drugnet Ireland

Newsletter of the Drug Misuse Research Division

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Welcome to Issue 12 of *Drugnet Ireland*, the newsletter of the Drug Misuse Research Division of the Health Research Board. The role of this publication is to disseminate information, news and research findings among those involved in the drugs area in Ireland.

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Tackling alcohol-related harm in Ireland

The Minister for Health and Children established the Strategic Task Force on Alcohol in January 2002 as recommended by the First Report of the Commission on Liquor Licensing. The brief of the Task Force is 'to recommend specific, evidence based measures to Government to prevent and reduce alcohol related harm.' The Task Force published an Interim Report in May 2002[1] which contained recommendations to:

- regulate availability
- reduce drink driving
- limit harm in drinking environments
- protect children and reduce pressure on adolescents to drink
- provide information, education and services
- develop key indicators to monitor the situation

Dr Jim Kiely, Chair of the Strategic Task Force on Alcohol, and the then Minister for Health and Children, Mr Micheál Martin TD, at the launch of the report (Photo: Mac Innes Photography)

Up to September 2004, progress has been made in a number of key areas:[2]

- Excise duty on cider and spirits was increased; further increases on a regular basis are intended.
- The Intoxicating Liquor Act 2003 was published and contained measures to deal with underage drinking as well as drunk and disorderly conduct.
- Bar staff have commenced training on responsible serving practices.
- The writing of draft legislation to reduce the exposure of children to alcohol marketing was commenced.
- The Road Traffic Act was revised to permit more extensive breath testing for drivers.
- The drinks industry has established a process for reviewing proposed advertising of alcohol products.
- The Irish Sports Council published the *Code of Ethics and Good Practice for Children's Sport in Ireland* in 2000, in line with the government's guidelines on child protection.
- A public awareness campaign (known as 'Less is More') has effectively raised awareness among the general public about the harms associated with excessive alcohol consumption.
- There is mandatory education on the misuse of alcohol in both the primary and secondary school curricula.
- A number of research studies have been completed, including the second national lifestyles survey, a study investigating public attitudes to alcohol policy changes, and a pilot project on identifying problem alcohol use in general practice.

On 22 September 2004, the Task Force presented its Second Report to the Minister for Health and Children.[2] This report reviews current trends in alcohol consumption and alcohol-related harm:

Tackling alcohol-related harm in Ireland (continued)

Between 1992 and 2002, alcohol-related mortality rates increased for: cancers related to alcohol; alcohol dependency; alcohol abuse and psychosis; chronic liver disease and cirrhosis; alcohol poisoning; and suicide.

Current trends in alcohol consumption in Ireland

- Ireland has the second highest per capita consumption in the European Union.
- Alcohol consumption per person over 15 years was 13.8 litres in 2003, a fall of 0.6 per cent compared with 2001/2.
- Beer is the most common product consumed.
- Binge drinking is more common in Ireland than in many other countries. Of every 100 drinking sessions, 58 end in binge drinking for men and 38 end in binge drinking for women.
- The HBSC 2002 study reported that at least half of boys and girls between 15 and 17 years were drinking at the time of the survey.
- Between 1993 and 2002, there was a dramatic increase in the number of off-licences.
- On average, alcohol expenditure represents 5.5 per cent of the total household expenditure.

Recent trends in alcohol-related harm

- Between 1992 and 2002, alcohol-related mortality rates increased for: cancers related to alcohol; alcohol dependency; alcohol abuse and psychosis; chronic liver disease and cirrhosis; alcohol poisoning; and suicide.
- There is little trend data on health service demand for treatment as a result of alcohol use, apart from the following information:
  - A recent study reported that a large proportion of the young people in North Dublin who required treatment in an accident and emergency at the weekend did so a result of excessive drinking.
  - A new study published in Addiction[3] reported an 80 per cent increase in alcohol-related emergency admissions at acute hospitals in the North Eastern Health Board, from 432 in 1997 to 777 in 2001.
  - In two health board areas, over 60 per cent of those treated for problem substance use reported that alcohol was their main problem drug, and polydrug use was reported by one-fifth of alcohol cases.
  - Alcohol is a factor in two-fifths of parasuicides.
  - In Ireland, as in other countries, there was a positive association between per capital alcohol consumption and population suicide rates from 1999 to 2000.
  - Figures from the Sexual Assualt Treatment Unit reveal a fourfold increase in recent years in the number of women requesting tests to ascertain whether they has been assaulted. Many of these women reported that they believed their drink had been spiked; however, toxicology only ever detected large quantities of alcohol, rather than other drugs.[4]
  - 85 per cent of women continue drinking during their pregnancy.
- Despite the introduction of penalty points, the number of people killed on the roads between 9.00 pm and 4.00 am (which is a proxy for alcohol-related deaths among road users) has remained relatively stable.

The Second Report of the Strategic Task Force on Alcohol has revised and expanded the recommendations in the Interim Report to include the following actions:

- Regulate availability by continuing to increase excise duty, restricting the numbers of outlets, restricting children's access to places where alcohol is served, and self-monitoring within the community.
- Control the promotion of alcohol through legislation to restrict advertising, sponsorship and sales promotions.
- Enhance society's capacity to respond to alcohol-related harm through community mobilisation, consultation with young people, providing alcohol-free alternatives and instituting professional training.
- Protect public, private and working environments through supporting parents and encouraging good practices in the workplace.
- The alcohol beverage industry will institute responsible serving in both licensed and off-licence outlets, ensure responsible labelling and promote low- rather than high-alcohol beverages.
- Continue to provide information and education through public awareness, education in schools and special programmes in community settings.
- Develop effective treatment services through early identification of problem alcohol use (through primary care, emergency health facilities and the justice system), and provision of specialist treatment (referral pathways and counselling).
- Maximise support from non-government organisations so that they can advocate for policy change and create public awareness on the harmful effects of alcohol.
- Research and monitor progress through an independent research and monitoring unit, utilising all sources of information and reviewing progress on key indicators.
- Implement the drink-driving recommendations presented in the 2002 report.

(Jean Long)

1. Strategic Task Force on Alcohol (2002) *Interim Report*. Dublin: Department of Health and Children.
2. Strategic Task Force on Alcohol (2004) *Second Report*. Dublin: Department of Health and Children.
3. O'Farrell A, Allwright S, Downey J, Bedford D, Howell F (2004) The burden of alcohol misuse on emergency in-patient hospital admissions among residents from a health board region in Ireland. *Addiction*, 99, 1279–1285.
4. O'Farrell A (2004) Ireland and its drink problem: the immediate adverse effects of binge drinking in Ireland. *Irish Medical Journal*, 97 (6), 165-166.

Garda study shows decline in drug-related crime

A recent study by the Garda Síochána Research Unit (Furey and Browne 2004) has sought to establish the link between opiate use and criminal activity in Ireland for the years 2000/2001.[1] An earlier study by Keogh (1997) focused on the drug-crime relationship in Dublin in 1996.[2]

Both studies combined the use of official police statistics and interviews with drug users. The purpose of the Keogh study was to provide reliable information on the relationship between illicit drugs and the commission of crime in the Dublin Metropolitan Area (DMA). The study by Furey and Browne extended the analysis to the other Garda Síochána regions throughout the state. Another difference between the two studies is that Furey and Browne examined the use of opiate-based drugs only, while Keogh included some individuals who used only non-opiates such as ecstasy, cocaine and amphetamines. However, the majority (93%) of the subjects in Keogh's report were opiate users.

The two studies incorporated three principal phases. Phase One involved an estimation of the total number of opiate users known to the Gardaí at the time of the study. In the Keogh study 3,817 opiate users were identified in the DMA in 1996, while Furey and Browne recorded a figure of 4,706 opiate users in the DMA. However, a valid comparison cannot be made between these figures. Firstly, Furey and Browne's figure is based on data for two years, 2000 and 2001, while Keogh's figure is based on data for a single year. Secondly, as Furey and Browne point out, the DMA is now larger than it was at the time of the Keogh study, incorporating an extra garda division.

Phase Two involved a survey of a sample of the drug users identified in phase one. The surveys sought to elicit data about the drug users themselves, their drug-taking environment and their criminality.

Phase Three involved an examination of national crime figures in order to estimate the relationship between opiate use and crime. Keogh estimated that drug users were responsible for 66 per cent of detected indictable crime, while Furey and Browne concluded that drug users were responsible for just 28 per cent of detected crime. While this difference is quite striking, it can be partly explained by some of the survey findings from Phase Two. A number of these findings are given in Table 1.

In the Keogh study 59 per cent cited crime as their main source of income, while the figure in the Furey and Browne study was 13 per cent. It is also noteworthy that the Keogh study reported an unemployment rate of 84 per cent among the sample, while Furey and Browne reported an unemployment rate of 55 per cent. This latter finding supports the economic motivation theory by suggesting a lesser dependence on the proceeds of crime in a context of available employment. It also indicates an ability among opiate users to maintain employment despite their addiction. A factor that may have contributed to this is the increased availability of drug treatment in the time between the two studies. Indeed, Furey and Browne found that 75 per cent of

Keogh estimated that drug users were responsible for 66 per cent of detected indictable crime, while Furey and Browne concluded that drug users were responsible for just 28 per cent of detected crimes.

Table 1

Variable	Keogh survey 1997	Furey and Browne survey 2002
Crime as main source of income	59%	13%
Unemployment rate among drug users	84%	55%
Most common age of first taking drugs	15 years	15 years
Drug first used – cannabis	51%	55%
Drug first used – heroin	32 %	27%
First introduced to drugs by friend	81%	86%
Estimated daily expenditure on drugs*	€51	€75
Percentage who sourced drugs from local drug dealer	46%	76%
Crime came before drugs	51%	33%
Drugs came before crime	30%	56%
Drug use and crime started together	19%	11%
Percentage who had been in prison	81%	66%

* Keogh estimated that the cost of one gram of heroin in 1997 was €100 (Keogh, 1997: 40). Furey and Browne do not provide a figure. However, the current cost of one gram of heroin is approximately €190.

Garda study shows decline in drug-related crime (continued)

respondents claimed that their receipt of drug treatment had in fact decreased their criminal activity.

A worrying finding of the Furey and Browne study relates to the apparent stabilisation of local drug markets over time and the ease of drug availability. The study records an increase from 46 to 76 per cent in the number stating that they sourced their drugs from a local dealer. This has important implications for local policing and other supply control initiatives.

Another difference between the two studies relates to the relationship between respondents' initiation into drug use and their criminal activity. While the Keogh study found that 51 per cent of respondents had committed crime before beginning to use drugs, a finding which is broadly consistent with the international literature, Furey and Browne recorded a figure of 33 per cent.

The survey findings of the Furey and Browne study must be treated with a degree of caution, however, because of the poor survey response rate. The response rate in the Furey and Browne survey was just 27 per cent (131 out of 486) compared to 78 per cent (351 out of 450) in the Keogh study. Furey and Browne compared the respondents and non-respondents in their survey according to two available variables, gender and possession of a criminal record, and found little difference between the two groups. This provides some evidence to suggest that the sample might not be totally unrepresentative of the total number of drug users known to the police. Furey and Browne highlight the difficulties they encountered in contacting potential respondents and point to a 123 per cent increase in homelessness between 1996 and 2002.

The difficulties encountered in accessing respondents for interview in this study show the obvious limitations of studies of this nature, where the police seek information about criminal behaviour from subjects they have arrested or known. This relates to a possible perception among respondents that by self-reporting criminal behaviour they risk exposing themselves to possible incrimination. Keogh, for example, encountered difficulties in acquiring specific information from respondents, particularly concerning their participation in violent criminal behaviour. Furey and Browne suggest that a possible reason for the reluctance among drug users to participate in their survey may have been related to a perceived deterioration in relations between the Gardaí and drug users since 1997, which, the authors contend, may have occurred as a consequence of a number of policing operations targeted at drug users.

Another methodological issue relates to the use of Garda-recorded crime statistics. In order to assist them in identifying known drug users and to establish the relationship between opiate use and crime, the two studies relied on different data sources. Keogh relied on manual data and an earlier Garda computer system while Furey and Browne utilised the new Garda Síochána PULSE system. The recent minority report of the Expert Group on Crime Statistics has highlighted major concerns in relation to the operation of this data system and also about earlier crime-recording practices.[3]

Despite these shortcomings, the Furey and Browne study provides useful and recent information about a hard-to-reach population.

(Johnny Connolly)

1. Furey M and Browne C (2004) *Opiate use and related criminal activity in Ireland 2000 and 2001.* Dublin: Garda Síochána Research Unit.
2. Keogh E (1997) *Illicit drug use & related criminal activity in the Dublin Metropolitan Area.* Dublin: An Garda Síochána.
3. Expert Group on Crime Statistics (2004) *Minority report.* Dublin: Department of Justice, Equality and Law Reform.

In brief *Compiled by Brigid Pike*

On 25 June the **World Drug Report 2004** was released by the UN Office on Drugs and Crime (UNODC). It was released to coincide with International Day against Drug Abuse and Illicit Drug Trafficking (26 June). The first volume covers market trends and provides in-depth trend analysis, and the second volume compiles detailed statistics on drug markets.
www.unodc.org

On 26 June a year-long campaign **'Drugs: Treatment Works'** was launched by the UN Office on Drugs and Crime (UNODC). It hopes to diminish the stigma attached to drug users by challenging the common misconception that 'once a drug abuser, always a drug abuser'. Campaign materials are available on the UNODC website.
www.unodc.org

In June a **Report on Alcohol Misuse by Young People** was released by the Joint Oireachtas Committee on Health and Children. Among its 10 key recommendations, the Committee recommended a complete ban on all alcohol advertising within a three-year period, and a complete ban on all acknowledgement or credit for sponsorship of sports events, clubs or teams that cater for members under 25 years of age, by any area of the alcoholic drinks industry.

