drugnet IRELAND

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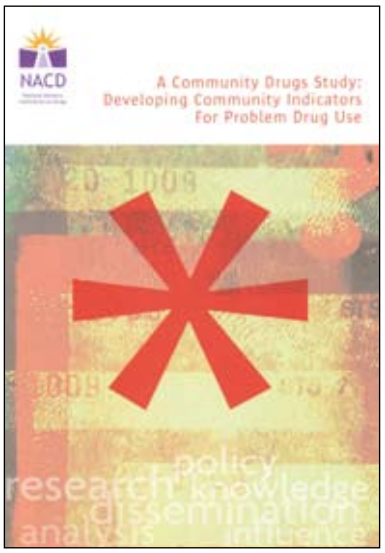
Newsletter of the Alcohol and Drug Research Unit

We have changed our name. The DMRD is now called the Alcohol and Drug Research Unit. See details on p. 32.

The NDC ***Directory of courses and training programmes on drug misuse in Ireland 2007*** is now available. See details on p. 31.

A community drugs study

On 23 November 2006, Noel Ahern TD, Minister of State with responsibility for the National Drugs Strategy, launched *A community drugs study: developing community indicators for problem drug use.*[1] Dr Hilda Loughran and Dr Mary Ellen McCann of University College Dublin completed the study on behalf of the National Advisory Committee on Drugs (NACD). This report focused on three communities' experiences of the changes in the drug situation and responses to it between 1996 and 2004. The three communities selected were Ballymun, Bray and Crumlin. Minister Ahern said 'this report provides evidence of the impact and effectiveness of Government policy on drugs since 1996'.



The objectives of the study as stated in the report (p. 8) were:

- To explore [communities'] experiences of drug issues from 1996 to 2004
- To describe initiatives developed between 1996 and 2002 which the communities perceive to have influenced any change
- To explore how the communities experienced their involvement in planning and implementation of such initiatives
- To assess how the then community infrastructure affected the communities' experiences.

A grounded theory approach was used to gather and analyse the data collected through focus groups, in-depth interviews, key participant interviews, transcriptions from team meetings, local documentation and reflections of the research co-ordinators. Local people were recruited and trained as community researchers, who then recruited the participants through their community network. A total of 97 participants were interviewed across the three sites. All data collected were transcribed, coded and analysed in order to construct individual community profiles for the period 1996 to 2004 and identify themes across the three community profiles. Twelve themes emerged.

The key findings of the study were:

- Between 1996 and 2004, polydrug use (which includes alcohol) replaced heroin as the main drug problem for all of the communities involved in the study. The misuse of both prescribed and non-prescribed benzodiazepines was noted. The use of cannabis was seen as widespread and had become a 'normal' practice by the end of the study period.
- Alcohol misuse had a major negative effect on the lives of residents in the communities. The more problematic aspects of alcohol use were under-age drinking and subsequent anti-social behaviour among this age group. The easy availability of alcohol was due to an increase in local supermarkets and off-licences in the three communities during the study period.
- There was an improvement in the provision of opiate treatment and community-based treatment interventions between 1996 and 2004. Methadone substitution programmes had some impact on heroin use but failed to tackle other drugs. Concerns were raised regarding the lack of treatment facilities for young people, in particular for alcohol.
- Drug-related deaths and deaths among drug users caused devastation in the three communities. In general, these were premature deaths of young people. There was a general perception that official statistics did not reflect the total numbers who died or the impact of these deaths on other family members and the community at large.

contents

A community drugs study *(continued)*

- A general sense of fear, vulnerability and intimidation was experienced among the communities as a result of open drug dealing in public areas. People reported that there had been a decrease in the use of public spaces after dark since 1996.
- A reduction in some types of crime was observed between 1996 and 2004, but the later phase of the study noted an increase in the number of murders associated with drug dealing.
- Participants reported a deteriorating relationship between the community and the gardaí.
- There was an increase in the number of children under 15 years who stayed in school and an increase in those who completed the Leaving Certificate during the reporting period. In some cases, school absenteeism replaced early school leaving.
- Employment opportunities had increased during the reporting period, and fewer people were unemployed in 2004.

The report states 'It was evident from the data that there were different perceptions among community members as to the prevalence of drug use in their areas, and the consequences of different patterns of drug use' (p. 77). This is due to the diversity of the communities and the difficulty in gathering data. The report's main conclusion is that a community-based reporting system is required to identify changes in the drug situation in specific communities. *(Siobhán Reynolds)*

1. Loughran H and McCann ME (2006) *A community drugs study: developing community indicators for problem drug use.* Dublin: Stationery Office.

Drug-related deaths and strategies for prevention

The report of a working group convened by the Irish College of General Practitioners (ICGP) to examine the issue of drug-related deaths and strategies for prevention was published on 21 December 2006.[1] The ICGP Working Group believes that, with suitable education and improved awareness of the issues involved in drug-related deaths, lives can be saved. The group supports the provisions for senior ambulance personnel with special training to carry naloxone as an emergency response to opiate overdose.

Recommendations made in the report include:

- A national co-ordinated strategy to prevent opiate-related deaths should be implemented.
- Links should be established between the National Suicide Prevention Strategy, the National Parasuicide Registry and the National Drug-Related Deaths Index, in view of the overlap between substance abuse and suicide.
- Appropriate information and resource materials should be standardised across all treatment and support locations.
- All personnel who treat drug users should receive training in overdose prevention and basic life-support. Family members of known drug users should also consider receiving basic life-support training.
- Individuals at high risk of overdose can be identified and service providers should address risky behaviours with these service users.
- Consideration should be given to the provision of overdose prevention education groups for service users.
- On discharge from prison, drug users should be allowed to link in with their local drug treatment agency, with contact numbers contained in a 'pre-release' pack.
- Prison service personnel should facilitate contact with local HSE services wherever possible when a known drug user is being discharged.
- Drug users undergoing detoxification should be told of the risks of overdose following detoxification.
- Garda members should receive training in overdose prevention.
- The National Drugs Strategy Team should research the feasibility of collecting data on non-fatal opiate overdoses or near misses.

The ICGP Working Group was chaired by Dr Ide Delargy, director of the Drug Misuse Programme of the ICGP and included representatives from the HSE, the voluntary sector, the Health Research Board and the Irish Prison Service. *(Ena Lynn)*

1. ICGP Working Group (2006) *Drug-related deaths and strategies for prevention.* Dublin: ICGP. The full report is available on the ICGP website at www.icgp.ie

Cocaine in local communities

In March 2004 CityWide published the results of a survey on the extent to which 27 community-based drug projects were dealing with the problems of cocaine use.[1] The results illustrated that cocaine was a growing problem.

CityWide conducted a follow-up survey on cocaine in local communities in 2006.[2] Twenty-eight projects responded to this survey, 13 of which had participated in the 2004 survey. The results show that local community drug projects have experienced a major increase since 2004 in people presenting with cocaine as their primary drug.

In 2004, four projects (15%) reported seeing clients with what they then described as problematic cocaine use. Two years later, 62% of projects reported treating clients presenting with cocaine as their primary drug. Figure 1 shows that a majority of projects reported an increase in cocaine use among clients since 2004.

The follow-up survey reports a deterioration in the general health of clients with problematic cocaine use, with 39% of the projects surveyed reporting a rise in the number of clients experiencing abscesses and wounds due to poor injecting habits. Twenty-two per cent of projects reported an increase in mental health problems, including depression, anxiety, stress, psychotic episodes and attempted suicide.

Projects also reported increases in weight loss, sexually transmitted infections (STIs), heart conditions, amputations, opiate users stabilised on methadone destabilising with cocaine use, and risk taking among clients using cocaine. One project reported being aware of one heroin-related death in the 10 years up to 2005, in comparison with knowledge of four cocaine-related deaths in 2006.

All projects expressed concern about clients who got into financial debt, resulting in their living in fear of violent reprisal for debts unpaid, and engaging in increased criminal activity to feed their addiction. The majority of projects surveyed reported an increase in violent and gun-related crime since 2004.

The projects reported a strain on resources due to cocaine use. This was due to the chaotic lifestyle and behaviours that can be associated with cocaine use and the reported problem of opiate-using clients destabilising through cocaine use.

Since 2004, in response to the growing problem of cocaine use, three cocaine-specific pilot projects have been set up and 93% of the projects surveyed in 2006 had key workers who had undertaken cocaine-related training. *(Ena Lynn)*

1. Citywide (2004) *Cocaine in local communities: Survey of community drug projects.* Dublin: CityWide Drugs Crisis Campaign. www.citywide.ie

2. CityWide (2006) *Cocaine in local communities: CityWide follow-up survey.* Dublin: CityWide Drugs Crisis Campaign. www.citywide.ie

Local community drug projects have experienced a major increase since 2004 in people presenting with cocaine as their primary drug.

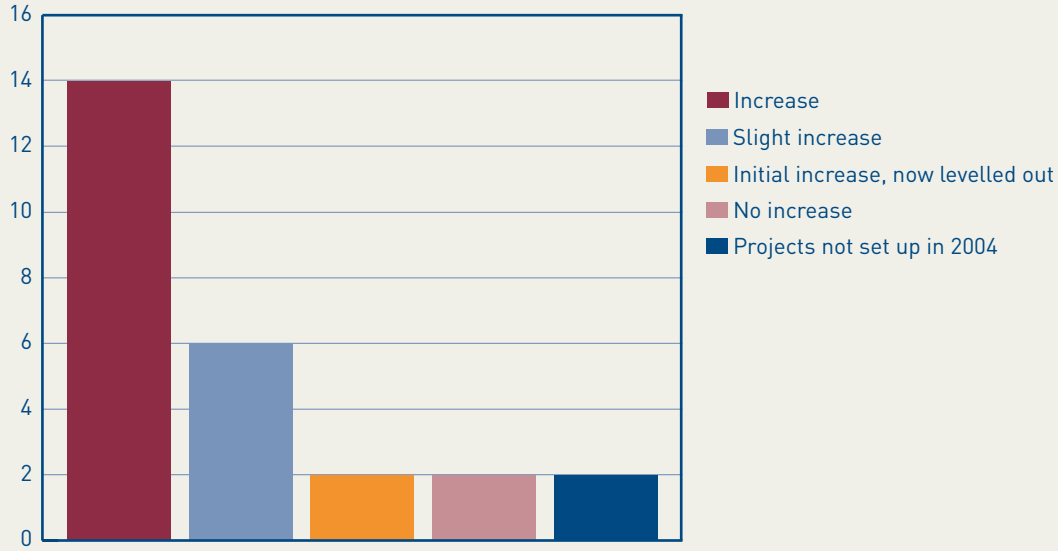


Figure 1 Number of projects reporting an increase in cocaine use among clients

Source: *CityWide (2006)*

Strategy to address adolescent substance misuse in the HSE South Eastern Area

Barry Cullen, Head of the Addiction Research Centre at Trinity College Dublin, prepared a report to assist with the development of a treatment response to drug and alcohol use among adolescents (12–18 years) living in Carlow, Kilkenny, South Tipperary, Waterford and Wexford.[1] The report presented a review of the literature which examined adolescent needs, substance misuse pathways and treatment outcomes. In addition, the author discussed with service providers the issues pertaining to prevention, early intervention and treatment for adolescents living in this area.

Alcohol and cannabis were the main problem drugs reported by adolescents living in the HSE South Eastern Area; opiate use was reported by only a small number of these adolescents. (Opiates are the most common main problem drug reported by adolescents living in the HSE Eastern Area.) The author reported that the pattern of substance use needed to be reflected in the development of the treatment response.

According to the author, there are intrinsic differences in the ways children and adults use alcohol and drugs and in their treatment needs. He describes two pathways into alcohol and drug use for adolescents. The first is the experimental or social use of alcohol or drugs (considered normal), and the second is the use of such substances as a coping mechanism to deal with stress and anxiety (considered problematic).

The recommendations of this report were influenced by the *Report of the working group on the treatment of under 18 year olds presenting to treatment services with serious drug problems.*[2] In general, the four-tier model of service delivery recommended by the national working group was accepted as the best model, but service providers recommended adaptations to reflect the situation in the HSE South Eastern Area. The adaptations to the model should reflect the types of substances used and a preference for the provision of day care instead of residential care at Tier 4. The model recommended in the working group report is described below.

Experimental substance use should be dealt with using a population-based approach (Tier 1), while substance use to deal with stress and anxiety should be dealt with using a treatment intervention (Tiers 2 to 4). In order to determine which pathway to substance use was taken by the adolescent, an appropriate assessment tool was required. A review of the evidence indicated that effective interventions for those requiring treatment were behavioural therapy, motivational counselling, multi-systemic treatment and family therapy. Family involvement in treatment was very important for younger or less mature adolescents, and less so for the more mature young person. A specialist day-care programme was recommended as an alternative to residential treatment, which, according to the author, should be used for respite purposes only. In order to ensure appropriate use of Tier 3 and Tier 4 services, referrals to these services should be made through Tier 2 services. The author recommended that adolescent services in the South East be delivered through a separate adolescent drug treatment service. The provision of community and youth projects in urban areas was considered adequate but there was a need to expand these to rural communities. During consultations with service providers, it was noted that many at Tier 1 were unaware of the availability of services required to manage those with problematic substance use, and in-service training was needed to ensure adequate knowledge and appropriate referral. *(Jean Long)*

1. Cullen B (2006) *Report to Health Service Executive Regional Drug Coordinating Office (Wateford) on recommendations for developing adolescent substance misuse treatment services in the region.* Dublin: Addiction Research Centre, Trinity College Dublin.

