadone treatment program. Significantly poorer outcomes were associated with urines positive for cocaine (OR 0.69 CI 0.59-0.81) benzodiazepines (OR 0.7 CI 0.53-0.93) with prescribing of low dose methadone (OR 0.65 CI 0.48-0.87), with urines positive for heroin at time of admission (OR 0.74 CI 0.56-0.97) and with behavioural sanctions (OR 0.8, CI 0.65-0.98). Improved outcomes were associated with granting of take away methadone (OR 1.34 CI 1.1-1.62). with an indication of improved outcomes associated with alcohol positive urines (OR 1.34 CI 0.95-1.9) and increased duration of clinic attendance (OR 1.21 CI 0.99-1.47). On multiple regression analysis low dose methadone (0.07 CI 0.01-0.33) prescribing remained negatively associated with urine heroin outcomes.

### Prognostic factors of 2-year outcomes of patients with comorbid bipolar disorder or depression with alcohol dependence: importance of early abstinence

Farren C, Snee L, Daly P and McElroy S  
*Alcohol and Alcoholism*, 2012, 11 October. Early online.  
[www.drugsandalcohol.ie/18576/](http://www.drugsandalcohol.ie/18576/)

**Aims:** To investigate the prognostic factors that determine 2-year outcomes in a group of alcohol-dependent patients with depression or bipolar disorder who were treated in an intensive 4-week inpatient programme.

**Methods:** This was a longitudinal study of an inpatient treatment cohort of dual affective disorder and alcohol-dependent patients, in Dublin, Ireland. Measurements included baseline demographics with follow-up measurements at discharge, 3 months, 6 months and 2 years after treatment, including alcohol consumption, depression, mania/elation, anxiety, craving, drug use and sample blood tests. Factor and regression analysis of multiple variables was carried out to predict outcomes.

**Results:** A total of 189 participants with alcohol dependence and comorbid depression (n = 101) or bipolar disorder (n = 88) were followed over 2 years after discharge from treatment. Retention rate was 76% over 2 years. Early abstinence (at 6 months) predicted better abstinence overall at 2 years; and bipolar alcoholics had a better outcome in drinks per drinking day than depressed alcoholics at 2 years. Younger participants (age 18–30 years) did relatively worse than middle-age (30–50 years) and older (51 + years) participants in measures of abstinence and number of drinks per drinking day at 2 years; and females did better than males in number of drinks per drinking day at 2 years.

**Conclusion:** Dual diagnosis of alcohol dependence and depression or bipolar disorder may be treated together with intensive intervention and follow-up, and various prognostic factors including early abstinence emerge over time that influence outcomes over 2 years.

### Best practice promotion in Europe: a web-based tool for the dissemination of evidence-based demand reduction interventions

Ferri M and Bo A  
*Drugs: education, prevention and policy*, 2012, 3 December.  
Early online  
[www.drugsandalcohol.ie/18927](http://www.drugsandalcohol.ie/18927)

In 2008, the EMCDDA initiated the creation of a web-based tool which bridges scientific evidence and current practice in the drug addiction field. The aim is to disseminate evidence-based interventions and promote sharing of best practice among European countries. The synthesis of the evidence is based on sound procedures, implemented according to the methods of the Cochrane collaboration (the Drugs and Alcohol Group) and the Grade working group. As of October 2012, the portal is composed of four modules on the effectiveness of demand reduction interventions, a collection of European projects on prevention, treatment, harm reduction and social reintegration and an inventory of European guidelines and standards. The summaries of evidence are user-friendly and provide plain language information on the interpretation of the measures of effect supporting the evidence, but do not provide specific recommendations. The main future challenge of the EMCDDA's best-practice promotion is to enhance the communication of evidence to better inform the decision making processes at both national and European levels.