In June **MEAS (Mature Enjoyment of Alcohol in Society Ltd)** released 'Underage Drinking is Rarely Black and White'. The research found that half the country's 16- and 17-year-olds are drinking alcohol 'regularly' and that domestic (at home) drinking by parents is a key influencer of their children. MEAS intends to use the research findings to inform the content and direction of its work in seeking solutions.
www.meas.ie

In June the **Safety, Health and Welfare at Work Bill 2004** was published. The Bill requires an employee, at work, to ensure that he or she is not under the influence of an intoxicant [alcohol or drug, and any combination of drugs or of drugs and alcohol] to the extent that he or she endangers his or her own safety, health or welfare at work or that of any other person. It also requires an employee, if reasonably required by his or her employer, to submit to any appropriate, reasonable and proportionate tests by a competent person.
www.oireachtas.ie

In June the **Dormant Accounts (Amendment) Bill 2004** was introduced in the Seanad, reforming the processes by which decisions are made about disbursements from the Fund. In 2003 the Dormant Accounts Fund Disbursements Board (DAFDB) published its first plan, covering the years 2003–05. The plan states that at least 40 per cent of total annual funding will be allocated to the area of economic and social disadvantage, and that, after the first year, not less than 50 per cent of the annual proportion allocated to economic and social disadvantage will be allocated to RAPID, CLÁR and drugs task forces.
www.dormantaccounts.ie

In July the **British–Irish Council** published a report on its work between 1999 and December 2003. The Irish government, with lead responsibility for drugs, reports on the work programme in relation to the drugs issue. The Northern Ireland Executive, with lead responsibility for transport, reports that it is considering the potential for taking forward work on driving and drug misuse within the Council.
www.britishirishcouncil.org

In July the **Drug Treatment Centre Board (DTCB)** published its annual report for 2003. New initiatives included piloting on-site hepatitis C treatment for hepatitis-C-positive attendees, and the development of dedicated, structured programmes for the growing number of clients who were presenting for treatment for cocaine use.
www.addictionireland.ie

In August **Merchants Quay Ireland (MQI)** launched its annual report for 2003. It shows that the numbers of drug users attending their Health Promotion Unit continued to increase, up by 5 per cent on 2002, to 3,331. MQI's strategic plan for 2004–2006 sets out its plans for the direct management of supported accommodation for homeless drug users, to meet the needs of homeless people and drug users in cities outside of Dublin, and to develop new innovative harm reduction services for homeless people and drug users.
www.mqi.ie

In September the **Drug Awareness Programme (DAP)** website, run by Crosscare, was awarded the Dublin Bus Inaugural Award for Serving the Community. The website offers on-the-spot confidential advice about drug problems. The website has already won the British Telecom Telephone Helpline Award 2003/04.
www.dap.ie

On 4 October a conference on **'Exploring Drug Issues through Community Research'** saw the launch of four community research reports funded by the National Advisory Committee on Drugs (NACD). The launch was followed by a workshop on the principles and practice of community research. The four community research groups funded by the scheme were the Ballymun Youth Action Project (BYAP), the Kilbarrack Coast Community Programme (KCCP), Merchants Quay Ireland (MQI) and the Tallaght Homeless Advice Unit (THAU). The reports will be discussed more fully in the next issue of *Drugnet Ireland.*
www.nacd.ie

The then Minister for Health and Children, Mr Micheál Martin TD, at the launch in July of the DTCB annual report

(photo: Fennell Photography)

Cannabis use by young people in Ireland

In Ireland one in every four boys reported using cannabis in the year prior to the survey.

The Health Behaviour in School-aged Children (HBSC) survey is a cross-national research study of the health and health-related behaviour of school-going children carried out every four years. The research is conducted by an international network of research teams in collaboration with the World Health Organization (WHO) Regional Office for Europe. The most recent survey was conducted successfully in 35 countries and regions, including Ireland. Findings from the Irish survey, including data on drug use, have been previously published.[1]

On 4 June 2004 the WHO published an international report which used data from the last HBSC survey.[2] The report, *Young people's health in context,* provides information on the prevalence of priority health-related behaviour and key health indicators, and places these findings in their social and developmental contexts. Previously unpublished data on cannabis use by young people in Ireland are presented in part of the report. The section on cannabis use is authored by Tom ter Bogt, Anastasios Fotiou and Irish researcher Saoirse Nic Gabhainn.

The target population in the HBSC survey is school-going children who are aged 11, 13 and 15 years. The HBSC protocol recommends a minimum survey sample size of 1,536 children at each of these ages. In Ireland the numbers of children surveyed at these ages were 1,012, 944 and 919 respectively, which were lower than the desired targets. It should be kept in mind that, in general, the smaller the survey sample the wider are the confidence intervals around the estimates obtained from the sample.[3] The protocol also required that children be selected using a cluster sampling design, where the initial sampling unit was the class (or school in the absence of a sampling frame of classes). Each child of the appropriate age in the classes selected and present in class on the day of the survey was asked to participate. In Ireland, individual schools within regions were first randomly selected and classes within schools were subsequently randomly selected for participation. The objective was to achieve a nationally representative sample of school-going children. The Irish HBSC survey was carried out between April and June 2002.

The findings on cannabis use presented in the report relate only to 15-year-olds. The numbers of children who responded to the cannabis questions are not given in the report. Results for boys and girls in Ireland compared with the average for all 35 HBSC countries and regions are shown in Table 1.

In Ireland one in every four boys reported using cannabis in the year prior to the survey. The rate was lower for girls: one in every seven had used cannabis in the previous year. Cannabis use for boys in Ireland was higher than the HBSC average, while that for girls was lower. However, the differences in the proportions are small and may be due to sampling variation.[4]

Four groups were identified among those who reported having used cannabis at least once in their lives, based on the number of times they had used it in the previous 12 months. The four groups were 'former users' who had not used cannabis in the last year, 'experimental users' who had used it once or twice, 'recreational users' who had used it between 3 and 39 times, and 'heavy users' who had used it 40 or more times. The percentage of young people in Ireland in each of these four groups compared with the HBSC average is shown in Table 2.

Table 1

	Boys aged 15 years		Girls aged 15 years	
	Ireland %	HBSC average %	Ireland %	HBSC average %
Cannabis use				
During lifetime	27.3	25.8	15.2	18.4
During last year	25.5	21.7	14.4	16.0

Source: *Young people's health in context* (p. 86)

Table 2

	Children aged 15 years	
	Ireland %	HBSC average %
Former user	1.5	3.6
Experimental user	7.9	7.3
Recreational user	6.4	7.9
Heavy user	3.6	2.8

Source: *Young people's health in context* (p. 88)

Cannabis use by young people in Ireland (continued)

Compared to the HBSC average, Ireland had a much lower percentage of 'former users', suggesting that young children in Ireland are more likely to continue their use after starting. Indeed, of the 35 HBSC countries and regions, Ireland ranked 30th on this indicator. The percentage of experimental cannabis users in Ireland was slightly higher than the HBSC average, while the percentage of recreational users was lower. Of most concern was the level of heavy cannabis use: a higher percentage of children in the sample in Ireland had used cannabis 40 or more times in the last year (3.6%) than the average for all samples in the 35 HBSC countries and regions (2.8%). The report notes that, while most users in all HBSC countries and regions belonged to the experimental and recreational use groups, the 'small numbers reporting heavy use at this stage of their lives may well be at risk of adverse health and social consequences and should be the focus of targeted interventions'. *(Hamish Sinclair)*

1. Kelleher C et al. (2003) *The National Health & Lifestyle Surveys. Survey of Lifestyle, Attitudes and Nutrition (SLÁN) & the Irish Health Behaviour in School-aged Children Survey (HBSC).* Galway: Centre for Health Promotion Studies, National University of Ireland.
2. Currie C *et al.* (eds) (2004) *Young people's health in context. Health Behaviour in School-aged Children (HBSC) study: international report from 2001/2002 survey.* Copenhagen: World Health Organization.
3. A confidence interval is a range of values which we can be confident includes the true value. By convention, a 95% confidence interval is reported. For example, if the proportion of cannabis users in a survey sample drawn from the population is found to be 17% and the 95% confidence interval is reported as ranging from 14% to 20%, then we can say that we are 95% confident that this interval includes the true proportion of cannabis users in the population. It is good practice to provide confidence intervals to indicate the level of precision associated with survey estimates.
4. Because researchers must normally take a sample rather than study an entire population, inaccuracies can occur in making inferences about a population value based on a sample value. Sampling variation or sampling error is an estimate of how much a sample value can be expected to differ from the true value in the population. The difference expected is accounted for by the level of precision chosen when calculating the sample size. Thus, differences observed between two estimated proportions may simply be due to a lack of precision.

Consequences of cannabis use

The National Advisory Committee on Drugs recently published *An overview of scientific and other information on cannabis.*[1] The report draws on relevant research from Ireland and abroad with a view to presenting a balanced account of how this illegal but widely used substance affects a range of outcomes. The review was conducted by four authors, from four different disciplines.

The pharmacological and toxicological effects of cannabis were considered by Dr Dominique Crowley.[1] The identification through laboratory studies of two cannabis receptors in the brain, linked to memory, movement and co-ordination, pain perception and the reward system, has resulted in a better understanding of cannabis effects in humans. The potential therapeutic value of cannabis compounds is difficult to assess, as a specific 'dose' of cannabis cannot be reliably administered. There is only anecdotal evidence to suggest that cannabis may have beneficial effects on mood disorders, but cannabis and its derivatives can be useful in the treatment of pain and nausea. There is a strong association between cannabis use and some mental health problems; people suffering from a depressive condition are much more likely to become heavy users of the drug than those without such a diagnosis.

Dr Crowley also examined the connection between cannabis use and short-term memory loss, cardiac problems and respiratory conditions. Evidence of a link between cannabis use and cancer and antenatal health problems has not been firmly established.

Dr Claire Collins reviewed the epidemiological evidence concerning the public health risks of the drug. Prevalence rates for cannabis use are highest among the 15–24 year age group, with over three-quarters of 16-year-olds saying they know where to obtain the drug and relatively low proportions perceiving cannabis use as risky behaviour. In about 80 per cent of cases, young people try out cannabis for the first time with their friends.

There is a strong statistical association between cannabis use during adolescence and subsequent use of other illicit drugs. However, most young people who try cannabis do not progress to either heavy cannabis use or the use of other illicit drugs. Another public health consequence of cannabis use is its association with traffic accidents, where it can often combine with alcohol as a contributory factor.

Dr Mark Morgan examined the psychological consequences of cannabis use. While there is little evidence that cannabis use has an impairing effect on cognitive functioning as measured by IQ tests, heavy cannabis use produces subtle cognitive

Consequences of cannabis use (continued)

impairments of memory, attention and the organisation of complex information.

It is often suggested that cannabis induces 'amotivational syndrome' where users appear to be apathetic, lethargic and unmotivated. However, recent studies have failed to find clear-cut evidence for this syndrome. A strong association between cannabis use and poor educational outcomes is a firmly established finding in the literature.

There is consistent evidence that young people attempting suicide are more likely to have a history of heavy cannabis use than are others. However, personality make-up and the presence of other substances must be considered when attempting to define the contributory role of cannabis.

Mr Johnny Connolly examined the criminological and sociological consequences of cannabis use. Many of the negative criminological and sociological consequences related to cannabis have been attributed to its legal status, rather than to any properties of the drug itself. The debate over cannabis law reform remains one of the most contested areas of international drug policy. The legal status of cannabis has come under increased scrutiny in recent years in Ireland. The National Crime Forum, established by the Minister for Justice, Equality and Law Reform in 1998, heard arguments for and against the decriminalisation of cannabis.[2] The recent declassification of cannabis in the United Kingdom has contributed to further debate on the subject.[3]

Cannabis is the most widely trafficked drug globally. In Ireland, as in most other countries, there are more seizures of cannabis than of any other drug. In 2002, cannabis-related seizures accounted for 54 per cent of the total number of drug seizures for that year and An Garda Síochána figures show a steady increase in the total number of cannabis-related offences in recent years.[4] Cannabis-related offences accounted for 64 per cent of the total number of offences in which criminal proceedings commenced in 2002.

This section also looks at the effect that drug laws have had on educational and employment prospects, relationships and travel in a number of countries. Cannabis laws can contribute to marginalisation and alienation, inducing a perspective among young people that the law is unfair, heavy-handed and out of touch.

It is difficult to establish the precise causative link between drug use and crime, aside from the obvious link to drug offences such as possession and supply. Recent studies have found an association between heavy use by juveniles and aggressive behaviour. A recent UK review concluded that those who use illicit drugs are more likely to be involved in crime, and vice versa.

Although there is clear evidence of violence associated with the drug trade, in the absence of any adequate studies of Irish drug markets it is impossible to state with any clarity the extent to which violence is associated specifically with the trade in cannabis.

The gateway theory holds that, although most cannabis users do not progress to other drugs, cannabis primes the user into taking other illicit drugs, either through a physiological mechanism or through personality and social factors. Among the factors which have been identified as increasing the probability of further harm are early onset of cannabis use, family and other problems, exposure to other illicit drug markets, and alcohol and tobacco consumption. Age and gender are also important factors.

Many countries have sought to address the gateway factor by introducing changes in cannabis law enforcement practices or through legal reforms. The chapter concludes by highlighting the need for further research in the drugs–crime area in Ireland. There is a particular need for more data describing the way in which laws are being implemented in the area of drug markets. *(Johnny Connolly)*

1. Collins C, Connolly J, Crowley D & Morgan M (2004) *An overview of scientific and other information on cannabis.* Dublin: National Advisory Committee on Drugs

2. Government of Ireland (1998) *National Crime Forum Report*. Dublin: Institute of Public Administration.

3. For an analysis of the legal changes in the UK see Connolly J (2004) Reclassification of cannabis in the UK, *Drugnet Ireland*, Issue 10, March 2004.

4. See An Garda Síochána Annual Reports for 1999 to 2002.

Drug situation, consequences and treatment in Irish prisons

Between 1997 and 2000, the Irish Prison Service commissioned a number of studies to examine the prevalence of blood-borne viruses[1,2] and the health status of the prison population.[3] Two independent qualitative studies were also completed.[4,5,6]

In the late 1990s, two studies[1,2] estimated the prevalence of antibodies to hepatitis B, hepatitis C and HIV among the prison population and described the risk factors associated with testing positive for each of these antibodies.

Among 1,193 prison inmates in 1998[1] the prevalence of antibodies to the hepatitis B core antigen was 9 per cent, to hepatitis C 37 per cent, and to HIV 2 per cent; two-fifths of prisoners tested positive for one or more of the infections. Of the 1,178 inmates whose injecting status was known, 43 per cent (509) had ever injected and, of these, one-fifth had started injecting in prison.