2. Working Group on treatment of under 18 year olds (2005) *Report of the working group on treatment of under 18 year olds presenting to treatment services with serious drug problems.* Dublin: Department of Health and Children.

Tier 1 Generic services provided by teachers, social services, gardaí, general practitioners, community and family groups for those at risk of drug use. Generic services would include advice and referral and would be suitable for those considering or commencing experimentation with drugs or alcohol.

Tier 2 Services with specialist expertise in either adolescent mental health or addiction, such as juvenile liaison officers, local drugs task forces, home-school liaison, Youthreach, general practitioners specialising in addiction and drug treatment centres. The types of service delivered at this level would include drug-related prevention, brief intervention, counselling and harm reduction, and would be suitable for those encountering problems as a result of drug or alcohol use.

Tier 3 Services with specialist expertise in both adolescent mental health and addiction. These services would have the capacity to deliver child-centred comprehensive treatments through a multi-disciplinary team. This team would provide medical treatment for addiction, psychiatric treatment, child protection, outreach, psychological assessment and interventions, and family therapy. These types of service would be suitable for those encountering substantial problems as a result of drug or alcohol use.

Tier 4 Services with specialist expertise in both adolescent mental health or addiction and the capacity to deliver a brief, but very intensive intervention through an inpatient or day hospital. These types of service would be suitable for those encountering severe problems as a result of drugs or alcohol dependence.

Community awareness and perceptions of substance use in Cork and Kerry

In the last issue of *Drugnet Ireland* the findings of the report *Smoking, Alcohol and Drug Use in Cork and Kerry 2004*[1] in respect of alcohol consumption and drug use were described.[2] Comparisons with the findings of an earlier study by the same author, Dr Timothy Jackson, in 1996, and with the results of other recent studies of substance use in Ireland, were also described.

In this article the findings of the report in respect of community awareness of illicit drugs and perceptions of drug-related issues are described, along with comparisons with the 1996 findings.[3] Mirroring the trend shown by the research that drug and alcohol use in the region had increased since 1996, the study also found that awareness of illicit drugs and drug use in the region had increased over the past eight years and that attitudes and opinions on substance misuse issues had shifted.

Drugs

Awareness of almost all drugs had increased since 1996. Significant increases were also found in the proportion of respondents claiming personal knowledge of drug situations, including knowing someone who had been offered drugs, had taken drugs in the last five years or regularly took drugs, or being in social gatherings in the last five years where drugs were taken by others. Since 1996 the proportion of respondents with such knowledge had increased for cannabis, cocaine, crack and heroin, while dropping for ecstasy, magic mushrooms and LSD. As in 1996, the main source of awareness among all respondents of people using drugs in their area was personal contacts.

Responses to a question about the harmfulness of individual drugs showed that, as in 1996, heroin, ecstasy, crack, cocaine and LSD were considered the most harmful, and cannabis the least harmful. Medically prescribed drugs fell midway in the ranking. The author reports that cannabis use was twice as frequent among those who thought the substance least harmful as among those who saw it as harmful. This difference had reduced since 1996, suggesting 'increasing tolerance of Cannabis in the population' (p. 119). On the other hand, the author reports that, despite their ranking among the most harmful drugs, ecstasy and LSD were also among the drugs reported as most frequently used.

With regard to 'gateway drugs', respondents were asked whether and to what extent they agreed or disagreed with the statement that people who use cannabis (and other 'softer' drugs) are likely to progress onto 'harder' drugs such as heroin or cocaine. The response indicates that the level of agreement with this statement had declined since 1996.

Respondents were asked to state how much of a problem they thought certain drug-related activities were in their area (i.e. within five minutes' walk). Using drugs was the most widely perceived 'very big' or 'fairly big' problem (45%), followed by drug-related criminal activities, including people being offered drugs for sale (36%), crimes committed by people acting under the influence of drugs (34%) and thieving in order to get money to buy drugs (30%). Perceptions that there were 'very big' or 'fairly big' drug-related problems in local areas had fallen 'slightly but significantly' since 1996, except for crimes committed by people under the influence of drugs and people becoming ill or dying due to the use of drugs, where perceptions of their seriousness had increased. Perceptions that there were drug-related problems were found to be more frequent among respondents in Cork City and County Kerry than in Cork County, among manual workers and small farmers (on 49 acres or less) than among professional, managerial and business people and larger farmers (see report for details of social classification system used in analysis), and among those living in deprived urban areas.

While 55% of respondents supported current drug prohibition laws, 'quite a significant minority' (33%) were of the opinion that some drugs (e.g. cannabis) should be legal, but with restrictions (e.g. licensing of a few shops/bars only). Since 1996 there had been a 12% increase in support for the legalisation of cannabis with restrictions, and a corresponding drop (14%) in support for continuing prohibition of all currently illegal drugs. Those who had ever taken drugs showed markedly greater support for the legalisation of cannabis and the relaxation of the prohibition laws, compared to those who had never taken drugs.

Drugs and alcohol

Responses to a question about whether alcohol or drugs caused more problems in society showed a reversal of opinion. In 1996, 81% of respondents considered drugs to be an equal or greater problem than alcohol, but by 2004 this proportion had dropped to 61%. Conversely, in 1996, 40% considered alcohol to be an equal or greater problem than illicit drugs, but by 2004 this proportion had grown by 27%. Disagreement with the statement that there is little difference in health terms between smoking cannabis and smoking tobacco or drinking alcohol had declined somewhat since 1996. *(Brigid Pike)*

Despite their ranking among the most harmful drugs, ecstasy and LSD were also among the drugs reported as most frequently used.

Since 1996 there had been a 12% increase in support for the legalisation of cannabis with restrictions.

1. Jackson TMR (2006) *Smoking, alcohol and drug use in Cork and Kerry 2004.* Cork: Department of Public Health, HSE South.
2. Fanagan S (2007) Repeat survey of substance use in Cork and Kerry. *Drugnet Ireland,* Issue 20: 1–2.
3. The sampling and research methods used in the study are outlined in Fanagan (2007). The information in this article is based on data gathered in the first part of the research. Field workers employed by TNS mrbi used a structured questionnaire to record responses during face-to-face interviews with individual respondents. These data were coded in SPSS and subjected to varied statistical tests. Results from the structured interviews regarding respondents' views on alcohol and smoking policies, their knowledge of substance use services and their leisure activities are not described in this article.

Tools for co-ordinating drugs initiatives in the regions

Co-ordination is as good as the decisions made by those responsible for planning and implementing the 'single integrated plan'.

The need for co-ordinated and integrated responses to the drugs problem throughout the country led to the establishment of the regional drugs task forces (RDTFs).[1] To achieve a co-ordinated response, the RDTFs were advised, when developing their strategies, to adopt a 'partnership approach involving the statutory, voluntary and community sectors, through the development of a single, integrated plan, which all organisations and agencies … support and are committed to implementing'.[2]

Although each of the 10 RDTFs has adopted its own distinctive mix of co-ordination tools, when the strategies are viewed together, the tools may be grouped around four main themes – governance, resources, communication, and service design.[3]

Governance

Co-ordination is as good as the decisions made by those responsible for planning and implementing the 'single integrated plan'. The RDTFs have given considerable thought to means of ensuring sound decision-making structures and systems, i.e. good governance.

The task force structure is one important contributing factor. A 'forum-type' structure, organised around the four pillars of the National Drugs Strategy, with membership depending on the skills and information individuals can bring to the subject matter, has been canvassed. Various sub-groups to support the RDTFs by addressing distinct county-based, local or operational issues have been suggested. One RDTF proposed establishing an independent 'expert group' to support the evaluation of possible projects in terms of best practice.

Securing the commitment of individual task force members is another critical factor. Members should be senior decision-makers in their own organisations, with the authority to commit resources, and should attend over a sufficiently long period to ensure continuity of knowledge and action. At a deeper level, 'shared values', enshrined if possible in a written agreement that also sets out common targets and goals, are regarded as important in winning the commitment of agencies and individual members.

In respect of systems, planning and evaluation are seen as two useful co-ordination tools. The RDTF strategy itself can form the framework and foundation for co-ordination among all involved in service delivery and resource provision. Evaluation that, among other things, helps to review and reflect on practice, inform further planning and practice, share and disseminate experiences and learning, and ensure resources are used appropriately and effectively, is also an important tool in sustaining a co-ordinated approach. It acts as a control mechanism, preventing an organisation from going off course or limping along ineffectually.

Resources

To be effective, co-ordination efforts need to be adequately resourced. Over and above core task force staff, one RDTF has identified the need for 15 additional posts to provide enhanced support and liaison services throughout the region. One RDTF has called for a dedicated budget and associated delegations and responsibility to enable it to fund work addressing the drugs issue in the region.

Communication

In line with their terms of reference, which call for the creation and maintenance of an up-to-date database on the nature and extent of drug misuse, and the provision of information on drug-related services and resources in the region,[1] the RDTF strategies identify a variety of opportunities for the production and exchange of information. It is the communication mechanisms for the exchange of information, including ideas and opinions, which are important for ensuring effective co-ordination.

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All 10 RDTFs report that they have engaged in extensive consultation in developing their strategies. This is in line with the 'Guidelines for the Development of RDTF Strategy Plans', which stipulate that ongoing consultation is also important.[4] A number of RDTFs propose group forums to ensure that they hear on a continuing basis the views of different stakeholders. Forums of drug educators, of treatment and rehabilitation service providers, of service users, of parents, and of communities in relation to matters such as community policing, estate management, or issues relating to illicit drug use and underage drinking are envisaged. Community development is also perceived as assisting co-ordination, partly through involving local communities in the actions of the RDTF and its members, and partly through building capacity that will enhance the participation of communities in decision-making processes.

Interagency co-operation is seen as depending on, at minimum, an open policy of sharing information, such as research and models of effective practice, and working together to identify new solutions and new initiatives. Furthermore, a number of RDTFs have made a case for a wider advocacy and liaison role for the RDTFs, seeking to influence decisions in respect of actions that will positively impact on drug misuse and underage drinking, but which fall outside their direct sphere of influence. For example, some RDTFs have called for liaison or co-operation with other agencies, such as county development boards, community forums, or social inclusion measures working groups, in pursuit of common goals, or for lobbying, for example for community facilities.

Co-ordinating drugs initiatives *(continued)*

Service design

Two 'clientcentric' approaches to service design have been championed by various RDTFs – a case-based approach, and a broader approach predicated on the need to address drug misuse in the context of wider social inclusion issues. Both these approaches require real and effective co-ordination.

Taking their lead from Action 47 of the National Drugs Strategy,[5] several RDTFs call for the delivery of case-based treatment and rehabilitation services. The 'key worker' role, supporting the service user through the various stages of treatment and rehabilitation, is seen as a necessary element of the case-based approach. In one RDTF strategy, the key worker is to be a member of a multi-agency group, which is to meet monthly to review cases, and all the agencies are to sign up to a protocol for working together in a case-based model. It is anticipated that this arrangement will lead to a co-ordinated continuum of care for clients.

In considering drug-related service design within the wider framework of social inclusion policy, one RDTF argues that it is important to tailor service developments to fit the needs of groups that are marginalised, disadvantaged or isolated. Such an approach may also overcome difficulties in co-ordinating responses: 'One route to tackling coordination problems at local level would be to focus on outcomes for socially excluded target groups and to work towards a problem-solving agenda where a common problem is identified and a strategy to address this jointly agreed.'[6] This may include addressing 'protective' factors, such as fostering strong and healthy communities, or providing good social or transport infrastructure, as much as 'risk' factors, such as treatment and rehabilitation initiatives.

An interesting feature of these clientcentric approaches to service design is the opportunity they afford service users, as distinct from providers, to drive the co-ordination effort. *(Brigid Pike)*

Several RDTFs call for the delivery of case-based treatment and rehabilitation services.

1. Department of Tourism, Sport and Recreation (2001) *Building on experience: National Drugs Strategy 2001–2008.* Dublin: Stationery Office, Actions 92–94.
2. National Drugs Strategy Team (2004) 'Guidelines for the Development of RDTF Strategy Plans'. Unpublished. Dublin: National Drugs Strategy Team, p. 1.
3. This survey is a sequel to the broad policy overview of the 10 RDTF strategies published in Issue 20 of *Drugnet Ireland.* See B Pike (2006) 'RDTF strategies push out boundaries'. *Drugnet Ireland,* Issue 20, pp. 11–12.
4. National Drugs Strategy Team (2004) 'Guidelines for the Development of RDTF Strategy Plans'. Unpublished. Dublin: National Drugs Strategy Team, p. 3.
5. Action 47 of the National Drugs Strategy reads: 'To base plans for treatment on a "continuum of care" model and a "key worker" approach to provide a seamless transition between each different phase of treatment. This approach will enhance movement through various treatment and aftercare forms. In addition, the "key worker" can act as a central person for primary care providers (GPs and Pharmacists) to contact in connection with the drug misuser in their care.'
6. Western Region Drugs Task Force (2006) *Shared solutions: First strategic plan of the Western Region Drugs Task Force.* Castlebar: Western Region Drugs Task Force, p. 42.