## Upcoming events

Compiled by Joan Moore ([jmoore@hrb.ie](mailto:jmoore@hrb.ie))

### January

31 January 2013

#### **Drugs and alcohol seminar: Managing the performance, safety and health risks of employee drug and alcohol use**

**Venue:** Ashling Hotel, Dublin 8

**Organised by / Contact:** EAP Institute

**Email:** [anita@eapinstitute.com](mailto:anita@eapinstitute.com)

**Tel:** +353 51 855733

[www.eapinstitute.com](http://www.eapinstitute.com)

**Information:** This seminar will consider the implications for business on a proposed new law to test all road users for drug driving. Currently commercial drivers who register a reading of greater than 20mg/100ml of alcohol are deemed not fit to drive and the proposed new drug testing will pose an additional threat to employee livelihood. Section 13(1) b of the Safety Health and Welfare at Work Act 2005 requires that an employee should ensure that he or she is not under the influence of an intoxicant to the extent that he or she is in such a state as to endanger his or her own safety health or welfare at work or that of any other person. Section 19(1) requires that employers should assess the risks presented by those hazards and include them in a written assessment. A further requirement under Section 20(1) of the Act is that the control measures for intoxicants should be included in the safety statement.

This seminar will also run on 23 May 2013 at The Prince of Wales Hotel, Athlone, Co Westmeath.

### February

14 February 2013

#### **Be the Change! DDN Service User Conference 2013**

**Venue:** National Motorcycle Museum, Birmingham, UK

**Organised by / Contact:** Drink and Drugs News

**Email:** [conferences@cjwellings.com](mailto:conferences@cjwellings.com)

**Tel:** 01233 633315

**Information:** This is your chance to have your say and network with colleagues all over the country. Activism, inspiration, enterprise and all pathways to recovery will be central to a programme that will give every opportunity for service users and professionals to share expertise and practical learning.

### March

#### **Alcohol Awareness Week planned for March 2013**

[www.alcoholforum.org](http://www.alcoholforum.org)

**Information:** Alcohol Forum, the alcohol-responsibility advocacy group based in the North Western area, has announced plans to launch the first ever national Alcohol Awareness Week in March 2013. The Forum is hoping to organise a national conference on 21 March in parallel with the event. Alcohol Forum is also a cross-border advocacy group and also offers support and advice to families affected by alcohol issues. See website for information about the Forum and for further details of the conference in due course.

### May

6–11 May 2013

#### **Testing the waters: 2013 conference**

**Venue:** Obergurgl, Austria

**Organised by / Contact:** European Science Foundation /

EMCDDA / Innsbruck Leopold-Franzens University

[www.esf.org/index](http://www.esf.org/index) /

[www.emcdda.europa.eu/wastewater-analysis](http://www.emcdda.europa.eu/wastewater-analysis)

**Information:** 'Testing the waters' is the title of the first international multidisciplinary conference on illicit drugs and wastewater. Wastewater analysis is a rapidly developing scientific discipline with the potential for monitoring real-time population-level trends in illicit drug use and for assessing the efficacy of drug control interventions. By sampling a source of wastewater – for example a sewage influent to a wastewater treatment plant – scientists can estimate the total quantity of drugs consumed by a community by measuring the levels of illicit drug metabolites excreted in urine. The conference will assess the state of the art in this emerging scientific

discipline, consolidate research findings and identify a common approach and set of methodologies for wastewater analysis and monitoring. For information on applications and abstract submission, see the ESF website.

16–17 May 2013

#### **Managing Drug and Alcohol Problems in Primary Care**

**Venue:** National Motorcycle Museum, Birmingham, UK

**Organised by / Contact:** Royal College of General Practitioners

[www.rcgp.org.uk/courses-and-events](http://www.rcgp.org.uk/courses-and-events)

**Information:** This, the 18th national conference, will once again examine the critical role primary care plays in working with drug users, their families and carers. The conference is the largest event in the UK for GPs, shared care workers, drug users, nurses and other primary care staff, specialists, commissioners and researchers interested in, and involved with the management of drug users in primary care.

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