In order to adjust for the over-representation of prisoners serving longer sentences and to ensure adequate representation of prisoners held on remand or serving shorter sentences, a survey estimating the prevalence of blood-borne viruses among 596 prison entrants was completed in 1999.[2] The prevalence of antibodies to hepatitis B core antigen was 6 per cent, to hepatitis C 22 per cent, and to HIV 2 per cent. One-third of the respondents had never previously been in prison (197); these had the lowest prevalence of antibodies to hepatitis B core antigen (2%), to hepatitis C virus (3%) and to HIV (0%). In total, 173 (29%) entrants reported ever injecting drugs. Only 7 per cent (14/197) of those entering prison for the first time reported ever injecting drugs, compared to 40 per cent (157/394) of those previously in prison. Of those who ever injected and had spent time in prison, 19 per cent started injecting in prison.

In the two studies,[1,2] the overall pattern of injecting drug use was similar among both inmates and re-entrants. The prevalence of antibodies to all three viruses was significantly higher among both inmates and entrants who reported injecting drug use (Figures 1 and 2).

After adjusting for other risk factors in both studies, injectors who had shared needles in prison were over four times more likely to test positive for hepatitis C than injectors who had not shared needles in prison. Injectors who started injecting more than three years prior to the survey were also more likely to test positive for hepatitis C than injectors who had not injected in the month prior to the survey. Injectors who had spent more than three of the last 10 years in prison were also more likely to test positive for hepatitis C than their counterparts who had spent less than three months in prison.

The authors of the two studies concluded that hepatitis C was endemic in Irish prisons, that injecting drug use was the most important risk factor, and that being in prison would seem to increase the risk of acquiring it.

Long and colleagues described and explored injecting practices,[4] strategies taken to deal with risk of infection[5] and actions necessary to address this situation;[4] 31 (16 injectors and 15 non-injectors) participants were interviewed.

The authors of the two studies concluded that hepatitis C was endemic in Irish prisons, that injecting drug use was the most important risk factor, and that being in prison would seem to increase the risk of acquiring it.

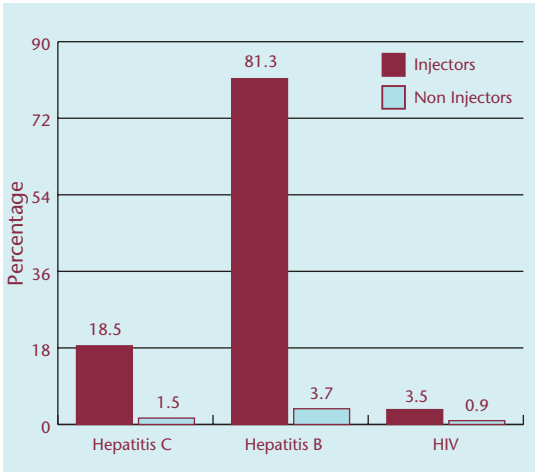


Figure 1

Prevalence of antibodies to hepatitis B, hepatitis C and HIV among prison inmates, by injector status, in 1998

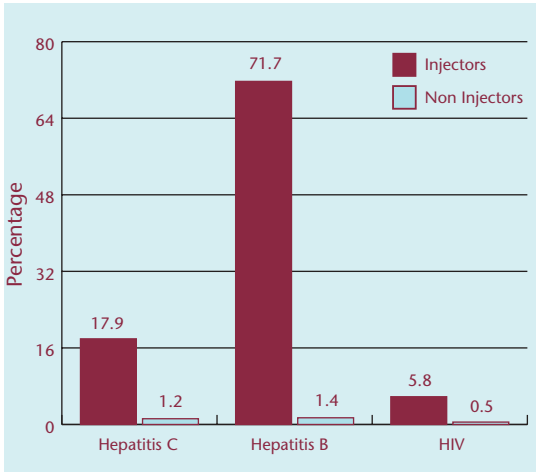


Figure 2

Prevalence of antibodies to hepatitis B, hepatitis C and HIV among prison entrants, by injector status, in 1999

Drug situation, consequences and treatment in Irish prisons (continued)

Injectors reported and non-injectors observed that 'injectors take a number of risks during detention that they would not take outside prison'. For example, the low availability of heroin encouraged the change from smoking to injecting; the scarcity of injecting equipment meant that sharing circles were far wider than outside prison; cleaning practices were inadequate for injecting equipment; and those who owned a syringe and needle rented them to other injectors as a means of acquiring the drugs to maintain their habit. The non-injectors in prison said they knew which prisoners were current injecting drug users. Almost all non-injectors had observed injecting drug use in prison and their reported observations of injecting practices were consistent with those reported by respondents who had injected in prison.

During the in-depth interviews, prisoners (both injectors and non-injectors) were asked how they dealt with the risk of either contracting or testing positive for hepatitis C. Two dominant themes emerged: denial and fear. Injector respondents dealt with the possibility of contracting or experiencing consequences of infection with hepatitis C by: living in the moment; distancing its effects in time; generalising the condition to all injectors; and comparing its consequences to those of HIV. This process allowed them to continue injecting without considering the consequences. According to most injector respondents, hepatitis C is common among those who inject drugs and, to date, its consequences have not been serious.

The fears expressed by injectors and non-injectors were in the main well founded. Fear of contracting, or actually contracting, blood-borne viruses deterred a number of heroin users from starting or continuing to inject heroin in prison. Similar numbers of non-injector and injector respondents reported that they feared contracting blood-borne viruses while in prison.

All respondents were asked: 'What action is required by the prison authorities to deal with drug use in prison?' Respondents suggested a number of interventions, including routine daily activities (such as education, work, and exercise), drug awareness programmes, individual counselling sessions and harm reduction services. Non-injectors were sympathetic to the plight of injectors, and both non-injectors and injectors supported harm reduction interventions and thought that the range of drug services in prison should mirror that currently available in the community, although half opposed or had reservations about needle exchange.

Prisoners viewed time in prison as an opportunity to address substance misuse and stabilise viral infections; health professionals should not miss this opportunity.

Hannon *et al.* (2000) documented the health status of prisoners in Ireland, including their mental health status.[3] The high rate of lifetime drug use (72% males, 83% females) occurred in a population that reported many mental health problems. In the clinical history section of this study, 30 per cent of male and 49 per cent of female respondents stated that they had spoken to a health professional about anxiety, depression or a mental, nervous or emotional problem in the past 12 months. Of these, 42 per cent of males and 58 per cent of females had sought help for depression, 13 per cent of males and 4 per cent of females for anxiety, and 14 per cent of males and 29 per cent of females for drug-related problems. Overall, 24 per cent of male prisoners and 34 per cent of female prisoners reported attending a health professional at the time of interview; of these, 17 per cent of males and 37 per cent of females were attending a psychiatrist. The association between psychiatric illness and problem drug use among prisoners was not examined in this study, but there is anecdotal evidence of a clear overlap between problem substance use and mental illness.

During 2000 and 2001 the Irish Prison Service, along with other agencies, examined the findings of these studies and developed both drug treatment service plans and healthcare plans for the prisoners.[7,8] By the end of 2002, the Prison Service was at an advanced stage of drafting an Irish Prison Drug Service Policy that would be in line with the current Irish drugs strategy *Building on Experience: the National Drugs Strategy 2001– 2008* (Department of Tourism Sport and Recreation 2001) and the World Health Organization's *Health in Prisons Project: Prisons, Drugs and Society 2002*.[9] This policy is awaiting approval from the Minister for Justice, Equality and Law Reform.

A number of positive developments have ensued, such as the introduction of evidence-based methadone treatment services that can be accessed by the majority of opiate-dependent prisoners. The Irish Prison Service is to be commended for its attempts to vaccinate a significant minority of prisoners against hepatitis B, something very few prisons, nor, indeed, community health services, have managed. The employment of registered nurses facilitated the separation of disciplinary and healthcare roles, although more needs to be done. The increased availability of drug-free units is also to be commended.

There is, of course, much more to do, such as harm reduction methods for those who continue to inject (for example, safe injecting information and limited needle exchange) and the management of morbidity (hepatitis C and sexually transmitted infections) associated with drug misuse. Counselling and psychological services are also necessary in Irish prisons and the feasibility of introducing the therapeutic community model of care for those who

Drug situation, consequences and treatment in Irish prisons (continued)

wish to address their substance misuse should be considered. The high levels of psychiatric co-morbidity are also worrying and indicate that a mental health strategy that is linked to the drug treatment service is urgently required.

The prison authorities and their healthcare staff have made large strides towards improving access to some drug treatment and healthcare services but, sadly, there is very little documentary evidence because of the failure to use the existing conventional health information system; this is a missed opportunity. *(Jean Long)*

1. Allwright S, Bradley F, Long J, Barry J, Thornton L and Parry JV (2000) Prevalence of antibodies to hepatitis B, hepatitis C and HIV and risk factors in Irish prisoners: results of a national cross sectional survey. *British Medical Journal,* 321: 78–82.

2. Long J, Allwright S, Barry J, Reaper-Reynolds S, Thornton L, Bradley F, Parry JV (2001) Prevalence of antibodies to hepatitis B, hepatitis C, and HIV and risk factors in entrants to Irish prisons: a national cross sectional survey. *British Medical Journal,* 323: 1209–1213.

3. Hannon F, Kelleher C, Friel S, Barry M, Harrington J, McKeown D, and McMahon A (2000) *General healthcare study of the Irish prison population.* Galway: National University of Ireland.

4. Long J, Allwright S, Begley C (2004) Prisoners' views of injecting drug use and harm reduction in Irish prisons. *International Journal of Drug Policy*, 15: 139–149.

5. Long J, Allwright S and Begley C (2003) Fear and denial: how prisoners cope with risk of or diagnosis with hepatitis C (abstract). *Irish Journal of Medical Science,* 172(2) Supplement 1: 27.

6. Dillon L (2001) *Drug use among prisoners: An exploratory study.* Dublin: Health Research Board.

7. Irish Prison Service (2000) *Report of the steering group on prison-based drug-treatment services.* Dublin: Department of Justice, Equality and Law Reform.

8. Group to Review the Structure and Organisation of Prison Health Care (2001) *Report of the group to review the structure and organisation of prison health care services.* Dublin: Stationery Office.

9. Irish Prison Service (2003) *Irish Prison Service Annual Report 2002.* Dublin: Stationery Office.

Service providers' views on harm reduction services

The National Advisory Committee on Drugs (NACD) commissioned Moore and colleagues[1] at Dublin City University to review the international evidence for harm reduction approaches and the availability of such approaches in Ireland. This article will concentrate on the section of that review that profiled harm reduction services in Ireland. For the purpose of the review, a harm reduction approach was defined as one 'that focuses on reducing the harm that substance misusers do to themselves and their families.' The aim of such approaches was 'to reduce the transmission of HIV, hepatitis and other infectious diseases and to maximise service users' health.' The harm reduction approaches asked about in the study were needle exchange (including types of injecting equipment distributed), methadone maintenance, replacement drugs, smoking or snorting pipes, and provision of information on safer injecting. Methods to prevent or manage overdose were not specifically examined in the study, nor was the availability or uptake of hepatitis B vaccine.

With assistance from the regional drug co-ordinators and area operations managers, a purposeful sample of services and key informants (n=16) was chosen to take part in a thirty-minute telephone interview. The telephone interview was administered using a pre-tested questionnaire containing a combination of open and closed questions. The 16 service providers interviewed, comprised nine who worked in the Eastern Regional Health Authority (ERHA) area and one from each of the remaining seven health boards. Three informants from outside the ERHA reported that their work did not include harm reduction with drug users who used paraphernalia to administer drugs and these interviews were discontinued at that stage. It was unusual that three participants selected in a purposeful sample had no experience working with injecting drug users, since such drug users live and are treated in each health board area. This limited the researchers' ability to provide a national picture.

The nine service providers working in the ERHA area reported working with injecting drug users, mainly opiate users. In addition, three service providers worked with cocaine users. Some service providers also reported treating cases reporting problem benzodiazepine use. According to service providers outside the ERHA area, the main problem substances were alcohol, cannabis and ecstasy.

All services providers in the ERHA area reported that methadone maintenance and one-for-one needle-

Service providers' views on harm reduction services (continued)

exchange facilities were available in their area. With the exception of filters, all other types of injecting equipment were provided to clients attending these services. Half of the service providers in the ERHA area reported that filters were not available at their service. In contrast, service providers outside the ERHA area stated that methadone maintenance was the mainstay of their harm reduction services and no injecting equipment was distributed. Pipes were not provided at any service in Ireland.

All service providers in the ERHA area and a tiny minority outside the area reported providing information on specific injecting techniques and care of an injection site. The service providers in the ERHA area also advised clients on safer smoking and polydrug use.

With respect to health promotion practices, the majority of service providers in the ERHA area said that their services provided information and demonstrations on safer injecting practices in line with current evidence. The authors do not report whether such interventions were provided by services outside the ERHA area.

On a national basis, the vast majority of service providers reported that the main purpose of harm reduction approaches was to reduce the harm that drug users did to themselves. Some service providers reported that harm reduction services reduced the transmission of infectious diseases. Two services providers mentioned that harm reduction services were a pathway to other health care services. Half of the health service providers in the ERHA area reported that these services promoted safer injecting practices.

All service providers reported similar vulnerable groups, such as women, children and homeless clients. In addition, service providers reported that priority groups included polydrug users, those with mental illness, and those testing positive for HIV. It is interesting to note that those testing positive for hepatitis C were not regarded as a priority or vulnerable group. Yet, it is accepted that hepatitis C is common among injecting drug users, that co-infection between hepatitis C and HIV leads to more aggressive liver disease, and that individuals with co-infection have a poorer prognosis than those with a single blood-borne viral infection.

All of the service providers in the ERHA area and half of those outside it reported that specific issues, such as blood-borne viruses, localised bacterial infections at injection sites and sexual health, were addressed in their programmes. It is not clear from the research the extent to which these issues were addressed.

According to the service providers both in and outside the ERHA area, services were normally available without appointment and were mainly provided during office hours, with a small number opening in the evenings (in the ERHA) and at weekends (methadone services outside the ERHA). The service providers said that the main means of advertising was by word of mouth. Services were also advertised through published directories and posters in clinics.