Ana Liffey after 25 years

The Ana Liffey Drug Project (ALDP) marked its 25th anniversary with a conference on 15 March entitled Harm Reduction for Problem Drug Users. The conference was held in Trinity College Dublin. Among those speaking at the conference were Dr Tim Rhodes, Centre for Research on Drugs and Health Behaviour, London School of Hygiene and Tropical Medicine.

In 1982 ALDP began providing a new type of service to drug users and their families in Dublin's inner city. The values underpinning this service – respect, welcome, participation and right – are as relevant today, even though the organisation has gone through a great deal of change since it first began to provide an alternative to the dominant abstinence-focused health and social services model. The Trinity conference looked at the development of ALDP over the past 25 years as the harm reduction approach, which originally placed ALDP well outside the mainstream of service provision, has gradually become accepted as a pragmatic and appropriate response to problem drug use in Ireland. *(Brian Galvin)*

ALDP has recently launched a website providing information on its services (www.aldp.ie/).

Libraries supporting a community response to addiction

The Library Association of Ireland is celebrating Library Ireland Week from 5–11 March 2007. Library Ireland Week 'celebrates and highlights the role of libraries, librarians and information professionals'.

A special library, by definition, maintains a more focused and specialised collection than traditional public or academic libraries. While researchers and practitioners based in larger organisations generally have access to a wide variety of library resources, access students and community-based organisations often find it difficult to locate specialised resources.

Many community-based organisations have developed substantial collections of resources which are generally made available to those who use their services. In this issue of *Drugnet Ireland,* in recognition of Library Ireland Week, we are featuring two specialist libraries; both are community based and located in Dublin.

> When someone needs help, the library is one of the few places where they feel comfortable. Going to a treatment centre may be a much scarier step. (Barbara Gay, Iowa Substance Abuse Information Centre)[1]

URRÚS

URRÚS is a Ballymun Youth Action Project (BYAP) initiative which provides training in relation to drug misuse. Founded in 1996, URRÚS aims to be a centre of learning and excellence and to develop and increase personal skills, effectiveness and employment potential. URRÚS has developed a range of training modules on drug abuse, addiction and community responses. Course participants include members of the community, Health Service Executive, community workers, gardaí, juvenile liaison officers and prison workers. URRÚS offers a range of one-day courses:

- Homelessness and Drugs
- Crack Cocaine
- Drug Use and Stress

Other courses are offered on a part-time basis over a longer period of time:

- Introduction to Addiction Studies
- Community Addiction Studies
- Diploma in Community Drugs Work (accredited by University College Dublin)

BYAP has recently moved to new premises in the Horizons Centre on Balcurris Road in Ballymun. In the new centre URRÚS has two dedicated training rooms, a dedicated library and staff offices all in one location.

Gabrielle Gilligan, (URRÚS Administrator) and Frantisek Anderko (library volunteer) in the URRÚS Library

The URRÚS library is a unique resource which supports the work of URRÚS, BYAP, students taking courses through URRÚS and all people living, working and studying in Ballymun. It is a reference library; items cannot be borrowed, but the full collection is available to users on the premises. The collection includes government publications, journals and magazines, international reports, text books, DVDs, video, electronic documents and local drug awareness publications and pamphlets. The collection covers a wide range of addiction-related topics, including counselling, health, family support, drug policy, education and training. Library users have access to a work station with a desktop computer, and an additional dedicated study desk. URRÚS staff are on hand to guide users to relevant resources.

Community Response

Community Response is a voluntary agency based in Dublin 8. The agency believes that the problem of drug use is best addressed by empowering individuals in the community through sharing knowledge, information and skills. Its training and education programmes include:

- Certificate in Addiction Studies (provided at Liberties College and accredited by NUI Maynooth)
- Behavioural studies programme (FETAC level 5)
- Workshops on addiction in the home, domestic violence and living with AIDS

Community addiction libraries *(continued)*

Deborah Taggart and Nicola Perry of Community Response in the Tommy Larkin Library

As well as providing substantial training and education programmes, Community Response supports a large outreach team that focuses on hepatitis C, HIV, health promotion, drug education, community development and family support.

The Community Response Library was set up in 2002 and was dedicated to the late Tommy Larkin in 2006. As well as a substantial collection of text books, government publications, annual reports, newsletters, pamphlets and news clippings, the library holds a large collection of material on hepatitis and HIV. Two computer workstations are available to users, providing free internet access and printing services. Library users also have access to a dedicated study desk and Community Response staff are available to guide users through the available resources. The library is frequently used for training workshops and as a meeting venue for the local drugs task forces.

Both libraries provide a wide range of addiction-related resources and are used by the community, students and practitioners undertaking further education and training in the addictions. 'Libraries are more than just books', says Sterphanie Asteriadis, Nevada Prevention Resource Centre Coordinator (USA). 'The more integrated they are into the community system, the more they can connect people with resources, and the better they serve their community.' [1]

Many thanks to Gabrielle Gilligan, Dermot King, Frantisek Anderko and Greg Christodoulu of URRÚS and to Derek Byrne, Deborah Taggart, May Peters and Nicola Perry of Community Response for welcoming me to their libraries. *(Louise Farragher)*

1. Perdue M (2006) A critical need: libraries can play a role in helping people with substance abuse problems. *American Libraries,* 37(3): 42–43.

URRÚS Library

URRÚS
Horizons Centre, Balcurris Road
Ballymun, Dublin 11
Tel: (01) 846 7980
Email: urrus@iol.ie

Tommy Larkin Library

Community Response
Carman's Court
14 Carman's Hall, Dublin 8
Tel: (01) 454 9772
Email: commresp@iol.ie

Please telephone in advance to make an appointment to visit the library.

Do you have an addiction resource library?

The National Documentation Centre on Drug Use is interested in making contact with you to develop an Irish network of addiction libraries and information centres.

Please contact Louise Farragher by phone at (01) 676 1176 ext 159 or by email at louise@hrb.ie for further information.

'When someone needs help, the library is one of the few places where they feel comfortable. Going to a treatment centre may be a much scarier step.' (Barbara Gay)

Eighth annual Service of Commemoration and Hope

The eighth annual Service of Commemoration and Hope, organised by the Family Support Network, was held in Our Lady of Lourdes Church on Sean McDermott Street on 1 February. This annual service is held in remembrance of loved ones lost to drugs and related causes and to publicly support families living with the devastation that drug use causes. This year's service focused on the Network's movement towards becoming an autonomous organisation. It has always been the intention that the Network would be run by families for families.

Sadie Grace of the Family Support Network highlighted the issue of intimidation, punishment beatings and shooting of drug users and innocent people. She urged communities to co-operate with the gardaí and stressed that the best way to make communities safer to live in is to work in partnership with all key stakeholders in dealing with this very contentious issue. The Family Support Network pledged its commitment to be part of this process.

Representatives from family support groups around Ireland attended the service. The Network would like to assist more family support groups to set up throughout the country. Ms Grace called on the government to deal more urgently with the drugs issue. She stated that if the three-year working plan the Network has submitted to the National Drugs Strategy Team is resourced, the Network will be able develop a professional service for families living with drug use throughout Ireland and continue the valuable work it has started.

Ruaidhri McAuliffe and Emily Reaper addressed the audience on behalf of UISCE (Union for Improved Services, Communication and Education). They acknowledged the role that families play in both the treatment of and recovery from drug addiction. They said that, by working together, both UISCE and the Network had become more aware of the problems facing drug users and their families.

Photo: Jim Berkeley

Noel Ahern TD, Minister of State with responsibility for drugs strategy, and Bishop Eamonn Walshe also addressed the gathering. They both acknowledged the work and commitment of the Network and reiterated the importance of working in partnership to decrease drug-related deaths. *(Ena Lynn)*

The Family Support Network was established by the CityWide Drugs Crisis Campaign (www.citywide.ie).

Photo: Jim Berkeley

ROSIE Findings 2: summary of detoxification treatment outcomes

As reported in issue 19 of *Drugnet Ireland,* the Research Outcomes Study in Ireland (ROSIE) released Findings 1 in September 2006. The study is being done by a team at the National University of Ireland, Maynooth, on behalf of the National Advisory Committee on Drugs (NACD). The aim of the study is to recruit and follow opiate users entering treatment and to document their progress after six months, one year and three years.

At baseline, the study recruited 404 opiate users aged 18 years or over entering treatment or, in the case of a sub-sample of 26 (6%), attending needle-exchange services. The participants were engaged in one of three different forms of treatment: methadone maintenance/reduction (53%, n=215), structured detoxification (20%, n=81) and abstinence-based treatment (20%, n=82).

The second paper in the ROSIE Findings series provides a summary of the outcomes for people in the detoxification modality one year after treatment intake.[1]

As the authors state, 'structured detoxification is a process whereby individuals are systematically and safely withdrawn from opiates, under medical supervision'. In Ireland, the most common method of opiate detoxification is to use methadone and to reduce the dose slowly over time. Structured detoxification programmes are provided in both inpatient and outpatient settings and usually last between four and twelve weeks.

The majority of the ROSIE detoxification cohort (n=81) was recruited from inpatient settings (56%, n=45), with the remainder being treated in outpatient settings (27%, n=22) or in prison (17%, n=14). The analysis presented in Findings 2 is based on the 62 participants who provided valid answers to each individual question during their treatment intake and one-year follow-up interviews.

The detoxification participants were typically male (77%) with an average age of 26 years and were largely dependent on social welfare payments (73%). Just less than half (47%) had children but the majority (62%) of these did not have their children in their care. Most had spent some time in prison (70%) and 11% had been homeless in the 90 days prior to treatment intake interview.

Treatment completion rates

The treatment completion rate was high, with 68% of participants successfully completing their detoxification programme (n=42). Just over one-quarter of the cohort (27%, n=17) dropped out of treatment and the remaining 5% (n=3) were transferred to another treatment type before completing the programme.

One year after treatment intake, 73% of participants (n=45) reported that they were in some form of drug treatment. Forty-two per cent (n=26) were on a methadone programme, 34% (n=21) were attending one-to-one counselling and 24% (n=15) were attending group work (Narcotics Anonymous (NA) meetings, aftercare programmes and structured day programmes).

Drug-use outcomes

The number of participants who reported using heroin, non-prescribed methadone, non-prescribed benzodiazepines, cocaine, cannabis or alcohol in the 90 days prior to interview decreased between treatment intake and one-year follow-up. The most substantial reduction was in heroin use, both in terms of the proportion of participants using the drug (79% at treatment intake compared with 39% at one year) and the frequency of use (an average of 38 out of 90 days at treatment intake compared with an average of 14 out of 90 days at one year).

Reported illicit drug abstinence rates increased from 8% at treatment intake (n=5) to 45% at one year (n=28). Abstinence from all drugs (including prescribed methadone) increased from 5% at treatment intake (n=3) to 39% at one year (24).

Crime outcomes

Overall, the proportion of participants who reported no involvement in crime had risen considerably at one year (75%) compared to treatment intake (19%). There was a reduction in the percentage of participants involved in acquisitive crime, from 35% (n=21) at treatment intake to 7% (n=4) at one year.

Risk-behaviour outcomes

Findings 2 reports a reduction in the number of participants who reported injecting drug use. At treatment intake 48% (n=30) of the cohort had injected a drug in the 90 days prior to interview, compared with 23% (n=14) at one year. A statistically significant decrease in injecting was reported for heroin and cocaine. There were no changes in participants' injecting-related risk behaviours. The proportion of participants who reported an overdose within the previous 90 days reduced from 5% (n=3) at treatment intake to 0% at one year. However, one participant from the detoxification modality died before the one-year follow-up. This is thought to have been due to an overdose but the cause of death has not yet been independently confirmed.

Health outcomes

Ten symptoms were used to measure the physical health of participants (see paper for details). The number of participants who reported seven of the ten physical health symptoms reduced between treatment intake and one year. As would be expected, there was a reduction in the number of

The treatment completion rate was high, with 68% of participants successfully completing their detoxification programme.

Findings 2 reports a reduction in the number of participants who reported injecting drug use.

ROSIE Findings 2 *(continued)*

The outcomes for ROSIE participants in detoxification treatment are positive when compared with national and international research.

participants reporting opiate withdrawal symptoms between treatment intake and one year.

Ten symptoms were also used to measure the mental health of participants (see paper for details). There was a reduction in the number of participants who reported suffering from any five of the ten mental health symptoms. Most of the reductions were in anxiety-related symptoms. While there were reductions in the remaining depressive-type symptoms, the results were not statistically significant.

Service contact

Findings 2 reports an increase in participants' contact with three social care services between treatment intake and one year. The proportion of participants contacting social services increased from 2% to 10%, those using employment/education services rose from 13% to 35% and the proportion contacting housing/homeless services increased from 19% to 23%.

The authors state that the findings presented in this paper demonstrate that participation in a detoxification programme is followed by reduced drug use and injecting, decreased involvement in crime, improved physical and mental health and increased contacts with social care services. The outcomes for ROSIE participants in detoxification treatment are positive when compared with national and international research. As noted in the paper, detoxification is part of a process that enables individuals to engage in further treatment (such as residential rehabilitation). Additional analysis of the ROSIE data is required in order to determine the effects of aftercare or follow-on interventions on treatment outcomes for those who have successfully completed a detoxification programme. *(Sarah Fanagan)*

1. Cox G, Comiskey C and Kelly P (2007) *ROSIE Findings 2: Summary of 1-year outcomes: detoxification modality.* Dublin: National Advisory Committee on Drugs.