All service providers reported either formal or informal links with other health and social care services. Many reported working closely with persons from the justice system. The service providers in the ERHA area reported links with self-help groups.

In general, service providers in the ERHA area reported that policy did translate into practice, although the majority stated that there were occasions when they had to 'bend the rules' to facilitate patient care. In contrast, the majority of service providers outside the ERHA area reported that policy did not translate into practice, and unofficial practices occurred at one service, in that needles, syringes and condoms were distributed.

The service providers in the ERHA suggested a number of developments to improve the current service, such as:

- Expansion of outreach work
- Greater access to low threshold services
- Increased variety of needle exchange outlets
- Adaptation of current services to deal with cocaine
- Provision of respite houses
- Greater inter-agency collaboration

The service providers outside the ERHA area requested:

- An increase in resources
- Clear policies and structures with respect to needle exchange and methadone maintenance
- Evidence based practice in relation to harm reduction interventions
- Strategies to reduce waiting lists for treatment
- Community-focused outreach services

(Jean Long)

1. Moore G, McCarthy P, MacNeela P, MacGabhann L, Philbin M, Proudfoot D (2004) *A review of harm reduction approaches in Ireland and evidence from the international literature.* Dublin: Stationery Office.

Outcomes and experiences of methadone maintenance

Methadone treatment has become the most common form of opioid substitute treatment and, as such, is the most extensively researched intervention worldwide. Internationally, there is evidence to suggest that methadone treatment can reduce drug-related morbidity and mortality and improve a person's health and social well-being. There are a limited number of studies measuring aspects of the effectiveness of methadone as a treatment for problem opiate use in Ireland. Cox and Lawless (2004)[1] undertook an evaluation of a methadone prescribing service in Dublin City 'to examine the role which prescribed methadone plays within the lives of a cohort of opiate-dependent individuals in Dublin City.'

The study employed a mix of quantitative and qualitative methods.

The quantitative study followed a cohort of individuals who entered a methadone maintenance programme in 1999 and continued in treatment for an 18-month period. A validated questionnaire, known as the opiate treatment index, was administered to 33 clients at some time following entry to methadone treatment at Merchants Quay Ireland in 1999 and to 17 clients who were still in treatment 18 months later. The questionnaire collected self-reported data on six domains: drug use, HIV risk-taking behaviours, social functioning, criminality, health status and psychological adjustment. Excluding social functioning, the data collected for all other outcomes was based on behaviours in the month prior to each interview. The data on social functioning pertained to behaviours in the six-month periods prior to each interview. Each domain had a number of questions, with a number of answer options. Each answer option had a score, with the lowest score indicating the lowest level of risk-taking or the best experience. The questionnaire collected some additional data on each client's demographic and social situation.

The main findings between baseline and follow-up study were:

- The mean opiate treatment index scores for HIV-related risk behaviours increased (accounted for by an increase in reported sexual risk behaviours rather than in drug-using risk behaviours) in the month prior to the follow-up study, compared to respective risk behaviours reported at the time of the baseline study.
- Criminal behaviour decreased substantially, with only one client reporting committing one or more crimes during the month prior to the follow-up study, compared to six clients reporting similarly at the time of the baseline study.
- Social functioning scores decreased considerably, indicating an improvement in housing, employment and family relationships at the time of the follow-up study, compared to the baseline study.
- Health status remained similar.
- Psychological adjustment scores decreased, indicating that mental health outcomes had improved over the 18-month period.

It is important to note that the sample size was small and that the improvements in mean scores were not tested statistically. Nevertheless, the findings suggest a number of positive outcomes associated with methadone maintenance therapy.

The qualitative study consisted of three focus groups. These were undertaken to ascertain the experiences of clients and service providers with respect to methadone maintenance. Two focus groups were carried out to ascertain the experience of clients who attended the methadone prescribing service or the day programme at Merchants Quay Ireland. Those who attended the day programme were receiving methadone maintenance in a health board clinic or general practice setting. The clients were asked about methadone maintenance and continued risk behaviour, use of counselling and other auxiliary services, impact of methadone on their lives, and their relationship with service providers. The third focus group comprised staff working in the methadone prescribing service or the day programme at Merchants Quay Ireland. The service providers were asked about the positive and negative aspects of methadone maintenance, issues that positively and negatively affect treatment outcomes, and other pharmaceutical treatment options.

Five themes were identified in the data transcribed from the focus groups:

- Theme 1 'Key players in methadone treatment'

  Clients welcomed the improvements in drug treatment services following the introduction of the methadone protocol, particularly the increase in the number of places available, the removal of all financial charges, the wide range of services available in the clinics for the less stable patients, and the transfer of stable patients to general practice settings. The clients' experiences at pharmacies were both positive and negative. The negative experiences were long waiting periods, lack of privacy and poor communication between the general practitioner and the pharmacist.

Outcomes and experiences of methadone maintenance (continued)

- Theme 2 'Methadone treatment and integration'

  The transition between active drug use and stabilising on methadone maintenance is a very vulnerable time for drug users. Clients reported that structured day programmes and formal training programmes provided them with a regular routine and the skills to gain future employment. Many who were employed reported that it was very difficult to meet the competing requirements of both a full-time job and the methadone treatment services. In general, those with full-time work feared that their employers would discover that they were on a methadone treatment programme and that they would lose their position. The majority of clients reported that methadone maintenance improved their relationships with their families and decreased their criminal activity.

- Theme 3 'Responding to methadone'

  Clients reported that, initially, methadone maintenance was very important when moving from active drug use to no drug use, but that they now worried about the long-term dependence on methadone itself. Some clients who were stable on long-term methadone maintenance expressed a desire to detoxify but feared that they would find it difficult to tolerate the withdrawal symptoms, or that they would relapse into heroin use. They also reported that service providers did not encourage them to detoxify but to maintain status quo. Clients requested that a broader range of detoxification methods be provided for those wishing to detoxify from methadone maintenance and that service providers facilitate their provision.

- Theme 4 'Managing methadone treatment'

  Most clients reported that the high turnover of counsellors at drug treatment centres was disruptive in maintaining a stable lifestyle or dealing with crises. The clients accepted that their drug use had to be monitored but asked for an alternative to urinalysis, as it was humiliating for both clients and service providers.

- Theme 5 'Methadone and health'

  Many clients on methadone reported dental problems that they associated with their methadone therapy. Many also reported that opiates were not their only problem drugs, with some reporting dependence on other prescribed drugs, such as benzodiazepines, hypnotics and tranquillisers. The clients also reported interactions between antiviral therapy and methadone.

Overall, the two elements of the study suggest that methadone maintenance therapy was successful in stabilising heroin users and in assisting them to establish a positive lifestyle. The provision of services at primary care increased the number of places and removed some of the stigma associated with drug dependence. Clients reported that the monitoring of drug use by urinalysis was humiliating and recommended that other methods be introduced. The studies highlight some of the issues that inhibit successful treatment, such as polydrug use, mental illness and infection with HIV or hepatitis C, and recommend comprehensive services to deal with these issues. The clients requested that service planners and providers develop a wide-ranging approach to assist those who wish to detoxify from long-term methadone maintenance. *(Jean Long)*

1. Cox G and Lawless M (2004) Maintaining or enabling? Evaluation of a methadone prescribing service in Dublin City. In *Pieces of the jigsaw: six reports addressing homelessness and drug use in Ireland.* Dublin: Merchants Quay Ireland.

Drugs and driving

Driving under the influence of drugs has been a statutory offence in Ireland since the Road Traffic Act 1961. The principal legislation in this area is covered under the Road Traffic Acts 1961 to 2002. Section 10 of the Road Traffic Act 1994 prohibits driving in a public place while a person 'is under the influence of an intoxicant to such an extent as to be incapable of having proper control of the vehicle'. Intoxicants are defined to include alcohol, drugs, or any such combination. The Medical Bureau of Road Safety (MBRS) is the independent forensic body responsible for chemical testing of intoxicants under the Road Traffic Acts.
A recent nationwide survey carried out by the MBRS in 2000 and 2001 included an analysis of seven drugs or drug classes in 2,000 blood and urine samples taken from drivers suspected of intoxicated driving.[1] Of the 2,000 specimens chosen, 1,000 were under the legal limit for alcohol and 1,000 were over. The drugs involved were: amphetamines, metamphetamines, benzodiazepines, cannabinoids, cocaine, opiates and methadone. The purpose of the study was to determine current trends in driving under the influence of drugs (DUID) in Ireland and also to establish an evidence-based model to inform future road safety strategies.

Drugs and driving (continued)

The results suggest that there is a significant DUID problem in Ireland. Sixty-eight per cent of tested drivers with essentially zero levels of alcohol were positive for one or more drugs, suggesting a strong trend of increasing drug positivity with decreasing levels of alcohol. Cannabinoids were the most common drug class encountered. The study found no significant gender difference in the overall drug-positive results, although over 90 per cent of apprehended drivers were male. The typical profile of the apprehended and tested DUID driver is young, male, driving in an urban area with a low or zero alcohol level, with a specimen provided between the hours of 6 am and 9 pm and with a presence of cannabinoids. The study also identified a pattern of middle-aged drivers under the influence of benzodiazepines – a legally prescribed drug which can also impair driving.

The authors conclude that the study highlights the need for an education and awareness campaign in relation to DUID. There should also be an emphasis, they suggest, on the dangers associated with driving while under the influence of prescribed drugs. The study recommends that if the Gardaí suspect a case of DUID and obtain a negative or low alcohol reading then they should take a separate blood or urine specimen so as to detect the presence of a drug or drugs other than alcohol.

One of the outcomes of the MBRS study will be an evidence-based review of the legislation on driving under the influence of drugs. The study also highlights the difficulties of law enforcement in this area, and concludes that, 'the goal of producing a valid, reliable and convenient roadside testing device for drugs is still paramount and not yet achieved'.[2]

A limitation of the study is that no random sampling of motorists occurred. Given that all of the blood and urine samples were taken from drivers apprehended by the Gardaí and suspected of driving under the influence of an intoxicant, the authors conclude that the information 'does not provide a full picture of use of drugs in the general driving population'.[3] *(Johnny Connolly)*

1. Cusack D, Leavy P, Daly L and Fitzpatrick P (2004) *Driving under the influence of drugs in Ireland: results of a nationwide survey.* Dublin: Medical Bureau of Road Safety.
2. Ibid, p. 2.
3. Ibid, p. 6.

Irish EU Presidency and the drugs issue

The Irish Presidency of the EU between January and June 2004 saw considerable activity in the drugs field, including the following:

- **EU Drugs Strategy 2005–2012** A preparatory conference 'EU Strategy on Drugs – The Way Forward' was held in Dublin on 10/11 May. The European Council welcomed the conclusions of the conference, and the Dutch Presidency is now tasked with drafting the new strategy with a view to its adoption no later than December 2004. A summary of the main elements discussed at the Dublin conference is available (9595/04 CORDROGUE 36 REV 1).
- **New Narcotic and New Synthetic Drugs – Proposal for a Council Decision on Information Exchange, Risk Assessment and Control** The Irish Presidency prioritised discussion on this proposal from the European Commission, with a view to obtaining agreement on a new joint action, revising the 1997 joint action. The text was agreed except for the scope of the instrument and its legal base. These issues are to be addressed under the Dutch Presidency. The original Commission proposal and subsequent documents are available (13821/03 CORDROGUE 90; 9152/04 CORDROGUE 30; 10431/04 CORDROGUE 42).
- **Supply/Demand Reduction and Synthetic Drugs – Action Plans** The Presidency received an update on the implementation of plans in the areas of supply/demand reduction and synthetic drugs. A report is available (10481/04 CORDROGUE 43 + COR 1). The Presidency also convened a brainstorming session on the issue of data collection and interpretation in the area of forensic analysis and profiling. The outcome of this session is available (6204/04 CORDROGUE 21).
- **National Co-Ordinators in the enlarged EU** The Irish Presidency hosted the first meeting of the national drugs co-ordinators in the enlarged EU, held on 15 June. Among other matters, the meeting examined the issue of cocaine, hearing presentations from the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) and the Irish National Advisory Committee on Drugs (NACD).
- **47th Session of Commission on Narcotic Drugs (CND)** The Irish Presidency co-ordinated the positions of the member states and accession countries in relation to resolutions put forward at the 47th session of the CND, held in Vienna in March. Ireland delivered eight statements in plenary sessions of the CND on behalf of the EU and acceding countries; sponsored an EU resolution on 'Optimising Integrated Drug Information Systems', which was adopted by the plenary session; and co-

Irish EU Presidency and the drugs issue (continued)

sponsored a further nine resolutions on behalf of the EU and acceding countries.

- **International Relations** The Irish Presidency prepared and co-chaired a series of high-level meetings with the EU's international partners in the drugs field, including Latin America and the Caribbean, the Andean Community, Iran, and the Western Balkans. *(Brigid Pike)*

The National Drugs Strategy Unit in the Department of Community, Rural and Gaeltacht Affairs supplied the information on which this news item is based. The documents cited in this article are available on the Council of the European Union's archive at http://register.consilium.eu.int/

Government Progress Report 2004: the drugs issue

In August the government published its second annual progress report on *An Agreed Programme for Government* (June 2002). Progress on drug-related priorities and targets includes the following:

Supply reduction

Progress is reported in developing a co-ordinating framework within each Garda District, to liaise with the community on drug-related matters and to act as a source of information for parents and members of the public.

- A co-ordinating framework linking Garda District, Divisional and National Drug Policing Plans is currently being put in place by the Garda authorities.
- The Garda Síochána Bill 2004 (published in February 2004) provides for the development of Joint Policing Committees at local-authority level and for the establishment of local policing fora in designated areas under the umbrella of such committees.
- These bodies are to act as fora where matters relating to local issues of policing and crime, including drug-related issues, can be discussed and where strategies and recommendations for dealing with issues locally can be formulated.
- A pilot Community Policing Forum initiative in Dublin's North Inner City has now been positively evaluated and has been approved for mainstreaming from January 2005 in accordance with procedures under the National Drugs Strategy. Other such fora are being supported on a pilot basis.

Drugs in prisons

- The draft Prison Drugs Policy currently being considered includes provision for treatment, rehabilitation and mandatory drug testing.
- Measures continue to be taken to reduce supply, for example, searching procedures, physical security including nets over exercise yards, CCTV in visiting rooms and new visitor procedures.
- A new set of Prison Rules, which will make provision for mandatory drug testing, is currently with the Office of the Parliamentary Counsel.

Prevention

- The 10 Regional Drugs Task Forces (RDTFs) have been established. They are currently working on mapping out the patterns of drug misuse in their areas, as well as services, including prevention, already available, with a view to co-ordinating these existing services and addressing gaps in service provision. Their plans are expected to become operational from mid-2005.
- The Department of Education and Science has established eight regional offices and a further two are due to be established before the end of 2004. Personnel from these offices will represent the Department on the RDTFs and, where relevant, on the Local Drugs Task Forces (LDTFs). Appointments have been made by the Department to six of the ten RDTFs and the remaining four appointments will be made by the end of 2004.

Treatment

- Health boards are continuing to work towards achieving immediate access for drug misusers to professional assessment and counselling, followed by commencement of treatment as deemed appropriate, not later than one month after assessment. The Progress Report states that direct access to counselling and assessment is in place, especially in larger urban centres.
- There has been an increase in the numbers of

Government Progress Report 2004: the drugs issue (continued)

general practitioners and pharmacists involved in the delivery of drug treatment. At the end of March 2004, there were 309 general practitioners and 298 pharmacists participating in the scheme. By the end of March 2004 there were 6,902 people registered on the Central Treatment List.

New initiatives announced in the 2002 Agreed Programme for Government, for which progress is not reported, include:

- the Garda Working Group tasked with examining drug prevalence levels and distribution networks and recommending appropriate resourcing requirements in light of its findings;
- the Drug Offenders Bill, which is intended to provide for registration of convicted drug dealers with the Gardaí and to provide for stiffer penalties for persons involved in the supply of drugs to a prisoner;
- corporate social responsibility initiatives in relation to combating drug misuse. *(Brigid Pike)*

Electronic versions of *An Agreed Programme for Government* and the *Government Progress Report* for 2003 and 2004 are available on the Department of the Taoiseach website at *www.taoiseach.gov.ie*

Sport and arts should be part of youth substance abuse prevention strategy

Sport and the arts should 'constitute an essential component of a broader child-centred, multi-tiered strategy for substance abuse prevention'. This is the main conclusion of an Oireachtas Committee report investigating the effectiveness of sport and the arts as deterrents against substance abuse by young people under the age of 18 in Ireland.[1]

Based on a review of national and international literature, and consultation with a wide range of interested parties, the Committee concluded that involvement in sport or the arts facilitates the holistic development of the person and reduces the propensity to abuse various substances.

Sport was found to be associated with enhanced self-esteem and self-discipline, the prevention of boredom and the promotion of leadership skills, empowerment, positive relationships and role models. Various artistic activities (e.g. music, visual arts, dance, drama) were found to contribute to cognitive development, greater self-awareness and self-confidence, and positive social interactions. Studies from Australia, the UK and the US were cited that found a positive link between engagement in sporting or artistic activities and reduced levels of involvement in substance abuse.

Exploring current provision of sports and arts programmes in Ireland, the Committee found that the formal education sector fails to give proper recognition to the role of both sport and the arts, as evidenced by a lack of dedicated time within the school day, a shortage of adequately trained teachers, and a lack of facilities. In the non-formal sector, the Committee found many dynamic and effective sporting programmes, but reported that they lacked long-term planning and coherent policy development, and were chronically under-funded and under-resourced. The arts area was even weaker: with youth arts programmes being provided largely as pilots, the Committee found a lack of long-term commitment and resourcing, and poor inter-agency co-operation.

The Committee made 13 recommendations, which would see the creation of a 'multi-tiered' infrastructure for delivering integrated and co-ordinated sport and arts programmes for young people:

- establishment of a Youth Affairs Ministry and Department, to maintain policy oversight and budgetary control in arts, sport and youth affairs;
- expansion of the role of statutory bodies, such as the Arts Council and the Irish Sports Council, to undertake tasks such as establishing best practice and ensuring a more integrated approach by the various organisations involved in programme provision and delivery;
- creation of local arts partnerships (LAPs) and the extension of local sports partnerships (LSPs), to co-ordinate the local delivery of sports and arts programmes;
- development of a variety of resourcing mechanisms, including innovative use of available resources, extending the school day by 30 minutes to provide for physical education within the school day, and accessing funds from the private sector and monies from the Dormant Accounts Fund and the Criminal Assets Bureau;
- inclusion of alcohol in the National Drugs Strategy.

Sport and arts should be part of youth substance abuse prevention strategy (continued)

The report calls for improved integration and co-ordination of policies and programmes. A statement on page 13 of the report highlights the challenge implicit in such aspirations:

> *Many young people come from troubled families and lack respect for the formal education structures where they are preached to and feel marginalized. Within the sporting environment, young people develop respect for their coaches and mentors. Coaches can then use their leadership positions to convey a positive non-*[substance] *use message to young people and can become positive role models for all participants.*

As well as co-ordinating the practical aspects of programme delivery, such as timing or resourcing, to ensure there are not overlaps or gaps in service provision, it is also necessary to examine the philosophical assumptions and principles underpinning various programmes, to ensure they complement and mutually reinforce one another, rather than cancel each other out or retard progress.[2] *(Brigid Pike)*

1. Houses of the Oireachtas. Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs. Fourth Report. *The Effectiveness of Investment in Sport and the Arts as a Deterrent Against Youth Substance Abuse.* April 2004.

2. EMCDDA. *Co-Ordination: A Key Element of National and European Drug Policy. Drugs in Focus,* No. 9, May–June 2003, calls for research into the effectiveness of present mechanisms for drugs co-ordination at both national and international level as a prerequisite to improvement.

Inter-agency protocols – a model of good practice for agencies working with current and former drug users in Blanchardstown

On 1 October 1 2004, the Blanchardstown EQUAL Initiative was launched at Croke Park as a model of good practice.[1] The agencies involved include the Rehabilitation/Integration Service (RIS) of the Northern Area Health Board (NAHB), Blanchardstown Local Employment Service, the BOND project, Coolmine Therapeutic Community, Hartstown/Huntstown Community Drug Team, Mountview/Blakestown Community Drug Team, Mulhuddart/Corduff Community Drug Team and the Tolka River Rehabilitation Project.

The Initiative was developed to establish a co-ordinated approach to providing quality supports and services to former and current drug users in the Blanchardstown area. The agencies involved expressed the view that clients can 'fall through the gaps' and are often not in a position to assess appropriate services when required. The key objective was to bring together statutory and voluntary agencies working with current and former drug users in order to establish clear inter-agency protocols and good working relationships. The primary aim is to enhance opportunities for the target group to progress towards employment opportunities.

Developments to date include a protocol on lead agency working, which provides a definition of the term and establishes the responsibilities of the lead agency. According to the protocol, a lead agency assumes the most significant role in providing and co-ordinating services to a client, including the provision of a key worker. Responsibilities include carrying out a needs assessment, holding and managing the overall care plan and tracking and following up on a client to prevent a 'fall through the cracks'. In addition, a protocol on confidentiality has been developed and adopted by all eight participating agencies, covering areas such as the limits of confidentiality, sharing client information, working with under-18s and accommodating clients' access to files containing information on them.

The development of the protocols followed extensive inter-agency work from mid-2003 to February 2004 assisted by an independent facilitator.[2] From February to April 2004 the protocols were piloted among the agencies. Preliminary evaluation results in Table 1 below show that co-operation between agencies is improving, particularly on the challenging issues of

Table 1 Indicators of inter-agency co-operation between organisations involved in protocols, 2004

Activity	February	March	April
No. of inter-agency referrals	22	25	26
No. of three-way meetings	0	7	10
No. of lead agency referrals	0	2	4
Total No. of inter-agency activities	22	34	40

Source: Blanchardstown EQUAL Initiative (2004) *Making inter-agency protocols work,* Appendix 2 (McDonnell).

Inter-agency protocols (continued)

three-way meetings and lead agency referrals. A three-way meeting is one between the lead agency, the agency the client has agreed to be referred to and the client.

The evaluation noted that three-way meetings were consistently reported as being positive both for introducing clients to new agencies and for resolving issues arising for clients between agencies. The lead agency approach is seen by most agencies as having clarified the roles of other services and allowed the interventions to be client-focused. Following the pilot phase, all eight agencies agreed to mainstream the use of the protocols in their work programmes; however, lead agencies recognise that these new approaches will take time to develop, to embed and to implement.

As part of the evaluation of the pilot phase, a facilitated focus group session was held with eight clients in early September 2004. All the clients had been through the inter-agency initiative and found it to be an improved way of working. According to the evaluator, they questioned why it was not used everywhere when it had so many advantages for service users.

While this initiative is quite new, its innovative approach to the process of working with current and former drug users has been acknowledged. The National Drugs Strategy 2001–2008 is premised on the theme of an inter-agency approach across the 100 actions; however, the strategy does not outline any specific recommendations or guidelines on how such an approach could be developed. The Blanchardstown EQUAL Inter-agency Initiative is an innovative exercise in attempting to work out the details of inter-agency relationships on the ground. It is a model with a great deal of learning outcomes to offer policy makers and service providers interested in establishing good inter-agency protocols. Its future development merits close attention. *(Martin Keane)*

1. Blanchardstown EQUAL Initiative (2004) *Making inter-agency protocols work: The development of common protocols by agencies working with current or former drug users: a model of good practice.* Dublin: Blanchardstown EQUAL Initiative.

2. Rita Burtenshaw of Burtenshaw Kenny Associates.

Community-based substance misuse prevention courses in primary schools: a study

Dún Laoghaire Rathdown Local Drugs Task Force (LDTF) developed three community-based projects in the late 1990s to fill the gap (at that time) in substance misuse education in local primary schools: the Whitechurch Addiction Support Project (WASP), the Parents Making Children Aware (PMCA) project and the Sallynoggin Parents Education and Awareness of Drugs Project (SPEAD). The three projects train local parents as facilitators to deliver school-based substance misuse education courses to fourth, fifth and sixth class students. Course materials include lessons on smoking, alcohol, drugs, assertiveness, and making choices. All three projects emphasise a focus on self-esteem. Projects use active learning methods including discussion, role-play, group work, games, worksheets and project work. Courses were delivered in 16 schools in the period September–December 2003.

In 2003 Dún Laoghaire Rathdown LDTF commissioned a research project to gather information on the opinions of four key groups in relation to the value of community-based substance misuse prevention courses now that primary schools have available to them the Walk Tall programme through Social, Personal and Health Education (SPHE).[1] The four key groups were: children who had received the courses delivered by the three projects; the parents/guardians of these children; the facilitators who delivered the courses (parents); and school personnel (principals and teachers) involved in the courses.

Information was collected over a four week period in November and December 2003 from these four key groups using the following methods:

- A random sample of 158 children from those who had finished the courses in the first term of the current academic year was surveyed by a questionnaire administered in the classroom setting. All children responded.
- Parents/guardians of the children were surveyed, with all children being given a questionnaire to bring home to their parents and to be returned by post. Of the 158 given out, 62 were returned, giving a response rate of 39 per cent.
- Questionnaires were sent to facilitators on each project. Of the 17 sent out, seven were returned, giving a response rate of 41 per cent.
- Forty-five questionnaires were sent to school personnel in the 16 participating schools; 19 were returned, giving a response rate of 42 per cent.

It should be noted that the response rates for the latter three key groups were low and thus may not be representative. Findings relating to two main questions in the study are shown in Table 1.

Community-based substance misuse prevention courses in primary schools: a study (continued)

Table 1

Research questions	Children	Parents	Course facilitators	School personnel
	First choice Preferences	First choice preferences	First choice preferences	First choice preferences
Who do key groups believe should teach children about substances/ prevention?	Course facilitators (55%) Parents (22%) Former drug user (20%) Other (3%)	Parents (62%) Course facilitators (20%) Former drug user (8%) Teachers (7%) Other (3%)	Course facilitators (43%) Parents (43%) Other (14%)	Parents (63%) Course facilitators (32%) Former drug user (5%)
Who do key groups believe children would find it easy to talk to about drugs?	Parents (45%) Course facilitators (30%) Friends (17%) Other (8%)	Parents (50%) Course facilitators (22%) Friends (14%) Family (7%) Other (7%)	Course facilitators (71%) Friends (29%)	Course facilitators (57%) Teachers (16%) Parents (11%) Friends (11%) Former drug user (5%)

This would support the view that school-going children want drug-specific information from credible sources and see course facilitators and former drug users among such sources.

It is interesting to note that, across the four key groups, teachers are rated quite low as an option to teach children about drugs or for children to talk to about drugs. Only a small percentage of school personnel themselves believe that children would find it easy to talk with teachers about drugs. Responses from school personnel included comments such as 'teachers do not have the expertise on drugs shared by course facilitators'; reservations were expressed about the priority given to 'social subjects' like drug education. Although these findings relate to the perceptions and views of these small groups and have limitations in terms of generalising to the national picture, they do raise questions for policy makers and educational authorities on the exclusive reliance on teachers to deliver drug education through the Walk Tall/SPHE programme in primary schools. Indeed, the position of teachers as providers of drug education is further challenged by the children's high rating of former drug users as teachers of substance use prevention. This despite the background that teachers were delivering the Walk Tall programme in most of the schools covered in this research, with no evidence that former drug users were involved in drug education.

When children were asked to suggest ways that schools could prevent children getting involved in drugs, the most frequent suggestion was: information accompanied by a video about drugs, the harm caused by drugs to the person and the risks of getting addicted to drugs. In addition, the children reported that what they 'liked' most about the course was the information given about various types of drug, including alcohol and nicotine. This would support the view that school-going children want drug-specific information from credible sources and see course facilitators and former drug users among such sources.

In terms of the usefulness of community-based drug prevention courses, 37 per cent of parents regard such courses as 'very useful', compared to 15 per cent who view school programmes such as Walk Tall as being 'very useful'. In addition, 90 per cent of school personnel and the majority of course facilitators reported that SPHE provision in the schools was greatly enhanced by the local courses. This demonstrates that three of the key groups surveyed in this research see a role for community-based drug prevention courses to complement the goals of SPHE in primary schools.