Young Scientist codeine study wins HRB prize

Aine Keating and Annie McCole from Coláiste Ailigh, Donegal, won the Health Research Board prize for the best health-related project at the BT Young Scientist Exhibition held in January 2007 at the RDS in Dublin.

The aim of their project was to highlight the ongoing problem of codeine addiction in Ireland. They contacted 120 pharmacies in Dublin, and in the west and north-west of Ireland, of which 83% responded to their survey. One hundred questionnaires were analysed. They interviewed two pharmacists and contacted various interest groups, including the Irish Pharmaceutical Union, the Irish Medicines Board, Cork University and GlaxoSmithKline.

Results of their survey show that soluble Solpadeine, which contains codeine, is the most common non-prescription medical product sold in the pharmacies surveyed, followed by Neurofen Plus, which also contains codeine.

The majority of pharmacists surveyed (94%) believed that some customers, estimated at an average of four per day, who purchased products containing codeine were addicted to codeine. Seventy-two per cent of the pharmacists would like to see a change in the legislation to limit the quantity of codeine that can be sold over the counter.

As a result of their survey, the students concluded that 'codeine addiction is a widespread problem around Ireland'. *(Ena Lynn)*

Dr Mairéad O'Driscoll (HRB) presents the prize for the best health-related project at the BT Young Scientist Exhibition 2007 to Aine Keating and Annie McCole from Coláiste Ailigh, Donegal.

Hepatitis surveillance in 2005

According to the Health Protection Surveillance Centre (HPSC) annual report for 2005,[1] there were 1,439 cases of hepatitis C reported in 2005, compared to 1,154 cases in 2004,[2] and 85 cases of hepatitis 'type unspecified'[3] in 2003. Of the cases reported in 2005, over 70% were notified by services in Dublin, Kildare and Wicklow and the remainder by HSE areas outside these counties. Age-standardised hepatitis C rates per 100,000 of the population living in each former health board area were calculated for 2004 and 2005 (Figure 1). In 2005, the rate was highest in the Eastern Region (at 69 per 100,000) and lowest in the North West (at 2 per 100,000). The rate of hepatitis C cases per 100,000 of the population increased in each of the former health board areas. Sixty-four per cent of hepatitis C cases reported were male. Of the cases for whom age was known, 80% were aged between 20 and 44 years. Data from blood-borne viral prevalence studies indicate that around 70% of injecting drug users attending drug treatment tested positive for antibodies to the hepatitis C virus.[4] Injecting practices and prison history are associated with hepatitis C status.

It is proposed to introduce an enhanced surveillance system for hepatitis C in Ireland in 2007. Enhanced surveillance is essential to identify risk factors and for planning prevention and treatment strategies. Risk-factor identification is required to fulfil the basic requirements of the European Monitoring Centre for Drugs and Drug Addiction key indicator on drug-related infectious diseases.

In 2004, an enhanced surveillance system was introduced to monitor risk populations diagnosed with acute or chronic hepatitis B. The number and proportion of chronic cases for whom risk-factor data were reported were very low in 2004 and 2005. Of those for whom risk-factor data were reported, the numbers reporting injecting drug use were very small (Table 1). These low numbers could indicate that an effective immunisation programme prevented many injecting drug users from contracting hepatitis B, or that drug treatment service providers were not aware of the need to report the risk factor status of chronic hepatitis B cases. The situation is likely to be due to a combination of both factors as one in five injecting drug users has hepatitis B, while, on the other hand, many injecting drug users in Dublin receive hepatitis B vaccine.[4] *(Jean Long)*

1. Health Protection Surveillance Centre (2006) *Annual report 2005.* Dublin: Health Service Executive.
2. Health Protection Surveillance Centre (2005) *Annual report 2004.* Dublin: Health Protection Surveillance Centre.
3. Disease category under which hepatitis C cases were notified up to the end of 2003.
4. Long J (2006) *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005.* Overview 4. Dublin: Health Research Board.

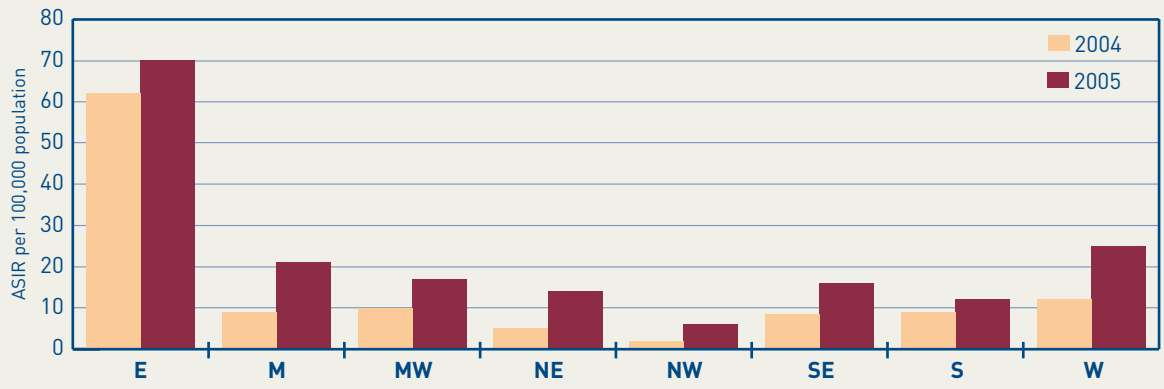

Figure 1 Age-standardised infection rates of hepatitis C per 100,000 population, by HSE area, 2004 and 2005

Source: *HPSC (2006)*

Table 1 Number (%) of acute and chronic hepatitis B cases reported to the HPSC, by risk factor status, 2004 and 2005

	Hepatitis B status					
	Acute	Chronic 2004	Unknown	Acute	Chronic 2005	Unknown
Risk factor status	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Total number of cases	57	497	169	74	706	124
Cases *with* reported risk factor data	36	95	1	49	185	13
Of which:						
Injecting drug users	57 (2.8)	0 (0.0)	0 (0.0)	0 (0.0)	3 (1.6)	1 (7.7)
Cases *without* reported risk factor data	21 (36.8)	402 (80.9)	168 (99.4)	25 (33.8)	521 (73.8)	111 (89.5)

Source: *Unpublished data from the HPSC*

Alcohol treatments: review of effectiveness

Those who seek treatment have typically experienced prolonged alcohol-related problems in health, relationships and finances.

In November 2006 the National Treatment Agency for Substance Misuse in the UK published a report reviewing the effectiveness of treatments for alcohol problems.[1]

Alcohol use exists along a continuum from problem-free use to very harmful and dependent use. A significant proportion of those who develop alcohol problems in the general population recover without formal treatment, but by responding to support and direction from family and friends or to self appraisal of the problem drinking. Those who seek treatment have typically experienced prolonged alcohol-related problems in health, relationships and finances and have had previous, failed, unassisted attempts at changing drinking behaviour.

Traditionally, alcohol treatment has had a narrow focus, concentrating on 'alcoholics' or those with severe alcohol dependence. It is now recognised that this exclusive focus needs to be broadened to include the large group of drinkers whose problems are less severe. Early intervention, before excessive drinking has produced a level of alcohol dependence that renders treatment difficult, is associated with better outcome and cost effectiveness. Treatments for harmful and hazardous drinkers may involve providing brief treatment or information and advice in an out-patient setting, whereas treatment for problem or dependent drinkers may involve complicated detoxification in residential settings (Figure 1).

Early detection is essential to identify problem drinkers who have not sought help, and targeted rather than universal screening is recommended. Screening instruments include questionnaires, biological markers of recent alcohol consumption and clinical indicators using clinical history or signs at physical examination. The AUDIT (Alcohol Use Disorders Identification Test) questionnaire has good sensitivity and specificity for detecting hazardous and harmful drinking and has been validated for use in a wide range of settings and populations.

The types of treatment available can be categorised into three groups – psychosocial treatment, non-alcohol-focused specialist treatment and pharmacotherapies. Psychosocial treatments typically focus on helping clients both to develop better skills and to improve their environment, and those with a clear structure and well-defined interventions have positive effects on alcohol problems. Non-alcohol-focused specialist treatments include coping skills, counselling, family work and complementary therapies and have a strong evidence base. Pharmacotherapies treat alcohol problems with drugs, including detoxification medications, relapse-prevention medications and nutritional supplements.

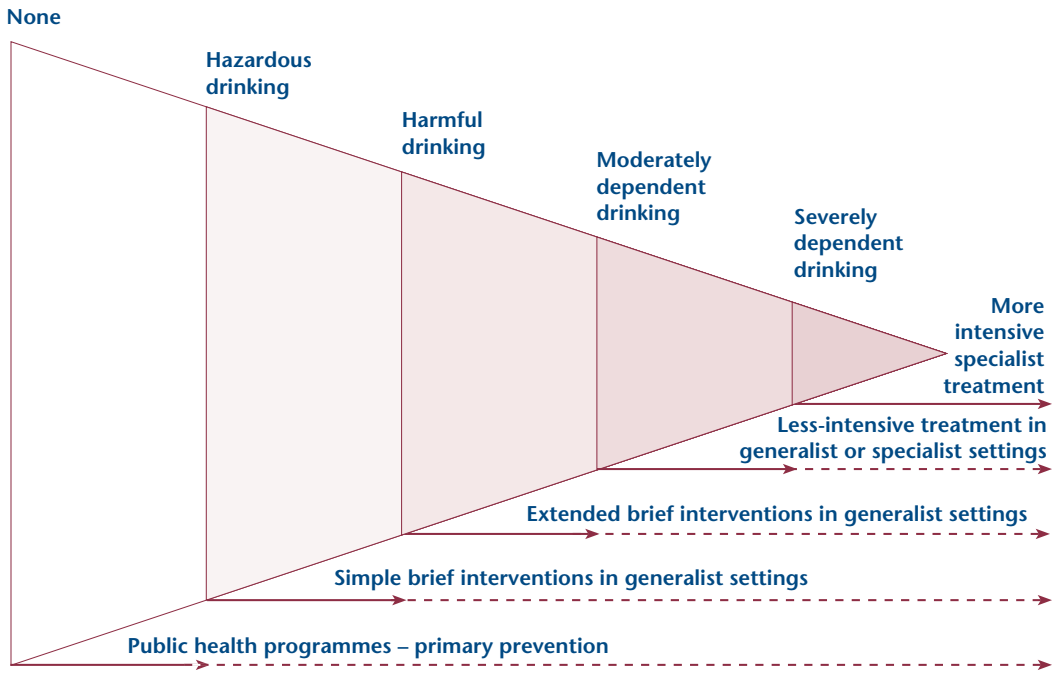

Figure 1 A spectrum of responses to alcohol problems

Source: *Rastrick et al. (2006),[1] adapted from Institute of Medicine (1990).[2]*

Alcohol treatments *(continued)*

The Mesa Grande is a type of league table based on accumulated evidence of treatment effectiveness from controlled trials and is useful as a broad indicator of which treatments are supported by research evidence. The treatments deemed most effective by this method fall mainly under the heading of 'cognitive-behavioural therapy', a psychosocial treatment based on social learning therapy. There is strong evidence for the effectiveness of this therapy among those with severe drinking problems. Two kinds of pharmacotherapy are also well supported by research evidence – acamprosate and naltroxone – but are best regarded as adjuncts to psychosocial treatment.

Brief interventions are given the highest rank in the Mesa Grande and are directed at hazardous and harmful drinkers who, typically, are not complaining about or seeking help for an alcohol problem. They are carried out in general community settings and are delivered by non-specialist personnel. Brief interventions, of various forms and delivered in a variety of settings, are effective in reducing alcohol consumption to low-risk levels, but most healthcare professionals have yet to incorporate screening and brief interventions for hazardous and harmful drinking into their routine practices.

Less intensive treatments are aimed at help-seekers and are usually delivered by specialist workers in alcohol treatment agencies. They are intended mainly for moderately dependent drinkers and are cheaper to deliver than conventional, more intensive treatments. These treatments often involve the participation of relatives and friends in the treatment process. Examples of such treatments include motivational interviewing, motivational enhancement therapy, brief conjoint marital therapy and condensed cognitive behavioural therapy. Motivational enhancement therapy is ranked second in the Mesa Grande.

For service users with moderate or severe alcohol dependence, alcohol-focused treatments in specialist alcohol or addiction services are most appropriate. The cognitive behavioural family of interventions is well researched and is shown to be effective for this group of service users. These treatments concentrate on the service user's drinking and alcohol-related problems and are best deployed in community settings where the service user has the opportunity to try out newly learned behaviour in the real environment and get immediate feedback on performance. Examples include community reinforcement approach, social behaviour and network therapy, behavioural self-control training and coping and social skills training.