In summary, the positive views of children, parents and school personnel on community-based drug prevention in schools would suggest that the question of mainstreaming this model requires further exploration by policy makers and educational authorities. This research demonstrates that these children want drug-specific information from their schools; their views and the views of school personnel raise questions about the capacity of teachers to deliver such specific information through the SPHE programme. *(Martin Keane)*

1. Collins B (2004) *Community-based substance misuse prevention courses in primary schools: a study.* Dublin: Dún Laoghaire Rathdown Local Drugs Task Force.

The EDDRA column

Welcome to the ninth EDDRA (Exchange on Drug Demand Reduction Action) column. The aim of this column is to inform people about the EDDRA online database, which exists to provide information to those working in the drugs area on current demand reduction action across Europe, and to promote the role of evaluation in reducing demand for drugs. The database is co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). This column will focus on an Irish project recently added to the EDDRA database, the Killinarden Drug Primary Prevention Group. This project is a useful example of good practice in drug prevention activities in Ireland.

The Killinarden Drug Primary Prevention Group (KDPPG) emerged in 1993 as part of a community-led response to what was perceived as an acute drug misuse problem in the Killinarden area of Tallaght. The KDPPG highlighted the lack of drug education programmes for parents and young people within the community and local schools. This often meant that young people who were exposed to drugs lacked proper information on the risks and consequences of using such drugs. The KDPPG took the innovative step of training local parents as facilitators to deliver drug education courses in local schools. The Group also acted as a support service to local families and community-based organisations seeking awareness on drug-related issues or wishing to address drug misuse within their particular setting. In drug prevention literature, the work of the KDPPG belongs to the category of selective prevention. These are interventions targeting specific at-risk areas and groups and are different from universal intervention which targets entire populations, e.g. whole school-going populations.

Currently the KDPPG delivers drug prevention activities to third, fourth, fifth and sixth class students in three primary schools in Killinarden. Activities designed to enhance the self-esteem of third and fourth class students include a mixture of games, role-play exercises and quizzes. Students in fifth and sixth classes receive drug awareness education including information on different types of drugs and the consequences of use. A follow-up programme aiming to build on the self-esteem and drug education activities is delivered in Killinarden Community School to students up to third year of secondary school. From 1995 to 2003, an estimated 800 young people participated in the various school-based drug prevention activities.

The work of the KDPPG was evaluated by Rourke (2003)[1] using in-depth semi-structured interviews with KDPPG staff and management, with local parents trained as facilitators, and with teachers and young people. Evaluation included a number of on-site observations of programme delivery in local schools. The evaluation was process orientated, looking at the project's implementation and how it was perceived among target groups. It also sought to assess the extent of awareness and understanding of the dangers associated with drug misuse among young being targeted by the intervention.

The evaluation findings highlight what can be achieved when a community is motivated to respond to the challenge of drug misuse facing local families. The findings demonstrate that the KDPPG has designed and implemented a project that is well received by the target groups and legitimised by local teachers.

- Parents trained as facilitators report improved parenting skills, increased knowledge about drugs and a perception that their work is making a valuable contribution to the prevention of drug misuse in their community. Many parents who were early school leavers report that the KDPPG was a key motivating factor in their returning to adult education.
- Teachers report that young people interact with local parents in a more open and discursive way than they might relate to teachers or to external 'experts'. Local parents are seen as having the credibility to 'tell it as it is'. Teachers also report that local parents are professional, efficient, punctual and well prepared when delivering their presentation.
- Young people are seen to relate well to the issues being raised by parent facilitators in the schools, for example, how young people perceive themselves, their experience of peer pressure and how to be assertive when offered drugs. In addition, young people have become more aware and more informed about the dangers and consequences of drug and alcohol misuse and many have become more assertive and seem less likely to succumb to peer pressure to use drugs.

The evaluator notes that contact made in schools between local parents and young people is continued and built on in the home and through interaction in the local community. For a high proportion of young people attending local schools, the consistent involvement with the KDPPG over a number of years serves to consolidate the central themes of drug prevention.

Perhaps the most surprising and interesting finding from the evaluation is the extent to which young people engaged with local parents/facilitators in the classroom setting on such sensitive issues as self-esteem and drug misuse. This is an important lesson for policy makers, school authorities and concerned parents to grasp. It shows that young people can trust and engage with local parents on sensitive issues providing that those parents have received appropriate training and are seen as credible in the classroom. *(Martin Keane)*

1. Rourke S (2003) *Evaluation of Killinarden Drug Primary Prevention Group.* Dublin: KDPPG.

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

If you have a project that has been evaluated and you would like to have it highlighted in this column and included on the EDDRA database, please contact the EDDRA Manager for Ireland, Martin Keane, Health Research Board, Holbrook House, Holles Street, Dublin 2. Tel: 01 6761176 Ext. 169; Email: mkeane@hrb.ie

Updated analysis from the National Drug Treatment Reporting System

Between June and September 2004, staff at the DMRD published three occasional papers on treated drug misuse in the seven health board areas outside the Eastern Regional Health Authority (ERHA) area, namely: the Midland, Mid-Western, North Eastern, North Western, Southern, South Eastern and Western Health Boards. The analysis presented in these papers is based on data submitted by service providers to the National Drug Treatment Reporting System (NDTRS).

Occasional Paper 11: *Treatment demand in the seven health boards areas outside the Eastern Regional Health Authority, 1998 to 2002*[1]

The data presented in Occasional Paper 11 provide a description of demand for drug treatment services in seven health boards. This paper will help inform service planning and provision.

The main findings and their implications are:

- The number of new and previously treated cases in the seven health boards (outside the ERHA area) almost trebled between 1998 and 2002.
- Both new and previously treated cases in the seven health board areas most frequently reported that cannabis was their main problem drug between 1998 and 2002. The total number of cases reporting cannabis as their main problem drug trebled, increasing from 409 in 1998 to 1,359 in 2002. The numbers treated for problem opiate use almost trebled, from 184 in 1998 to 532 in 2002. Opiate use was more common in the health board areas bordering the ERHA area. Though small, the numbers treated for cocaine use increased consistently.
- Although there was a small decrease in the proportion of cases taking more than one drug (polydrug use), from 84 per cent in 1998 to 77 per cent in 2002, it remained a common practice and is associated with poorer treatment outcomes. Polydrug use is an issue that needs to be addressed in a client's treatment plan.
- The number of treated cases who reported injecting more than doubled, from 148 in 1998 to 342 in 2002. Half of the injector cases had started injecting before they were 20 years old. Injectors have a higher risk of acquiring blood-borne viral infections and experiencing overdose than non-injectors. This suggests that the drug treatment services outside the ERHA area require prevention and treatment interventions to deal with blood-borne viruses (in particular HIV, hepatitis B, and hepatitis C) and drug overdose (in particular opiate-related overdose).
- The proportion of treated cases under 18 years old increased by four per cent over the reporting period and, as expected, was much higher for new cases than for those previously treated. Those under 18 years old require different approaches to treatment and it is important that this is recognised in service planning.
- The low levels of educational achievement and employment among chronic problem drug users emphasises the importance of close links between treatment interventions and social and occupational reintegration programmes.

Occasional Paper 12: *Trends in treated problem drug use in the seven health boards areas outside the Eastern Regional Health Authority, 1998 to 2002*[2]

The data presented in this paper describe trends in treated problem drug use in seven health board areas. The total numbers include 7,545 cases who lived and were treated in the seven health boards between 1998 and 2002. In this paper, problem drug use is described in relation to person, place and time. This paper will assist policy makers, service planners and public health practitioners to develop appropriate responses to problem drug use in the future.

The main findings and their implications are:

- Both the incidence and prevalence of treated problem drug use almost trebled between 1998 and 2002 (Figure 1). For example, the incidence of treated problem drug use increased from 24.8 per 100,000 of the population in 1998 to 69.7 per 100,000 in 2002. This observed increase may be explained by a true increase in use, an increase in access to treatment services, new legislation encouraging more people into treatment, or an increase in the number of centres reporting cases to the NDTRS. The most likely explanation is a combination of all these factors.

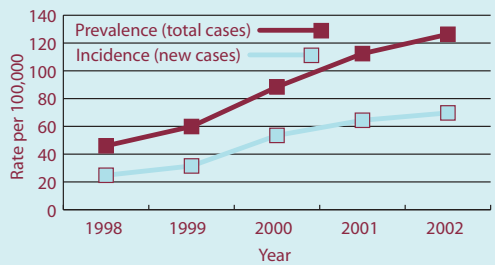


Figure 1 Incidence and prevalence of treated problem drug use among persons aged between 15 and 64 years living and treated in the seven health board areas, based on returns to the NDTRS per 100,000 population, 1998 to 2002 (Central Statistics Office 2003)

Updated analysis from the National Drug Treatment Reporting System (continued)

- The incidence of treated problem drug use for the reporting period was highest in the Southern Health Board area, followed closely by the South Eastern Health Board area. The Western Health Board area had the lowest incidence, indicating lower drug use rates than in the rest of Ireland, lower access to or uptake of appropriate treatment services, or lower levels of participation in the NDTRS. This requires investigation.
- The total number of treated cases reporting cannabis as their main problem drug trebled, increasing from 392 in 1998 to 1,328 in 2002. The numbers treated for problem opiate use also increased steadily, from 116 in 1998 to 439 in 2002. Opiate use was more common in the health board areas bordering the ERHA area. The second most frequently reported main problem drug was ecstasy for new cases and opiates for previously treated cases. Though small, the number of new cases reporting cocaine use increased from six in 1998 to 42 in 2002. These findings indicate that treatment services must cater for a wide spectrum of illicit drugs rather than focus on one or two drugs, and must be capable of adjusting treatment approaches in accordance with changing patterns of problem drug use.
- Although there was a small percentage decrease in polydrug use among treated cases, from 84 per cent of cases in 1998 to 79 per cent in 2002, it remained a common practice and is associated with poorer treatment outcomes.
- The number of treated cases who reported injecting trebled, increasing from 96 in 1998 to 284 in 2002. Injectors have a higher risk of acquiring blood-borne viral infections and experiencing overdose than non-injectors.
- The proportion of treated cases under 18 years old increased by just over three per cent during the reporting period and, as expected, was much higher for new cases than for those previously treated. Those under 18 years old require different approaches to treatment and it is important that this is a consideration during service planning.
- The main problem drug reported by new cases was examined by selected socio-demographic and drug-using characteristics and some important relationships were identified. Young teenagers initiated drug use with cannabis and volatile inhalants. The use of opiates, ecstasy and amphetamines was commenced in mid to late teens. There were differences in type of drug used by males and females, with very high proportions of males treated for cocaine and cannabis use compared to their female counterparts. The highest rates of employment were among those using drugs commonly associated with social events, and the lowest rates of employment were among those who used opiates and benzodiazepines. This observation (along with the high rates of early school leaving) has important implications for the social and occupational reintegration of opiate and benzodiazepine users.

Occasional Paper 13: *Trends in treated problem opiate use in the seven health board areas outside the Eastern Regional Health Authority, 1998 to 2002*[3]

The data presented in this paper describe trends in treated problem opiate use in seven health board areas. The total numbers include the 1,495 opiate cases who lived and were treated in the seven health board areas between 1998 and 2002. In this paper, treated problem opiate use is described in relation to person, place and time. This paper will assist policy makers, service planners and practitioners to develop appropriate responses to problem opiate use in the seven health board areas.

The main findings and their implications are:

- The incidence of treated problem opiate use increased sharply, from 2.0 in 1998 to 8.3 in 2002, per 100,000 of the 15–64-year-old population (Figure 2). This observed increase may be explained by a true increase in use, an increase in access to treatment services, new legislation encouraging more people into treatment, or an increase in the number of centres reporting cases to the NDTRS. The most likely explanation is a combination of all these factors.

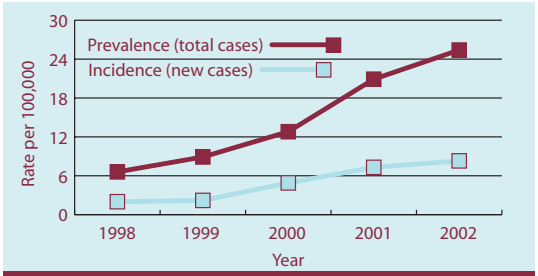


Figure 2 Incidence and prevalence of treatment for an opiate as a main problem drug among persons living and treated in the seven health board areas per 100,000 of the 15–64-year-old population (Central Statistics Office 2003), based on returns to the NDTRS, 1998 to 2002

- The prevalence of treated problem opiate use has also increased steadily, from 6.6 per 100,000 of the 15–64-year-old population in 1998 to 25.4 in 2002, and this is an indicator that problem heroin use has a chronic element requiring continued care or repeated treatment over time.
- There was a spread by county in demand for treatment for problem opiate use among new cases living in the seven health board areas, with very high rates of treated problem opiate use in counties Carlow, Cavan, Louth, Meath, and Westmeath. These data will be useful when assessing the adequacy of existing services or identifying new sites for treatment services.

Updated analysis from the National Drug Treatment Reporting System (continued)

- The lowest rates of treatment for problem opiate use were along the western seaboard; this may be partly due to under-reporting.
- For new cases reporting problem opiate use, the time interval between commencing opiate use and starting treatment remained between 3.5 and 3.8 years from 1999 to 2002. Polydrug-using practices may be initiated during the interval between first taking any drug and the age at which opiate treatment is sought. During the time interval between commencing opiate use and seeking treatment, opiate users may change from smoking to injecting opiates and, subsequently, may contract blood-borne viruses, such as hepatitis C, indicating the need for proactive interventions to discourage the move from smoking to injecting and bring opiate users into treatment earlier.
- The proportion of opiate cases treated in the seven health board areas who reported polydrug use decreased from 80 per cent in 1998 to 74 per cent in 2002. Polydrug use is one of the factors that may impede successful treatment for problem opiate use unless specific interventions are introduced to address this problem.
- For cases treated in the seven health board areas who reported opiates as their main problem drug and reported using more than one drug, the most common secondary drug used was cannabis. During the period under review, the use of cocaine and benzodiazepines as second drugs increased, while the use of amphetamines as a second drug decreased. An exact knowledge of polydrug use is very important for the correct and comprehensive management of opiate users.
- Of note, there was an increase in the actual number of injectors treated in the seven health board areas. Opiate injectors have a higher risk of acquiring blood-borne viral infections and of experiencing overdose than non-injectors. This suggests that the incidence of blood-borne viral infections and opiate-related deaths has increased in the seven health board areas during the period under review, but specific data are not available.
- Problem opiate users' educational characteristics indicate that individuals who leave school early are more likely to become problem opiate users, or that the lifestyle of problem opiate users renders it difficult to stay in full time education, or a combination of both factors. In line with national employment trends, there was an increase in the proportion of new and previously treated opiate cases who reported having regular employment up to 2001 and a subsequent decrease in 2002. Taken together, these two findings indicate the importance of a social, educational and economic reintegration strategy for the successful treatment of opiate users.

(Jean Long)

1. Long J, Kelleher T, Kelly F, Sinclair H (2004) *Treatment demand in the seven health boards outside the Eastern Regional Health Authority, 1998 to 2002.* Occasional Paper 11. Dublin: Health Research Board.
2. Long J, Kelleher T, Kelly F, Sinclair H (2004) *Trends in treated problem drug use in the seven health boards outside the Eastern Regional Health Authority,* 1998 to 2002. Occasional Paper 12. Dublin: Health Research Board.
3. Long J, Kelleher T, Kelly F, Sinclair H (2004) *Trends in treated problem opiate use in the seven health boards outside the Eastern Regional Health Authority, 1998 to 2002.* Occasional Paper 13. Dublin: Health Research Board.

These papers are available on the Health Research Board website at www.hrb.ie

Update on newly diagnosed HIV infections

The National Disease Surveillance Centre reported that there were 399 newly diagnosed HIV infections reported in 2003.[1] There were 47 new diagnoses among injecting drug users during 2003, compared to 50 in 2002 and 38 in 2001. There was a higher number of new infections among male injectors (30, 64%) than among female injectors (17, 36%). The average age of HIV diagnosis for injecting drug users was 29 years. Of the 47 newly diagnosed cases, 45 were born in Ireland and 43 lived in the Eastern Regional Health Authority area. The cumulative total of HIV cases reported to the end of December 2003 was 3,408, of whom 1,131 (33%) were injecting drug users. *(Jean Long)*

1. NDSC (2004) *Newly diagnosed HIV infections in Ireland.* Quarter 3 & 4 2003, & 2003 Annual Summary. Dublin: National Disease Surveillance Centre.

National Documentation Centre on Drug Use

The National Documentation Centre on Drug Use (NDC) is preparing to launch its redesigned website. The website is being changed to accommodate a range of new information resources and to make existing resources more accessible to visitors. The new site will provide visitors with:

- a simplified search option which will allow them to search the NDC simply by choosing the subject heading which interests them
- most recent news stories available on the website's home page
- electronic versions of all articles from back issues of *Drugnet Ireland*, which will appear as they do in the print version of the newsletter
- information notes on aspects of drug use in Ireland, including prevalence, legal issues, drugs policy and infectious diseases
- table of contents for current issues of NDC journals
- an electronic version of the DMRD's national report on the drugs situation in Ireland in an easily accessible and readable format

The NDC is continuing to develop its electronic library – there are now over 700 full-text documents available on the website – and its collection of books, reports and other literature. NDC users have made extensive use of the library's inter-library loan and document delivery services and over 500 journal articles have been supplied to users this year. The NDC is also adding several titles to its journals listing and these will be available to library visitors from early next year.

Group visits to NDC

A number of groups have visited the National Documentation Centre on Drug Use recently to learn about the resources available and how the NDC's information resources can assist them in their work and study. Among the visiting groups were the MSc in Drug and Alcohol Policy (TCD) class, the Diploma in Addiction Studies (TCD) class, Graduate Diploma in Nursing Addiction and Substance Related Difficulties (DCU) class and a delegation from Norway who were on a EURAD study visit to Dublin to mark Norway's Action Week Against Drugs. A number of other visits have been planned for the winter and NDC staff will also be making a number of external presentations. If you are interested in arranging a visit, or a presentation on the NDC in another location, please contact the National Documentation Centre on Drug Use at ndc@hrb.ie.

Current Research and Evaluation Database

The National Documentation Centre is currently compiling a database of ongoing research and evaluation in the drugs area in Ireland and a directory of researchers and evaluators. This contains details of research interests and projects which the researcher or evaluator is currently involved in.

The 2004-06 MSc in Drug and Alcohol Policy (TCD) class on a visit to the NDC

Online forms, which researchers and evaluators can use to provide details of their work, are currently available on the NDC website. These forms are short, easy to complete, and will allow researchers and evaluators to create a thorough and informative record of their work. These information resources will be available to all website visitors when the redesign of the site is complete. If you wish to add your name to the directory, or provide information on research you are currently working on, please contact Damien Walshe at dwalshe@hrb.ie *(Brian Galvin)*

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

The National Documentation Centre on Drug Use is funded by the Department of Community, Rural and Gaeltacht Affairs under the National Development Plan, 2000–2006.

A delegation from Norway, with Ms Grainne Kenny, attending a EURAD study visit to Dublin to mark Norway's Action Week Against Drugs, were welcomed to the NDC by Dr Hamish Sinclair of the DMRD

From *Drugnet Europe*

Social integration efforts, 'much needed' for foreign inmates

Cited from Petra Paula Merino, Drugnet Europe No. 46, April–June 2004

European prison populations today contain an overrepresentation of social, cultural and ethnic minorities, many being immigrants from outside the EU. … Foreign inmates experience difficulties in accessing general care, legal support and addiction services, the main barrier being linguistic. This ultimately jeopardises their chances for social integration as they are more likely to experience health and addiction problems and less likely to be given a chance for parole. Participants at a recent conference on 'Prisons, drugs and society in the enlarged Europe' [organised by the European and Central and East European Networks of Drug Services in Prison] called for comprehensive interventions to prevent imprisonment and integrate immigrants into society by facilitating their access to employment, health and social services and education. Meanwhile, effective in-custody measures cited included peer-support approaches, cultural mediation and repatriation of inmates to prison units in their home country. Other urgent measures proposed related to the prevention of diseases among detainees, especially HIV, hepatitis B and tuberculosis.

Treatment now more 'available, accessible and diverse'

Cited from Drugnet Europe No. 47, July–September 2004

Measuring public expenditure on drug treatment is an important indicator of governments' commitment to the drug problem. Preliminary estimates from an EMCDDA study of drug-related public expenditure from 1990–2000 suggest that, in Member States, 70–75% of the drug budget was spent on law enforcement and around 25–30% on the health sector, including treatment for drugs and related diseases. Although data are insufficient to draw clear-cut conclusions, and more cost analyses are required for an accurate picture of spending, preliminary research shows that within the EU, the average health-related expenditure for problem drug users is around €2,000 per person per annum.

ELDD offers easy access to EU drug legislation

Cited from Cécile Martel, Drugnet Europe No. 47, July–September 2004

In 1990, the European Community took its first legislative action in the field of drugs by ratifying Article 12 of the 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Since then, the EU has adopted a battery of over 60 directives, regulations, recommendations and framework decisions addressing the drug phenomenon, primarily in line with the Treaties of Maastricht and Amsterdam. The EMCDDA has now made these texts available in one easily accessible archive in its European Legal Database on Drugs (ELDD). … A descriptive overview of drug legislation at EU level – the 'European Union profile' – has also been published. This is divided into the following sub-sections: development of legislation; controlled substances; drug use and possession; trafficking and drug-related crime; prevention, care and treatment; precursors; money laundering and confiscation. The main purpose of the feature is to provide policy-makers, researchers, journalists and the general public with an accessible, up-to-date and comprehensive reference collection of EU drug legislation.

[The European Legal Database on Drugs is accessible at **http://eldd.emcdda.eu.int/**]

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

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

Addiction Research Centre Annual Conference

'Towards a comprehensive system for treating alcohol-related problems' was the title of the fourth annual conference held by the Addiction Research Centre in Trinity College Dublin in September 2004. A panel of speakers addressed various aspects of alcohol treatment from both a national and an international perspective.

The first two speakers outlined the effectiveness, diversities and similarities of alcohol treatment systems internationally.

- Dr Thomas Babor, University of Connecticut, focused on the scientific evidence for strategies and interventions designed to prevent or minimise alcohol-related harm, including treatment services. He summarised the results of Project MATCH, the largest controlled treatment evaluation study ever conducted.[1] This study looked at the effectiveness of matched medication-free therapy for individual clients. At the end of his presentation Dr Babor discussed the implications for alcohol policy of research on treatment methods.
- Dr Harold Klingemann, University of Applied Sciences, Bern, discussed the diversity and similarities across alcohol treatment systems. He firstly defined treatment and examined its concepts; this was followed by a description of the International Study of the Development of Alcohol Treatment Systems (ISDRUTS), which was carried out between 1984 and 1990 in 16 countries. He ended the presentation by focusing on the trends in alcohol treatment in various countries, which include: new financing schemes, increased monitoring, evidence-based practice and less focus on illicit drugs.

The second session focused on the developments and failures of Irish alcohol treatment systems.

- Mr Rolande Anderson, Irish College of General Practitioners, presented a paper entitled 'Helping Patients with Alcohol Problems'. An in-depth look at the increase in alcohol consumption in Ireland and its societal costs was followed by an examination of the relationship between the severity of alcohol problems and the type of interventions needed. He identified opportunities for recognising problem alcohol use among attendees at general practice. Mr Anderson concluded his presentation by calling for an increase in the amount of research/resources presently allocated to alcohol-related problems in Ireland, particularly at primary care level.
- Dr Shane Butler, Addiction Research Centre, Trinity College, began his paper by reviewing alcohol treatment planning and service delivery in Ireland over the past 20 years. He continued by identifying the main factors that explain the failure to create an integrated, comprehensive treatment system at local and regional levels in this country. Finally, he argued that there is a need to challenge popular perceptions of and professional intransigence towards alcohol misuse in Ireland.

The final session of the day focused on alcohol policy and the prospects for change.

- Dr Betsy Thom, Middlesex University, provided an overview of trends in the development of alcohol treatment policy in England since 1950. She outlined ways in which treatment policy has changed and the factors that have prompted change or resulted in stagnation.
- In the final paper of the day, Barry Cullen, Addiction Research Centre, Trinity College, explored the need to re-orient the Irish alcohol treatment system towards a public health model. He argued that there is a need to develop more research into alcohol misuse; it is also necessary, he claimed, to acknowledge and learn from the failures in the current system and to listen to the demands for change from the public and from professionals working in the area. He concluded by outlining prospects for change, which include: the need for major investment, the need to consider an integrated drug and alcohol approach, and the need for substantial organisational change at all levels within health and social care systems. *(Fionnola Kelly)*

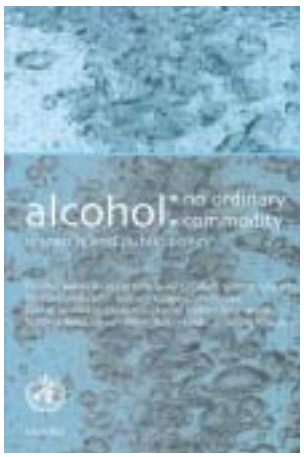
1. For more detailed information on Project MATCH, see Babor T and Del Boca FK (2003) *Treatment matching in alcoholism.* Cambridge: Cambridge University Press

Recent publications

Books

Binge drinking and youth culture: alternative perspectives
MacLachlan M and Smyth C (eds) *The Liffey Press* 2004
ISBN 1 904148 42 5

The contributors to this book do not align themselves with a single definition of the term 'binge drinking'; rather, they emphasise the negative consequences that arise from the *pattern of drinking* in the context of youth culture. The book examines the relationship between binge drinking and the factors that impact on it, and offers a selection of snapshots from perspectives that the editors feel have not been sufficiently developed to date. It reviews the influence of advertising, the consumption of pleasure, the use of education strategies, the physiological effects of drinking in moderation and to excess, as well as the response of society to the problem.



The first section, Literature Review, considers the causes, consequences and possible 'cures' for binge drinking from a psychosocial perspective. The second section, Differing Perspectives, considers arguments that, on the one hand, alcohol in moderation confers health benefits, while on the other, excessive alcohol consumption may facilitate a path to suicide. This section contains a chapter exploring the connections between alcohol, culture and suicide in Ireland. The next section, Contextualising Consumption, provides both quantitative and qualitative analysis of the relationship between youth culture and alcohol consumption, specifically in the Irish social, economic and cultural context. The final section, Debates, highlights some of the issues raised in an open forum discussion with a range of contributors.

Alcohol: no ordinary commodity – research and public policy
Babor T *et al. Oxford University Press* 2003
ISBN 0 19 263261 2

From a public health perspective, alcohol is no ordinary consumer product. On a global level, it is a major contributor to disease, disability, and premature mortality. It also has an adverse impact on many aspects of social life. *Alcohol: no ordinary commodity* describes recent advances in alcohol research that have direct relevance to the development of effective alcohol policies at the local, national and international levels. It covers the search for policies that protect health, prevent disability, and address the social problems associated with the misuse of alcohol. The book is, at its core, a scientific treatise on what alcohol policy is, why it is needed, which interventions are effective, how policy is made, and how scientific evidence can inform the policy-making process.

The book opens with an introduction to the alcohol policy agenda. The second section presents a snapshot of drinking patterns and alcohol-related problems throughout the world, providing a global panorama of the challenges faced. The third section critically reviews the evidence for six strategies that have often been used as a basis for alcohol policy: taxation and pricing, regulating the physical availability of alcohol, modifying the drinking context, measures against drink-driving, regulating alcohol promotion, education and persuasion programmes, and treatment and early intervention services. Section four provides an international analysis of the policy-making process. The book concludes with a consumer's guide to effective alcohol policy, synthesising what is known about how communities and nation states can effectively manage this extraordinary commodity.