Pharmacotherapies are generally targeted at a narrow spectrum of symptoms or psychological problems and are usually insufficient to constitute a treatment package when given alone. Pharmacotherapies, when combined with psychosocial therapies, consistently improve addiction outcomes. Detoxification is a common procedure which may be undertaken in any treatment setting and chlordiazepoxide is the drug of choice for uncomplicated detoxification. Relapse-prevention medication includes sensitising agents which produce an unpleasant reaction when taken with alcohol, and anti-craving medications which act upon endogenous neurochemical systems to reduce alcohol cravings. An example of a sensitising agent is disulfiram, while naltrexone and acamprosate are examples of anti-craving medications.

There is no best treatment or intervention for alcohol problems. Rather, there is a range of effective treatments for different types of service user in different settings. People whose problems are more complex by virtue of severe dependence, psychological morbidity or social disorganisation are likely to need more intensive treatments. The selection of which treatment to offer therefore depends on clinician preference, client choice and availability of trained and enthusiastic therapists. Effective treatment requires a delivery system that has the following three components: organisational support to clinical services, well-trained therapists and a repertoire of specific interventions that meet service users' needs. The stepped-care model of treatment represents a cost-effective implementation of treatment services. The basic principle of this approach is that alcohol misusers are initially offered the least intrusive and least expensive intervention that is likely to be effective.

Providing effective treatment is likely to significantly reduce the social costs relating to alcohol as well as improving individual social welfare. The variation in the course of alcohol problems over time means it is a better investment to spend fewer healthcare resources during each contact with the service user, while allowing the intervention to extend over a longer period. Although healthcare costs may increase in the short term for drinkers who have not accessed healthcare services prior to alcohol treatment, they are likely to decrease thereafter. It is claimed that for every £1 spent on treatment in the UK, £5 is saved elsewhere, making alcohol treatment highly cost effective in comparison with other healthcare interventions. *(Deirdre Mongan)*

1. Raistrick D, Heather N, Godfrey C (2006) *Review of the effectiveness of treatment for alcohol problems.* London: National Treatment Agency for Substance Misuse.

2. Institute of Medicine (1990) *Broadening the base of treatment for alcohol problems.* Washington DC: National Academies Press, Figure 9.1.

Most healthcare professionals have yet to incorporate screening and brief interventions for hazardous and harmful drinking into their routine practices.

The stepped-care model of treatment represents a cost-effective implementation of treatment services.

The evidence base for treatment of problem cocaine use

Introduction

Cocaine is a central nervous system stimulant that leads to immediate but short-term euphoria, alertness and a sense of well-being. It may also reduce anxiety and social inhibitions while increasing energy and self-esteem. For the user, the desire for the positive short-term effects of cocaine often overrides concern about the longer-term consequences of acquiring and using the drug. Cocaine dependence is a common and serious condition which has become a substantial public health problem. There is a wide and documented range of consequences associated with chronic use of cocaine, such as medical, psychological and social problems.

On 3 May 2006 the Heath Service Executive (HSE) organised a workshop on cocaine. Dr Brion Sweeney, clinical director of the HSE Northern Area Addiction Services, presented the evidence base for the treatment of problem cocaine use and stated that cognitive behavioural therapy in conjunction with other interventions was the most successful form of treatment. He went on to state that prompt, accessible and tailored interventions increased the effectiveness of such treatment. He pointed out that the evidence indicated that medication had limited effect in the treatment of cocaine dependence, but said that new developments were expected in this area.

This article presents details of the summary evidence presented at the workshop. Where possible, the evidence is based on systematic reviews.[1] A systematic review is an overview of primary studies that used explicit and reproducible methods.

Indicators

The indicators used to measure the success of treatment for problem cocaine use are: the absence of drug metabolites in the urine during and following treatment; retention in and completion of treatment interventions; and attendance at aftercare.

Treatment

Therapeutic management of people addicted to cocaine is based on abstinence from cocaine use. In the initial period following cessation, the person being treated may experience an intense craving for cocaine, and symptoms such as depression, fatigue, irritability, anorexia and sleep disturbance. The past decade has seen a sustained search for an effective medication for the management of cocaine dependence.

Medications

A number of studies have concentrated on finding a medicine to alleviate depression associated with cocaine use and to reduce cocaine craving. Lima and colleagues[2] completed a systematic review of 18 randomised control trials on the use of **antidepressants** in treating cocaine dependence. The authors found that trials had not shown that antidepressants helped reduce cocaine dependence, although this might have been partly because many people stopped using the antidepressants too early. More people might have benefited if they had continued to use antidepressants for an appropriate period of time. The findings and recommendations were similar for cocaine users who were also dependent on heroin or were on methadone programmes. Individuals attending methadone treatment programmes may benefit from supervised consumption of anti-depressants and this approach should be tested using an appropriate research method.

Because chronic use of cocaine decreases dopamine concentrations in the brain, it was thought that pharmacological treatment that controlled dopamine levels could theoretically reduce these symptoms and contribute to a more successful therapeutic approach. Soares and colleagues[3] evaluated the efficacy and acceptability of **dopamine agonists** for treating cocaine dependence through a systematic review of 17 studies. The authors reported that dopamine agonists had been used for reducing the symptoms that patients experienced during the initial period of abstinence from cocaine. This review of trials found that the evidence of success was not adequate to support the use of dopamine agonists as a treatment for cocaine dependence.

The anti-convulsant **carbamazepine** (a tricyclic medication that is widely used to treat a variety of neurological and psychiatric disorders) has been used for treatment of cocaine dependence. Lima-Reisser and colleagues[4] examined whether carbamazepine was effective in the treatment of cocaine dependence through a systematic review of five studies. The review of trials found that carbamazepine had not been shown to help reduce cocaine dependence. The drop-out rate from treatment was high, adverse effects were common, and there was no significant fall in the participants' cocaine use.

Silva de Lima and colleagues[5] reviewed the efficacy of pharmacotherapy in treating cocaine dependence. The drug treatments included in the trials were grouped into the following categories: antidepressants, carbamazepine, dopamine agonists, and miscellaneous other drugs. The miscellaneous treatments included naltrexone, mazindol, lithium, disulfiram, phenytoin, nimodipine, lithium carbonate, NeuRecover-SA and risperidone. The effects of these drugs were compared with each other or with a placebo. Seven studies were included in the review. The authors concluded that there was no current evidence to support the clinical use of most of these drugs, including **disulfiram**, in the treatment of cocaine dependence.

Acupuncture

Auricular acupuncture (insertion of acupuncture devices into a number of specific points in the outer ear) is a widely used treatment for cocaine dependence. Gates and colleagues[6] assessed its effectiveness in a review of seven study trials, all of which were of low methodological quality. The review

Treatment of problem cocaine use *(continued)*

found no evidence that auricular acupuncture was effective in the treatment of cocaine dependence. High-quality randomised trials of auricular acupuncture may be justified.

Therapeutic communities

Therapeutic communities are a popular treatment for the rehabilitation of drug users in the USA and Europe. In a review of seven studies, Smith and colleagues[7] examined the effectiveness of therapeutic communities compared to other treatments for substance misusers, and investigated whether their effectiveness was modified by client or treatment characteristics. Differences between the studies reviewed precluded any pooling of data; results were summarised for each trial individually. The authors concluded that there was little evidence that therapeutic communities offered significant benefits in comparison with other residential treatments, or that one type of therapeutic community was better than another. There was some evidence of reduced re-offending among prisoners who had participated in therapeutic communities while in prison. However, methodological limitations may have introduced bias to the studies, and firm conclusions could not be drawn due to the limitations of the existing evidence.

Cognitive behavioural therapy

Cognitive behavioural therapy is a system of psychotherapy which attempts to reduce excessive emotional reactions and self-defeating behaviours by modifying underlying erroneous thinking and maladaptive beliefs. According to experts in this area, the cognitive approach, when applied to substance abuse, helps individuals deal with the problems leading to emotional distress and gain a better perspective on their reliance on drugs. Specific cognitive strategies are said to help individuals establish stronger internal controls and reduce their urges to take drugs. In addition, cognitive therapy can help patients to combat depression, anxiety or anger, which increase addictive behaviours.

Since there were no systematic reviews in the Cochrane Library that examined the evidence of effectiveness of psychotherapeutic interventions (such as cognitive behavioural therapy) in the treatment of cocaine dependence, some individual studies were reviewed for the purposes of this article.

Crits-Christoph and colleagues[8] examined combinations of psychosocial treatments for cocaine dependence. They compared four different treatments – cognitive therapy, psychodynamic therapy, individual drug counselling, and group drug counselling alone. The first three treatments mentioned included group drug counselling along with the specific individual therapy. Treatments were intensive and provided over a six-month period. The clients were followed up at six and at twelve months. The authors found that, when compared to the two forms of psychotherapy and to group drug counselling alone, individual drug counselling plus group work showed the greatest improvement in the number of days the clients did not use cocaine over a one-month period. The authors were surprised by this finding because in 1991 Carroll and colleagues[9] reported that relapse-prevention therapy (a form of cognitive behaviour therapy) was more effective than interpersonal psychotherapy, and had higher abstinence and recovery rates. In 1994, Higgins and colleagues[10] reported that relapse prevention therapy with the addition of incentives was more effective than relapse prevention therapy alone. The clients who received incentives were more likely to complete their treatment and had a longer duration of cocaine-negative urines. Crits-Christoph and colleagues reviewed the evidence from the earlier studies mentioned and pointed out that the counsellors selected to participate in their study followed a detailed manual and provided intensive counselling with a strong focus on drug abstinence. They reported that psychotherapy was more effective in clients with psychiatric symptoms, and pointed out that their own study involved a relatively small number of such clients. In a follow-up analysis of the same cohort,[11] the authors noted that there was no difference between the four types of treatment in other important measures of success, such as psychiatric symptoms, alcohol use and employment rates, nor in relation to interpersonal, social and family issues.

Brief intervention

Bernstein and colleagues[12] conducted a randomised control trial to determine whether brief motivational counselling was more effective that written information in reducing cocaine use among clients attending an outpatient clinic in Boston. Six months following intervention, they found marginally higher rates of abstinence among those who attended brief motivational counselling than among those who received written information. For those reporting both cocaine and opiate use, the abstinence rates were 22% among those who were given brief motivational counselling, compared to 17% among those who received information; among cocaine users, the corresponding abstinence rates were 17% and 13% respectively. It is interesting to note that providing information on cocaine itself and its associated treatment options did encourage some respondents to seek help. Indeed, despite the title of this paper, the differences in abstinence rates for the two interventions were neither clinically nor statistically significant.

Vaccine

Hall and Carter[13] state that 'a **cocaine vaccine** is a promising immunotherapeutic approach to treating **cocaine** dependence which induces the immune system to form antibodies that prevent **cocaine** from crossing the blood brain barrier to act on receptor sites in the brain. The most promising application of a **cocaine vaccine** is to prevent relapse to dependence in abstinent users who voluntarily enter treatment'. Two published studies examined the use of cocaine vaccine among human populations.[14,15] Both studies showed some promising results; however, general availability of a cocaine vaccine is not imminent.

Management of cocaine dependence in the UK

The Drug Treatment Agency (DTA) in the UK emphasises a number of key practices which improve the success of cocaine treatment. According to the DTA, once the initial contact with a treatment service is made, rapid intake,

Treatment of problem cocaine use *(continued)*

proactive reminders, and practical help with attendance improve treatment uptake rates. Once cocaine users start treatment, they tend to stay longer and respond better if they feel that their concerns are being positively addressed and that their key worker is empathic and understanding. This indicates the crucial role that key workers play in motivating and retaining clients.

The above evidence and experience indicate that the following strategies would help cocaine users manage their dependence:

- Ensure seamless pathways through a four-tier service with clear strategies at each level.
- Provide information or brief intervention at accident and emergency, harm reduction and opiate treatment services. The information should cover the dangers of cocaine use, the symptoms of dependence and the treatment services available.
- Once contact is made with treatment services, ensure rapid intake, provide proactive reminders, and give practical help with attendance.
- Complete an assessment of the client's situation and needs.
- Address the client's immediate concerns and practical needs.
- Assign a key worker who is empathic and understanding.
- Develop basic criteria for assigning clients to either cognitive therapy or individual counselling.
- Ensure that extensive training and detailed manuals are available for those providing therapy and counselling (examples on the US National Institute on Drug Abuse website (www.nida.nih.gov).
- Enhance compliance with anti-depressant medication through directly observed treatment approaches and by dealing with complications as soon as possible.
- Consider the provision of incentives for particular client groups if and when necessary.
- Provide complementary therapies to enhance the client's' well-being, rather than dealing solely with their addiction.
- Include interventions implemented to address problem cocaine use in surveillance systems and research projects so as to add to the existing evidence base.

(Jean Long and Eamon Keenan)

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Trends in alcohol and drug disorders in psychiatric facilities

The latest annual report from the National Psychiatric In-patient Reporting System (NPIRs) on activities in psychiatric inpatient units and hospitals shows that the total number of admissions to inpatient care has continued to fall.[1] The report, *Activities of Irish psychiatric units and hospitals 2005,* was published in November 2006 by the Health Research Board (HRB) and is the latest in a series that began more than forty years ago.

In 2005, there were 2,995 cases admitted with an alcohol disorder, of whom 962 were treated for the first time.[1] Figure 1 presents the rates of first admissions to inpatient psychiatric services between 1990 and 2005 with a diagnosis of alcohol disorder, per 100,000 of the population.[1-4] It is notable that the rate decreased steadily between 1991 and 2004 and more than halved during the reporting period. The rate of new admissions stabilised in 2005. The trend since the early nineties reflects changes in alcohol treatment policy and practice during the period and the resultant increase in community-based and special residential alcohol treatment services. Of the 3,007 discharges with an alcohol disorder, just under 43% spent less than one week in hospital and 17% spent more than one month in hospital.