Cocaine
Streatfeild D *Virgin Books Ltd* 2002
ISBN 0 7535 0627 0

This book presents a definitive history and overview of cocaine in all its manifestations – from its first medicinal uses thousands of years ago to the worldwide chaos it causes today. Over a two-year period, the author's research took him from the British Library to the jungles of Bolivia and Colombia. He interviewed cocaine users and dealers in many places, including the crack houses of New York and America's secure prisons. He talked to experts and to those involved with the cocaine trade, from both sides of the law and sometimes in dangerous circumstances: economists, scientists, botanists, lawmen, historians and traffickers.

The cocaine story is presented in three parts, beginning with the discovery of the stimulant properties of the coca plant *Erythroxylum coca* by pre-Incan tribes in Peru. Streatfeild describes the plant and the various processes involved in preparing the leaves for chewing, and in making medicinal compounds, such as have been used in South American for millennia. He goes on to explain how the coca leaf became cocaine and was embraced in the 1880s by the medical profession (particularly Sigmund Freud) for use mainly as an anaesthetic. He describes early attempts to discover how cocaine affects the brain and the gradual realisation of its addictive effects, leading to attempts to control it by legislation. Further chapters describe how the cocaine problem grew from the early twentieth century, and explore its links with crime and racism. The second part of the book chronicles the historical background of the cocaine 'explosion', the rise of drug barons, and the evolution of crack. The author's findings and experiences in Mexico, Bolivia, Peru and Colombia are related in separate chapters in the final section.

Recent publications (continued)

Journal articles

The following are summaries of a selection of articles relating to the drugs situation in Ireland recently published in international journals.

Cocaine use in Europe – a multi-centre study
Haasen C, Prinzleve M, Zurhold H, Rehm J, Güttinger F, Fischer G, Jagsch R, Olsson B, Ekendahl M, Verster A, Camposeragna A, Pezous A-M, Gossop M, Manning V, Cox G, Ryder N, Gerevich J, Bacskai E, Casas M, Matali JL and Krausz M
European Addiction Research 2004; 10(4): 139–146

An increase in the use of cocaine and crack in several parts of Europe has raised the question whether this trend is similar to that in the USA in the 1980s. However, research in the field of cocaine use in Europe has been only sporadic. Therefore, a European multi-centre and multi-modal project was designed to study specific aspects of cocaine and crack use in Europe, in order to develop guidelines for public health strategies. Data on prevalence rates were analysed for the general population and for specific subgroups. Despite large differences between countries in the prevalence of cocaine use in the general population, most countries show an increase in the last few years. The highest rate, with a lifetime prevalence of 5.2 per cent, was found for the United Kingdom, although with a plateau effect around the year 2000. With regard to specific subgroups, three groups seem to show a higher prevalence than the general population: (1) youth, especially in the party scene; (2) socially marginalised groups, such as the homeless and prostitutes or those found in open drug scenes; (3) opiate-dependent patients in maintenance treatment who additionally use cocaine. Specific strategies need to be developed to address problematic cocaine use in these subgroups.

Cocaine use in Europe – a multi-centre study: patterns of use in different groups
Prinzleve M, Haasen C, Zurhold H, Matali JL, Bruguera E, Gerevich J, Bácskai E, Ryder, N Butler S, Manning V, Gossop M, Pezous A-Mm, Verster A, Camposeragna A, Andersson P, Olsson B, Primorac A, Fischer G, Güttinger F, Rehm J and Krausz M
European Addiction Research 2004; 10(4): 147–155

The study investigates patterns of cocaine powder and crack cocaine use in different groups in nine European cities. A multi-centre cross-sectional study was conducted in Barcelona, Budapest, Dublin, Hamburg, London, Paris, Rome, Vienna, and Zurich. Data were collected by structured face-to-face interviews. The sample comprises 1,855 cocaine users out of three subgroups: 632 cocaine users in addiction treatment, mainly maintenance treatment; 615 socially marginalised cocaine users not in treatment; and 608 socially integrated cocaine users not in treatment. Measurements: Use of cocaine powder, crack cocaine and other substances in the last 30 days, routes of administration, and lifetime use of cocaine powder and crack cocaine. The marginalised group showed the highest intensity of cocaine use, of heroin use and of multiple substance use. Of the integrated group, 95 per cent snorted cocaine powder, while in the two other groups, injecting was quite prevalent, but with huge differences between the cities. Ninety-six per cent of all participants had used at least one other substance in addition to cocaine in the last 30 days. The use of cocaine powder and crack cocaine varies widely between different groups and between cities. Nonetheless, multiple substance use is the predominating pattern of cocaine use, and the different routes of administration have to be taken into account.

The burden of alcohol misuse on emergency in-patient hospital admissions among residents from a health board region in Ireland
O'Farrell A, Allwright S, Downey J, Bedford D and Howell F
Addiction 2004; 99(10): 1279

The aim of this study was to identify in-patient emergency admissions to acute hospitals of residents from a health board region in Ireland with an acute alcohol intoxication diagnosis; to profile the admissions and to assess whether the increase in alcohol consumption in Ireland has been mirrored by an increase in alcohol-related emergency admissions over the same time period. There were 3,289 acute alcohol intoxication admissions to acute hospitals of residents from the study region recorded for years 1997–2001 inclusive. There were 777 acute alcohol intoxication admissions in 2001, compared to 432 admissions in 1997, an increase of 80 per cent. This study shows that alcohol intoxication accounted for a substantial number of emergency in-patient admissions to acute hospitals in one health board region in Ireland and that the age-standardised recorded acute alcohol-related emergency admission rate increased significantly over the five-year period. This increase mirrored the national increase in alcohol consumption over the same time period.

Addressing violence in methadone maintenance treatment
Quigley P
Heroin Addiction & Related Clinical Problems 2004; 6(1): 5–18

Violence is a core public health issue that is linked to substance misuse in complex and interactive ways. Qualitative data on 220 violent episodes were collected over a three-year period from service users and staff at Dublin methadone clinics.

Recent publications (continued)

Inductive analysis of the data led to a typology of violent events, which may help to inform clinical and social responses to the problem. Witnessed clinic episodes were interpreted as consequences of disturbed individual states or traits, or in terms of immediate situational conflict. Client narratives were construed as illustrations of family violence, local feuds, delinquency, dealing, retribution and abuse. A variety of pertinent clinical and organisational solutions are put forward in the context of a necessary community development and social inclusion process.

Methylenedioxymethamphetamine (MDMA, 'Ecstasy'): a stressor on the immune system
Connor TJ
Immunology 2004; 111(4): 357–67

Drug abuse is a global problem impacting on health. One such health concern stems from the fact that many drugs of abuse have immunosuppressive actions and consequently have the potential to increase susceptibility to infectious disease. This article is focused on the impact of the amphetamine derivative, methylenedioxymethamphetamine (MDMA; 'Ecstasy') on immunity. Research conducted over the last five years, in both laboratory animals and humans, has demonstrated that MDMA has immunosuppressive actions. As many of the physiological changes elicited by MDMA closely resemble those induced by acute stress, it is suggested that exposure to MDMA could be regarded as a 'chemical stressor' on the immune system. Finally, the potential of MDMA-induced immunosuppression to translate into significant health risks for abusers of the drug will be discussed.

Imaging features of soft-tissue infections and other complications in drug users after direct subcutaneous injection ("skin popping")
Johnston C and Keogan MT
American Journal of Roentgenology 2004; 182(5): 1195–202

Drug abuse is a serious problem, both globally and at a local level, with more than 13,400 opiate abusers in Dublin, Ireland, alone. Infectious complications are responsible for 60–80 per cent of hospital admissions of IV drug users. In 2000, in the United Kingdom and Ireland, fatalities associated with soft-tissue inflammation and severe systemic sepsis were linked to 'skin popping' (injection of drugs into the skin and subcutaneous tissues rather than directly into a vein). Clostridium species were implicated in the pathogenesis. Superficial infection may progress to more widespread local or distant disease. Primary soft-tissue infections in IV drug users include cellulitis, abscess, myositis, pyomyositis, and necrotizing fasciitis. Secondary effects of IV drug use include septic arthritis and tenosynovitis, secondary osteomyelitis, vascular complications, soft-tissue ulceration, and fistula formation. In this review, the range of complications caused by skin popping that may develop will be shown. Early imaging to define disease extent and complications is important because clinical deterioration can be precipitous.

Ireland and its drink problem: the immediate adverse effects of binge drinking in Ireland
O'Farrell A
Irish Medical Journal 2004; 97(6): 165-166

This editorial reviews recent research relating to drink patterns and consequences of binge drinking, including studies in Ireland. Studies on alcohol-related hospital attendances and hospital admissions, alcohol-related road traffic accidents, suicides, violent assault, sexual violence and rape. The author concludes that many of the acute problems related to alcohol arise due to the adverse effect of the unhealthy binge drinking pattern in Ireland.

(Joan Moore, Louise Farragher)

Upcoming events – a selection

November 2004

2 November 2004
Seminar: Drugs – Mood, Memory and Mayhem
Speaker: Dr Desmond Corrigan
Venue: Drug Treatment Centre Board, Trinity Court, 30–31 Pearse Street, Dublin 2.
Seminar Price: €30.00 per Seminar or €120.00 per Series (5 for the price of 4)
All places must be pre-registered, full details available from:
Tel: 01 648 8600 Fax: 01 648 8700
E-Mail: seminars@dtcb.ie
www.addictionireland.ie

Information: Dr Desmond Corrigan is a senior lecturer in the School of Pharmacy, Trinity College Dublin, Chairperson of the National Advisory Committee on Drugs and Chairperson of Dun Laoghaire–Rathdown Local Drugs Task Force 1997–2000. He is the author of *Facts about Drug Misuse in Ireland,* now in its 4th edition.

4–5 November
2e Congrès de Médecine en Milieu Pénitentiaire / The 2nd European Congress of Prison Medicine
Venue: Palais des Congrès, Strasbourg
Organised by / Contact: EVENYS Caroline Chaussat ou Flore Labouret, 17, rue de Seine - 92100 Boulogne
www.congres-ucsa.com/english/default.htm

11–14 November 2004
Fifth Annual National Harm Reduction Conference
Venue: New Orleans
Organised by / Contact: Paula Santiago
Tel: 001 212 213-6376 ext 15
Email: santiago@harmreduction.org
www.harmreduction.org/conf2004/index.html

Information: Theme of conference 'Working Under Fire: Drug User Health and Justice 2004'. Participants will share their experiences, as well as discuss solutions to common concerns and issues, such as housing, medical care, the impact of drug use on families, the need for needle-exchange programs and new developments in the political and criminal justice arenas.

18–19 November 2004
From Information to Response – The role of qualitative research in designing strategies to prevent drug use
Venue: Folkets Hus, Malmö, Sweden
Organised by / Contact: Ms Marie Pertoft, Nymans & Schulz
Tel: 46 (8) 429 23 32.
Email: meeting@nymans.se
www.mobilisera.nu/templates/GeneralPage____3501.asp

For questions regarding the programme, please contact Philip Lalander, SoRAD
Email: philip.lalander@hik.se

Information: The conference is being organised by The Swedish National Drug Policy Coordinator and the EMCDDA. The main objective of the conference is to make better use of qualitative methods as tools to get closer to changing trends and attitudes among young people in order to inform policies and prevention interventions and build on what is really going on in the minds and social worlds of young people. Related to this is the need to access information about changes in drug use before these changes cause too much damage. Keynote speakers will introduce the main themes, which will be elaborated in workshops with presentations from different European countries. EU national drug policy co-ordinators will draw conclusions on the practical value of the knowledge presented at the conference. The conference targets European policy makers in the drugs field, professionals and researchers. The programme includes plenary presentations and workshops by researchers and prevention professionals.

February 2005

21–22 February 2005
National Drug Treatment Conference
Venue: Victoria Park Plaza Hotel, London
Organised by / Contact: Exchange Conference in association with The Alliance or contact Monique at Exchange Conferences
Tel +44 (0) 20 7928 9152
Email: moniquetomlinson@wdi.co.uk
www.exchangesupplies.org

Information: A two-day annual conference addressing all aspects of drug treatment. The conference will include presentations on:

- The impact of stimulant, benzodiazepine and other non-opioid drug use on opiate maintenance treatment
- Amphetamines: use, problems and responses
- Regulation of practitioners – achieving a balance
- Magic bullets? Frameworks for evaluating new treatments
- 'Geriaddicts': aging and dependence
- Models of counselling: are they all the same?

and will debate the motion: 'This house believes we need more compulsory drug treatment and testing services'

Upcoming events – a selection (continued)

March 2005

20–24 March 2005
16th International Conference on the Reduction of Drug Related Harm
Venue: Waterfront Hall, Belfast.
Organised by / Contact:
Nicola Johnston, Project Planning International Montalto Estate, Spa Road, Ballynahinch, Co.Down, Northern Ireland BT24 8PT.
Tel: 02897 561993
Fax: 02897 565073
Email: nicola@project-planning.com
www.ihrcbelfast.com

Information: A range of broad, over-arching themes will provide the focus for the 16th International Conference on the Reduction of Drug Related Harm. The broad themes include:

- drugs and drug use in conflict and post-conflict situations
- alcohol and tobacco and harm reduction
- criminal justice and harm reduction
- harm reduction and young people
- HIV/AIDS and drugs, including prevention, treatment and care
- harm reduction – dimensions and principles
- drug laws – the international perspective

The conference is being organised by the Department of Health, Social Services and Public Safety (DHSSPS) for Northern Ireland, in association with the International Harm Reduction Association (IHRA).The conference programme is currently being developed and will include sessions on alcohol and tobacco, as well as ensuring that the issues which typically form the core of IHRA conferences will continue to be addressed and debated. The organisers are also keen to ensure that the conference continues to appeal to those with a long history of working in the harm reduction field, as well as to those for whom it is a relatively new phenomenon.

All of the documents referred to in this issue of *Drugnet Ireland* are available in the National Documentation Centre on Drug Use. For information, contact the National Documentation Centre on Drug Use, Health Research Board, Holbrook House, Holles Street, Dublin 2. Tel: 01 676 1176 Ext 175; Email: ndc@hrb.ie

If you have information on upcoming conferences or other events, please let us know so that we can include it in future issues of *Drugnet Ireland.* Send information to Brian Galvin, Drug Misuse Research Division, Health Research Board, Holbrook House, Holles Street, Dublin 2. Tel: 01 676 1176 Ext. 168; Email: bgalvin@hrb.ie

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