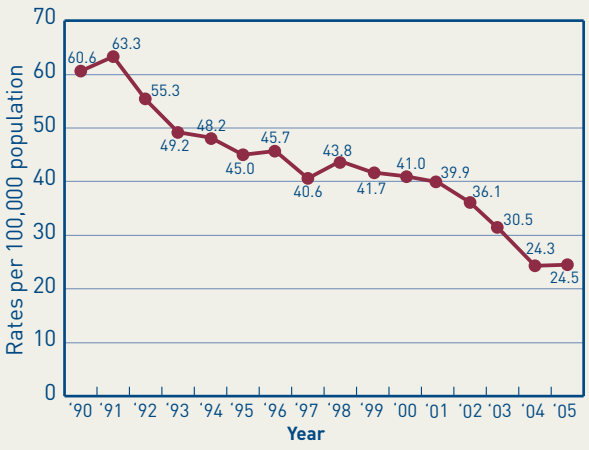


Figure 1 Rates of psychiatric first admissions with a diagnosis of alcohol disorder (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the NPIRS, 1990 to 2005

In 2005, there were 777 cases admitted with a drug disorder, of whom 308 were treated for the first time.[1] There are no data presented in the report on psychiatric co-morbidity. Figure 2 presents the rates of first admissions to inpatient psychiatric services between 1990 and 2005 with a diagnosis of drug disorder, per 100,000 of the population.[1-4] It is notable that the rate increased steadily between 1990 and 1995, with a dip in 1996, and further annual increases between 1997 and 2001. The rate was almost three times higher in 2001 than it was in 1990. The dips in 1996 and 2002 can be partly explained by the fact that the rates are calculated from new, larger census numerators in 1996 and 2002 compared to the year preceding each of these years. The small number of drug dependence cases each year would be sensitive to this change in numerator. The increasing rate of new cases of drug-related admissions between 1990 and 2001 reflects the increase in problem drug use in Ireland and its burden on the psychiatric services. There was a notable decrease in 2002, which was sustained in 2003. This overall decrease since 2001 possibly reflects an increase in community-based specialised addiction services during this period. The increased rate in 2005, partly accounted for by the diminishing denominator in the 2002 census, may reflect a failure of community-based specialised addiction services in Dublin to deal with drugs other than opiates, and of community-based specialised addiction services outside Dublin to deal with opiate users. Of the 818 discharges with a drug disorder, just under 45% spent less than one week in hospital and just over 19% spent more than one month in hospital. *(Jean Long)*

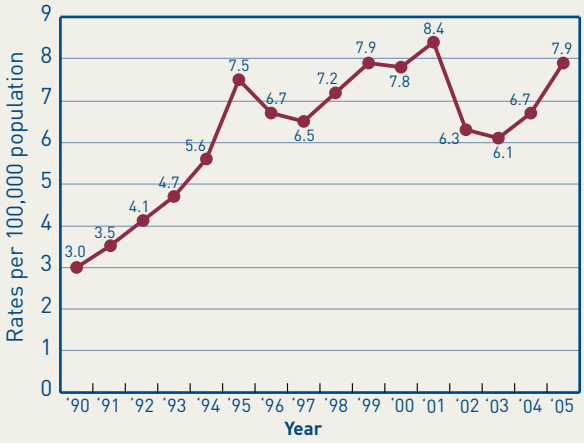
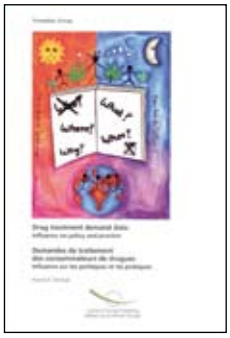


Figure 2 Rates of psychiatric first admissions with a diagnosis of drug disorder (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the NPIRS, 1990 to 2005

1. Daly A, Walsh D, Ward M and Moran R (2006) *Activities of Irish psychiatric units and hospitals 2005.* Dublin: Health Research Board.
2. Daly A, Walsh D, Moran R and Kartalova-O'Doherty Y (2004) *Activities of Irish psychiatric services 2003.* Dublin: Health Research Board.
3. Daly A, Walsh D, Comish J, Kartalova-O'Doherty Y, Moran R and O'Reilly A (2005) *Activities of Irish psychiatric units and hospitals 2004.* Dublin: Health Research Board.
4. Walsh D and Daly A (2004) *Mental illness in Ireland 1750–2002: reflections on the rise and fall of institutional care.* Dublin: Health Research Board.

The impact of drug treatment demand data on policy and practice



Determining whether research findings have influenced policy and practice is not easy. A recent publication by the Pompidou Group of the Council of Europe attempts to address this issue in relation to drug treatment demand data.[1]

The Pompidou Group has advocated the systematic and routine collection of information on clients entering treatment for problem drug use (treatment demand data) since the mid-1980s. During the early 1990s the Pompidou Group developed and tested a standard set of core data to be collected on a routine basis from drug treatment providers, using comparable procedures and criteria. As a result of this early work, a treatment demand protocol was developed and implemented in many European countries, while in other countries existing systems were adapted to become as comparable as possible with the Pompidou Group methodology.[2] The protocol and the experience gained through its application served as a starting point for the harmonisation of the treatment demand indicator in the EU by the European Monitoring Centre for Drugs and Drug Addiction.

Given that treatment demand data have been collected in many European countries for the best part of two decades, it is understandable that questions should be asked about how these data have been used to influence policy and practice development. The Pompidou Group publication takes a very pragmatic approach to answering this question. In order to establish the link between the use of treatment demand data and a subsequent policy or practice decision, it was necessary to have documentary evidence to support the connection. For example, a policy recommendation had to be supported or based on the findings of treatment demand data and a reference to this effect had to be evident in the relevant policy document.

Three case studies, one each from Ireland, Italy and Slovenia, are provided to illustrate this documentary link. The Irish case study is described below.

In July 1996, the Irish Government set up a Ministerial Task Force to review the measures to reduce the demand for drugs and, in the light of that review, to recommend changes in policy, legislation or practice to facilitate more effective drugs reduction strategies. In its first report,[3] published in October 1996, the Task Force recognised that Ireland's drug problem was primarily an opiates problem – mainly heroin – and, further, that Ireland's heroin problem was principally a Dublin phenomenon. Using maps produced by the Health Research Board's drug treatment reporting system showing the areas of residence of those receiving treatment for drug misuse in the greater Dublin area in 1995, the Task Force identified 10 local areas where the heroin problem was most acute. An additional, eleventh, area was identified in Ireland's second major city, Cork. It was noted that there was a high correlation between these areas and areas of economic and social disadvantage. The Task Force concluded that 'in view of the link between economic and social deprivation and drug misuse, strategies to deal with the problem need to be focused on these areas'. As a result, the Task Force recommended a series of drugs initiatives, one of which was the establishment of local drugs task forces comprising statutory, voluntary and community representatives, in each of the eleven worst-affected areas. Each local drugs task force was mandated to draw up a profile of all existing or planned services and resources available in the area to combat the drugs crisis and to agree a development plan to build on these.

The Government accepted the recommendations contained in the first report of the Ministerial Task Force and local drugs task forces were set up in 1997. In its second and final report, published in May 1997, the Ministerial Task Force identified a further two worst-affected areas in Dublin and recommended that local drugs task forces should be established in these areas also.[4]

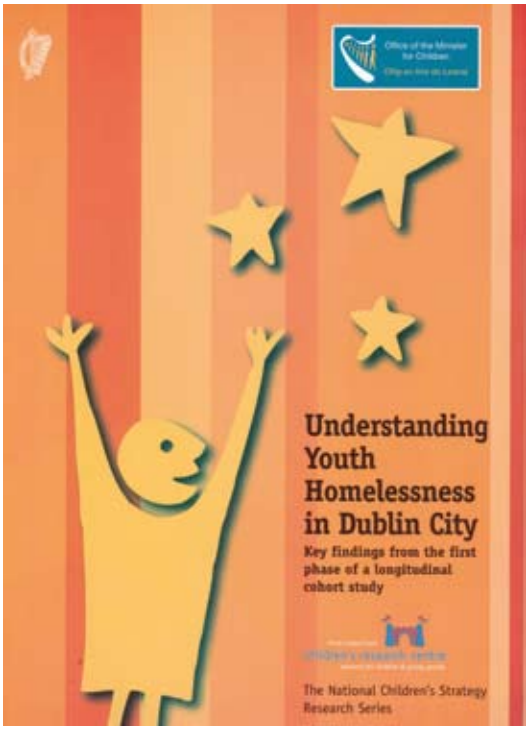
Today, local drugs task forces provide a mechanism through which local communities are able to work closely in partnership with the statutory sector to tackle local drug problems. Indeed, it is recognised that a critical factor in the success of the whole process was the involvement of local community groups since they 'brought to the table the most direct knowledge of the drugs issue at a local level and the most direct stake in improving the situation.'[5]

Local and, more recently, regional drugs task forces continue to use data from the National Drug Treatment Reporting System to monitor the drug situation in their areas and to plan services. *(Hamish Sinclair)*

Task forces continue to use data from the National Drug Treatment Reporting System to monitor the drug situation in their areas and to plan services.

1. Sinclair H (2006) *Drug treatment demand data: influence on policy and practice.* Strasbourg: Council of Europe.
2. Stauffacher M and Kokkevi A (1999) The Pompidou Group treatment demand protocol: the first pan-European standard in the field. *European Addiction Research,* 5: 191–6.
3. Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996) *First report of the Ministerial Task Force on measures to reduce the demand for drugs.* Dublin: Department of the Taoiseach.
4. Ministerial Task Force on Measures to Reduce the Demand for Drugs (1997) *Second report of the Ministerial Task Force on measures to reduce the demand for drugs.* Dublin: Department of the Taoiseach.
5. PA Consulting Group (1998) Evaluation of drugs initiatives. Department of Tourism, Sport and Recreation. Final report. Dublin: PA Consulting Group (unpublished).

Research on youth homelessness in Dublin



Recent research by Mayock and Vekic (2006)[1] presents data from the first phase of a two-phase longitudinal cohort study of young homeless people living in the Dublin metropolitan area. The research focused on young people living in Dublin for at least six months prior to the commencement of the study. The study used 'life history' interviews with 40 young people recruited through homeless services and street settings. In qualitative research when this method is used, interviewees are invited to tell their 'life stories', then the researcher invites them to explore in depth significant life events that are broadly related to the aims of the research. The aim of this technique is to uncover as far as possible the interviewees' interpretations of significant life events and to allow them to elaborate on issues that may not have figured in the initial research aims but nonetheless are viewed as relevant to the research.

The interviews were conducted between September 2004 and February 2005. Fifty per cent of the cohort was aged between 15 and 17 years. Nineteen of the cohort reported becoming homeless initially at the age of 14 or younger, while 12 initially became homeless at age 15. This would suggest that the early to mid-teen years is a period of great risk for becoming homeless.

The research identified three broad pathways into homelessness for the study cohort. The authors caution against interpreting these pathways as 'causes of homelessness', suggesting that they be viewed rather as key circumstances and experiences that appeared to push the young people towards homelessness.

- Household instability and family conflict of varying degrees figured largely in the experience of most of these young people from an early age. For example, parental discord and/or marital breakdown, the presence of a step-parent and parental alcohol and drug abuse figured prominently in the events leading to that initial experience of homelessness.
- Forty per cent of the cohort reported a history of state care of varied duration, moving between foster homes, residential care placements or residential placement homes. Their accounts of these experiences suggest that they did not integrate and, according to the authors, this instability produced exceptional vulnerability and deep resentment about their separation from parents and/or siblings.
- Negative peer association and problem behaviour were reported by some of the young people as contributing to poor relations with the family and caregivers. However, as the authors suggest, '[this] behaviour cannot be divorced from a range of other home based problems such as family illness, bereavement, conflict between parents or alcohol abuse by a parent' (p. 16).

At the time of interview, only eight of the cohort did not use illicit drugs, with the average age of first drug use being 11.5 years for the males and 13 years for the females. Fifty per cent of the cohort reported having used heroin, with almost all reporting their heroin use as problematic to the point of dependency. The majority of those who used heroin had first experimented with it after they became homeless.

The vast majority of the young people in this research had used or were using the Out Of Hours Service (OHS) in the city centre. This crisis service was set up to respond to the accommodation and care needs of homeless youth aged 18 or under. Young people can only access the service by going to a Garda station after 8pm. It is then the duty of the gardai to contact the OHS social work team who will determine where to place the young person in the emergency service if returning to the home is not an option. This means that these young people continue to move between city-centre hostels and become particularly vulnerable to exposure to alcohol and drug use, criminal activity and intimidation and bullying. According to the authors, 'this initial period of contact with the city centre homeless "scene" was a common point of initiation into a whole range of risky behaviours

Forty per cent of the cohort reported a history of state care of varied duration.

The majority of those who used heroin had first experimented with it after they became homeless.

Youth homelessness *(continued)*

and, within a relatively short period of time, a large number had become immersed in the street-based social networks' (p. 22).

For example, when exposed to the experience of homelessness over an extended period, young people became heavily involved in using drugs and committing crime on a daily basis to finance their drug use. According to the authors, this led to a process of 'acculturation' into the street scene where they 'learned the street competencies they need to survive by becoming embedded in social networks of homeless youths' (p. 23). However, some of the cohort who managed to avoid the transient nature of hostel life and remained in the one place for an extended period of time were able to escape the street homeless scene, avoid drug use and attend school.

This study provides a useful sociological insight into the lived experiences of young homeless people. The findings of this first phase, although in strict interpretative terms limited to this cohort, require attention from the various state agencies charged with preventing homelessness. Pillinger recommends this approach in the strategy on preventing homelessness.[2] Supported measures need to be put in place at local level, particularly in the Dublin suburbs, to prevent young homeless people congregating in the city centre and becoming involved in drug use and criminal behaviour. The advantages of a decentralised approach to homelessness in Dublin is that these young people are accommodated closer to their homes, can continue contact with their families, and can remain in school. *(Martin Keane)*

1. Mayock P and Vekic K (2006) *Understanding youth homelessness in Dublin city: key findings from the first phase of a longitudinal cohort study.* Dublin: Stationery Office.
2. Pillinger J (2006) *Preventing homelessness: a comprehensive preventative strategy to prevent homelessness in Dublin, 2005–2010.* Dublin: Homeless Agency.

Launch of Homeless Agency annual report 2005

The ultimate aim is to eliminate long-term homelessness and end the need for people to 'sleep rough' by 2010.

The Minister of State at the Department of the Environment, Heritage and Local Government with responsibility for Housing and Urban Renewal, Mr Noel Ahern TD, launched the 2005 annual report of the Homeless Agency[1] on 30 November 2006 at the agency's headquarters in Parkgate Hall, Dublin 8.

The report contains information on progress made on the strategic aims of the 2004–2006 action plan of the Homeless Agency, *Making it home.*[2] The ultimate aim is to eliminate long-term homelessness and end the need for people to 'sleep rough' by 2010. Examples of short-term progress outlined in the report include:

- a decrease of 19% in the number of households reporting as homeless recorded in Counted in 2005[3]
- the allocation of local authority social housing to 183 homeless households, and housing association social housing to 89 homeless households (out of a total of 1,644 allocations of social housing in 2005)
- the expansion of specialist healthcare services, including a pilot outreach service for people experiencing homelessness and alcohol issues in Ballymun
- the development of the Dublin City Tenancy Sustainment Service as a measure to prevent homelessness
- the completion of a large number of commissioned research and evaluation reports containing a range of recommendations that will be incorporated into the forthcoming Homeless Agency Partnership Action Plan 2007–2010.

Commenting on the activities of 2005 in the report, the outgoing director, Dr Derval Howley, noted that it was a year that presented a mix of successes and challenges. Mr Cathal Morgan has taken over as the new director of the Homeless Agency. I wish him every success in his new position. *(Martin Keane)*

1. Homeless Agency (2006) *Annual report 2005: making it home.* Dublin: Homeless Agency.
2. Homeless Agency (2004) *Making it home: An action plan on homelessness in Dublin 2004–2006.* Dublin: Homeless Agency.
3. Homeless Agency (2005) *Counted in 2005.* Dublin: Homeless Agency.

National Advisory Committee on Drugs – progress report

In January 2007 the National Advisory Committee on Drugs (NACD) published its second progress report,[1] presenting its goals and achievements from August 2003 to December 2005. The NACD advises the government in relation to the prevalence, prevention, treatment and consequences of problem drug use in Ireland, and it comes under the auspices of the Department of Community, Rural and Gaeltacht Affairs. In 2004, the government renewed the NACD's mandate and a new work programme was developed to cover the years 2005–2008.

The report comprises an overview of the NACD's background and functions, its current work programme, publications, communication, ongoing research and research-funding allocation, and the findings of an external review.

The NACD operates a broad-based committee system of experts drawn from relevant government departments, as well as from the statutory, community, voluntary, and academic agencies. Five sub–committees advise on the selection of research questions and the commissioning of research. The sub–committees cover the following aspects of drug use: consequences, early warning and emerging trends, prevalence, prevention and treatment/ rehabilitation.

In the period covered by the report, the NACD produced 19 publications as a result of commissioned or grant-aided research. The publications cover a range of drug-related subjects, including the first drug prevalence survey of Ireland and Northern Ireland, an overview of cocaine use in Ireland, drug use among the homeless and an examination of the role of family support services in drug prevention.

The NACD's ongoing commissioned external research programme is examining community studies, families' experiences of support, drug prevalence, treatment outcomes, the national Drugs Awareness Campaign and the opiate prevalence study. Final reports from these projects are expected. The NACD's internal research programme includes ongoing projects such as the Best Practice in Rehabilitation Briefing, the Drug Trend Monitoring System and interagency work for prevention.

An external review conducted in 2004 by Talbot Associates concluded that the NACD is effective and meets a real need. *(Louise Farragher)*

The NACD Progress report is available on the NACD website at www.nacd.ie

1. National Advisory Committee on Drugs (2006) *Progress report: August 2003–December 2005.* Dublin: Stationery Office.

In the period covered by the report, the NACD produced 19 publications as a result of commissioned or grant-aided research.

National Development Plan and the drugs issue

On 23 January 2007 the National Development Plan 2007–2013 (NDP) was launched.[1] Setting out the government's investment plans (€184 billion) for the next seven years, the NDP includes funding for measures to address the drugs issue under three of its five priority areas – Social Inclusion, Human Capital and Social Infrastructure. Some of this funding will support specifically drug-related measures, but larger amounts will support measures aimed at broader groups such as the socially excluded, the disadvantaged, the isolated, the vulnerable, those outside the mainstream educational system or 'distant from the labour market' – all categories in which drug misusers may be found.

Under the Social Inclusion Priority (€49.6 billion in total), the NDP earmarks €319 million for the 'National Drugs Strategy Sub-Programme', subsumed under the Local and Community Programme. Allocated on an annual basis through the Vote of the Department of Community, Rural and Gaeltacht Affairs (which has responsibility for the overall co-ordination of the National Drugs Strategy), this €319 million will be channelled mainly through two existing funding mechanisms – the drugs task forces and the Young People's Facilities and Services Fund (YPFSF). In respect of these two funding mechanisms, the NDP states:

- The range of projects being undertaken through the Local Drugs and Regional Drugs Task Forces will be developed and strengthened over the coming years. Strategic plans, developed by the Drugs Task Forces and based on the identified needs of the areas involved, will continue to be central to the effort to counteract the problems of drug misuse.

The NDP includes funding for measures to address the drugs issue under three of its five priority areas – Social Inclusion, Human Capital and Social Infrastructure.

NDP and the drugs issue *(continued)*

'The focus of drugs policy in the coming years will continue to be on illegal drugs that do the most harm and on the most vulnerable drug misusers, their families and communities'.

- The YPFSF will continue to assist in the development of youth facilities (including sport and recreational facilities) and services in disadvantaged areas where a significant drug problem exists or has the potential to develop. The geographic coverage of the Fund may be expanded to other disadvantaged urban areas. The YPFSF will continue to target 10 to 21 year olds who are 'at risk' due to factors including family circumstances, educational disadvantage or involvement in crime or substance misuse. The Fund will continue to build on and complement youth measures under the Children's Programme in the areas where it is operational. (p. 265)

Over the past 10 years some €245 million has been allocated to these initiatives. Between 1997 and July 2004, some €84 million was allocated to the local drugs task forces, and in 2006 some €12 million was allocated to the regional drugs task forces. Between 2000 and 2006 the YPFSF was allocated €149.65 million.

Acknowledging that the National Drugs Strategy will expire in 2008, the NDP endorses the current approach in the short-term – 'the focus of drugs policy in the coming years will continue to be on illegal drugs that do the most harm and on the most vulnerable drug misusers, their families and communities'. It also highlights the partnership approach and the importance of evidence-based approaches. The NDP also confirms the pillars of the Strategy and the recommendations made in the mid-term review, including, among other things, extending the availability and range of treatment options in response to emerging needs, including the increased prevalence of cocaine and polydrug

Allocations under two other investment priorities, which may be expected to have an impact on drug-related matters

Priority	Programme	Sub-Programme	Comment
Human Capital (€25.8 billion)	Training and Skills Development	Upskilling the Workforce (€2.8 billion)	Will seek to ensure that persons with little or no education or skills are not isolated and vulnerable to potential economic downturn. This will be delivered through measures which address early school leaving through combining education with labour market participation and upskilling.
		Activation and Participation of Groups outside the Workforce (€4.9 billion)	Will provide training and development programmes for a wide range of groups requiring special interventions, such as Travellers and ex-offenders.
Social Infrastructure (€33.6 billion)	Health Infrastructure	Primary, Community and Continuing Care (€2.1 billion)	Will help to improve the physical facilities required to implement the national policy on team-based primary healthcare, including primary care infrastructure at local level, the delivery of local services in an integrated way, the fullest possible integration between hospital and community-based services, better or increased access to services, and the development of strong community-based supports for vulnerable or targeted population groups. The NDP notes that access to a quality multi-disciplinary primary care service was one of the issues raised in public consultations on poverty and social inclusion, and that disadvantaged groups have greater needs for the varying elements of such a service and therefore potentially more to gain from it.
	Justice (€2.3 billion)	Not broken down into sub-programmes	Detention and rehabilitation facilities are to be improved. New prison complexes in Dublin and Munster will enable the Irish Prison Service to develop modern rehabilitative facilities for prisoners. In respect of juvenile detention, investment will fund the redevelopment of existing detention facilities and the development of new facilities to meet the provisions of the Children Act 2001 in respect of offending children aged under 18 years sentenced to detention by the courts.
	Sports, Culture, Heritage and Community	Sports (€991 million)	Will support the availability of a range of facilities for sporting, exercise and recreational purposes. Among other benefits, sport is explicitly regarded as an alternative for young people at risk of engaging in anti-social activity, drug abuse or other criminal activity.

NDP and the drugs issue *(continued)*

use; implementing the (soon to be announced) integrated rehabilitation framework as a priority in the coming years; and using education and awareness programmes and sport and recreational alternatives to divert people (particularly young people) away from drug use.

The drugs issue will also be addressed through other programmes under the Social Inclusion Priority, including those targeting children and young people, people of working age who find themselves outside the mainstream educational system, at a distance from the labour market, or in need of reintegration into society after spending time in prison, and communities seeking to identify and address issues and challenges, such as the drugs issue, in their own areas. *(Brigid Pike)*

1. *National Development Plan 2007–2013: Transforming Ireland – a better quality of life for all.* Dublin: Stationery Office. Available on line at www.ndp.ie Funding under the NDP is allocated across five investment 'priorities', and under each of these priorities there is a series of 'programmes' (28 in total) and 'sub-programmes' (some 86 in total).

Drug Policy Action Group: Policy Paper 1

Criminal justice drug policy in Ireland

The Drug Policy Action Group (DPAG)[1] is a member of the International Drug Policy Consortium, a global network of 24 national and international non-governmental organisations established 'to promote objective and open debate on the effectiveness, direction and content of drug policies' and to support 'evidence-based policies that are effective in reducing drug-related harm'.[2] The first policy paper published by the DPAG examines current criminal justice drug policy in Ireland.[3] The paper was written by two leading commentators on the drugs issue in Ireland, Seán Cassin OFM, founder of Merchants Quay Ireland and a member of the National Drugs Strategy Team, and Dr Paul O'Mahony, Trinity College lecturer and author of a number of books on the Irish criminal justice system.

An analysis of criminal justice policy must consider not only the way in which drug laws are formed in statute but also how they are implemented in practice throughout the system, from police to courts. Highlighting the separation of powers between the legislature and the judiciary, the authors illustrate this point by suggesting that 'sentencing practice by judges tends to be more lenient than the laws envisage with only a small proportion of all convictions for all drug related offences resulting in a prison sentence' (p. 3).

The causative complexity of the drugs–crime relationship is not, the authors suggest, sufficiently reflected in policy formation. For example, the report criticises 'most politicians' and An Garda Siochána for adhering to policy statements that 'explicitly minimise distinctions between drugs and forms of use' (p. 3). Present policies in Ireland, they argue, 'make no distinction between harms resulting from different kinds of drug use and no distinction between the actions of different user groups'. According to the authors, a consequence of this perceived failure to distinguish between the harmful effects of different drugs is that it can encourage misperceptions among experimental drug users and lead them into further more harmful drug use. It is argued, for example, that people who occasionally use cannabis and ecstasy with little ill effect 'can be led by the prevalent exaggerated claims about the dangers of the less dangerous drugs to dismiss as equally harmless the more problematic drugs like heroin or crack cocaine' (p. 4).

The central argument of the report is that there is an excessive reliance on legislation and the criminal justice system as a mechanism for dealing with the country's illegal drug problems and that this is generating more problems than it is solving. This apparent imbalance is reflected in disproportionate expenditure on drug services by the Department of Justice, Equality and Law Reform, when compared with expenditure by the Department of Health and Children. Furthermore, the authors argue that most of the recently introduced criminal drug laws target 'already disadvantaged drug using groups' rather than drug suppliers. They suggest that, given that most drug-related prosecutions are for possession rather than supply,

> it is the user who is predominantly targeted and more deeply inserted into a criminal justice system that can do little to promote personal development or the removal of obstacles to personal growth. This over reliance on the criminal system merely serves to recycle successive generations through criminal processes that become a life norm that perpetrates [sic] the criminal and disadvantaged sector. (p. 4)

The causative complexity of the drugs–crime relationship is not, the authors suggest, sufficiently reflected in policy formation.

DPAG: Policy Paper 1 *(continued)*

The report calls for a greater use of 'pragmatic' approaches to problematic drug use, such as methadone prescription and needle exchange.

Accepting that supply control initiatives can offer 'a containment of criminal elements', the authors argue that an over-reliance on this approach promotes public attitudes that are both anti-drug and anti-drug-user. They suggest that, at times of 'moral panic', and fuelled by an often alarmist media approach, public and political attitudes towards drug users can harden, thus creating and perpetuating 'a culture of marginalised people' who are also criminalised.

The primary focus of drug policy, according to the authors, should be on addressing the demand for drugs and the reasons why some people engage in problem drug use. They advocate a humanistic approach to tackling such problems, premised on the belief that 'people are capable and willing to develop themselves when the internal and external obstacles to that development are removed or reduced' (p. 5). Calling for what they regard as a more appropriate balance between supply control and demand reduction initiatives, the authors highlight 'ambiguities' or apparent conflicts in policy approaches. For example, anti-social behaviour measures such as evictions obtained under the Housing (Miscellaneous Provisions) Act 1997 can render drug users homeless, thereby contributing to increased levels of 'drug use, nuisance and health risks' (p. 5). Another example they cite is what they see as the 'persistent disparity in approaches between the Health Services and the Prison Services whereby equal access to services ceases for those beginning a custodial sentence'. The report calls for a greater use of 'pragmatic' approaches to problematic drug use, such as methadone prescription and needle exchange.

Despite the centrality of the multi-agency and partnership approach to the National Drugs Strategy 2001–2008, the authors question whether there is 'adequate understanding or commitment' to the partnership approach at senior levels in the departments of Justice, Health and Finance. In support of this position, the authors identify what they see as 'the failure to mainstream pilot projects and provide them with a statutory framework, the lack of projected plans to cover the ongoing developments in service delivery, and [the] failure to apply benchmarking to NGOs' (p. 5). They state that the perceived failure at departmental level has ramifications throughout the whole infrastructure of the National Drugs Strategy.

> This apparent lack of partnership working at government department level leads to considerable frustration in the system at local, regional and national team levels and especially amongst those who are exceptionally committed to the partnership approaches. (p. 5)

Finally, the authors call upon the National Drugs Strategy Team (NDST) 'to assume its hitherto dormant role of initiating and developing policy for the Government' (p. 6).

The DPAG makes a number of specific recommendations, including:

- The Cabinet sub committee on social inclusion should request the Law Reform Commission to assist them to review and propose repeals or revisions of drug laws.
- The NDST should appoint a dedicated policy sub-group to review changes in Ireland's criminal justice drug policy.
- Ireland should adopt a system of classification of drug substances similar to that in Britain, where drugs are grouped on the basis of their harmfulness to the individual and to society.
- The role of public representatives on local and regional drugs task forces should be focused on implementing better drug laws which make a distinction between drug activities that actually cause harm and those with low or no harmful consequences.
- The Health Service Executive should support greater access to harm reduction facilities like needle exchanges, safe injection rooms and more widely available alternative prescribing options for long-term drug users.
- An Garda Síochána should develop more focused programmes of training in harm reduction approaches for Garda recruits.

Despite some academic contributions and a discussion of the merits of cannabis decriminalisation at the National Crime Forum,[4] Irish debate in the area of criminal justice drug policy has been limited. The DPAG report is an important contribution in that respect. *(Johnny Connolly)*

1. www.drugpolicy.ie
2. www.idpc.info
3. Cassin S and O'Mahony P (2006) *Criminal justice drug policy in Ireland.* Policy Paper 1. Dublin: Drug Policy Action Group.
4. National Crime Forum (1998) *National Crime Forum: report 1998*. Dublin: Stationery Office.

In brief

On 2–4 November 2006 the **European Forum for Urban Safety,** a network of more than 300 European local authorities, hosted an international conference entitled 'Safety, Democracy and Cities'. The conference was seeking to develop a European model of security. Among the workshops held in the course of the conference was one on drugs. The conference adopted a policy document, the Zaragoza Manifesto. zaragoza2006.fesu.org

On 6–7 November 2006 the **European Parliament** hosted a gathering of local, regional and national authorities, as well as civil society organisations from Europe and beyond, who presented on existing and future alternatives in European drug policy, and explored the role of Europe in the process towards the UN summit in 2008.The conference was organised by ENCOD, European Coalition for Just and Effective Drug Policies. www.encod.org

On 15 November 2006 **Coolmine Therapeutic Community** launched its strategic plan *A pioneering record: A dynamic future 2006–2008.* Committed to drug-free or abstinence-based outcomes for its clients, Coolmine acknowledges that over the past 30-odd years drug treatment policy in Ireland 'has shifted gradually towards a "harm-reduction" philosophy'. In his foreword, the Chairperson writes, 'We now have a greater consciousness of our unique and vital role as colleagues to providers who use different approaches to tackling the same issues. Emerging best practice models and environmental changes mean that a one-size-fits-all approach is not appropriate or effective for Ireland today.' www.coolminetc.ie

On 22 November 2006 the **Special Residential Services Board (SRSB)** hosted its annual 'network event'. The purpose of the network events is to explore areas of best practice and discuss topical issues that are related to young people within the child care and educational systems in Ireland today. The theme of this year's event was 'Working with Young People Who Will Not Engage'. www.srsb.ie

In November 2006 the **Children's Research Centre** published a research study, *Free time and leisure needs of young people living in disadvantaged communities,* by Tina Byrne, Elizabeth Nixon, Paula Mayock and Jean Whyte. It is a study into the free time and leisure needs of young people (aged 12 to 18 years) living in four areas in Ireland designated as disadvantaged under the Government's RAPID Programme. Among the findings of the research, in respect of social environment, the researchers reported that, 'While describing a strong attachment to their communities, the young people were very aware of their negative characteristics, including high levels of exposure to the use and sale of drugs. There was unanimous agreement among the young people that there are insufficient public and private leisure amenities available to them in their areas.' www.tcd.ie/childrensresearchcentre

On 7 December 2006, under the auspices of the **British–Irish Council (BIC),** a Ministerial Meeting on the Misuse of Drugs was held in Belfast. Chaired by Noel Ahern TD, Minister of State with responsibility for the National Drugs Strategy, the meeting focused on the challenges presented by cocaine use. Ministers found that similar issues arose in relation to cocaine in each administration but that the problem was at various stages of development in the different jurisdictions. www.british-irishcouncil.org

On 7 December 2006 the **Drug Treatment Centre Board (DTCB)** held its inaugural conference on adolescent addiction, *Treatment of adolescent addiction – A national problem.* The aim of the conference was to equip professionals working with adolescent substance misusers with knowledge and skills that will assist in the delivery of appropriate services. www.addictionireland.ie

On 14 December 2006 the **Blood Borne Virus Forum (BBVF)** made a presentation to the Oireachtas Joint Committee on Health and Children. A voluntary group established in Ireland in 2001 and comprising representatives of statutory, voluntary and community agencies, the BBVF called for 'equivalence of care for all people affected by hepatitis C no matter how they picked it up' and called on the Oireachtas Committee 'to consider calling for a comprehensive national policy so that we can examine service development for everybody. We would appreciate if an appropriate budget were allocated to support service development. We seek the release of the regional hepatitis C strategy, which is under review again, and we would like it to be made national.' www.oireachtas.ie

In December 2006 ***Eurobarometer 66: Public opinion in the European Union – First results*** was published. Fieldwork was conducted in September–October 2006. More than a quarter (26%) of EU citizens surveyed agreed, and two-thirds (68%) disagreed, with the statement: 'Personal consumption of cannabis should be legalised throughout Europe'. Young Europeans tended to be opposed to the legalisation of cannabis (57% of respondents aged 15 to 24 disagreed with the statement). However, opinions varied from country to country. In Finland (8%) and Sweden (9%) the idea was rejected outright, whereas in the Netherlands just under half of the respondents felt that cannabis should be legalised throughout Europe (49%). In Ireland the rate of agreement was above the EU average (30%). www.ec.europa.eu/public_opinion

On 12 January 2007 the **National Advisory Committee on Drugs (NACD)** published its *Progress report: August 2003–December 2005.* It also released a series of research summary sheets covering the same period. www.nacd.ie

In January 2007 the ***Garda policing plan 2007*** was launched. The plan includes actions and performance targets in respect of drug trafficking, dealing and using; enforcing the law in relation to underage drinking and substance abuse in both public places and licensed premises; and increasing the number of detections for both drink and drug driving. www.garda.ie

(Compiled by Brigid Pike)

Pompidou Group work programme 2007–2010

The Council of Europe's response to drug use and drug trafficking is carried out through a multi-disciplinary co-operation group known as the Pompidou Group. Named after French president, Georges Pompidou, it was set up in 1971 and now comprises 35 member states.

The mission of the Pompidou Group is to contribute to the quality of European drug policies, practices and research by identifying issues raised through practical experience, promoting evidence-based policies and facilitating communication between professionals of various disciplines and between EU and non-EU countries. The work of the Pompidou

Objectives	Activities/topics	Expected output
Objective 1: Demand reduction		
Prevention		
Promote participation by young people in prevention	European prevention prize	Three prizes every other year for projects exemplifying participatory approaches
Promote internet-based support	Programme on virtual training and resource centre	Interactive support tool for practitioners working with parents
Treatment		
Identify needs, problems and experience-based knowledge	Consider treatment modalities for specific substances and groups	Identify good practice approaches
Objective 2: Supply control		
Criminal justice		
Review the operation of drug courts/ specialised magistrates	Assess implementation procedures and evaluation	Identify good practice
Review judicial co-operation and the process of joint investigations	Identify barriers in practice	Identify good practice standards and future priorities
Airports		
Improve law enforcement in European airports	Facilitate access to databases for frontline officers	Identification of data needs
Objective 3: Transversal issues		
Ethics and human rights		
Explore ethical issues and human rights basis for drug policies and programmes	Implications of workplace drug screening Implications of research findings in neurosciences and genetics	Promotion of good practice
Research		
Register research activity	Develop web-based research registry in collaboration with EMCDDA	Inventory/Register
Co-operation		
Promote inter-service co-operation at implementation level	Develop European network of partnerships at frontline level responding to drug problems	Exchange of best practice; training; strategies to address public nuisance
Promote drug awareness among media personnel	Develop European training project for journalists on drug prevention and use	Training courses; national follow-up activties; examples of new reporting formats

Pompidou Group work programme *(continued)*

Group is structured around six platforms: prevention, treatment, criminal justice, airports, ethics and human rights, and research.

In November 2006, the Ministerial Conference, which is the political authority of the Pompidou Group and which meets every four years, agreed a draft work programme for 2007–2010.[1] The work programme concentrates on the following main objectives: developing effective programmes in the areas of demand reduction and supply control, addressing transversal issues and facilitating co-operation and joint activities. Some of the planned activities to be undertaken in line with these objectives are outlined in the table below.

The expected results from the activities undertaken through the work programme include the identification of barriers in practice and priorities for further action, and the setting of standards of good practice. The format in which these outcomes are presented and disseminated varies and is tailored to the needs of specific target groups, be they policy makers, practitioners or researchers. Outputs may include policy papers, recommendations and guidelines for standards, comparative studies, expert reports or on-line resources. A particular focus is placed on education and training and the transfer of know-how. Another priority of the Pompidou Group is to identify overlaps and avoid duplication in practice, particularly among the various international organisations active in the drugs area. Consequently, co-operation initiatives are planned with a range of groups, including the Mediterranean Network (Algeria, Morocco, Tunisia, France and the Netherlands), the European Monitoring Centre for Drugs and Drug Addiction and the World Health Organization. The work of the Pompidou Group is evaluated on an ongoing basis. *(Johnny Connolly)*

A particular focus is placed on education and training and the transfer of know-how.

1. Pompidou Group Ministerial Conference (2006) *Work Programme 2007–2010.* Strasbourg: Council of Europe. Available on the Council of Europe website at www.coe.int/pompidou

EMCDDA broadens its scope

Since mid-January 2007 the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has taken on a more active role in monitoring new drug-use patterns and emerging trends throughout the 27 member states.

The European Parliament and the Council of the EU have adopted a new mission statement for the EMCDDA, replacing the one founding the agency in 1993. While reaffirming the EMCDDA's main purpose as providing EU member states with 'factual, objective, reliable and comparable information at European level concerning drugs and drug addiction and their consequences', the new document broadens the scope of the EMCDDA's tasks.

The EMCDDA is now allowed to collect, register and analyse information on 'emerging trends in polydrug use' — the simultaneous use of more than one drug — including the combined use of licit and illicit psychoactive substances.

Reference is also made in the new mission statement to providing information on best practice in the EU member states and facilitating exchange of such practice between them. This will include the sharing of experience in areas such as drug prevention, and reducing supply and drug-related harm. The EMCDDA will also develop tools and instruments to help member states and the European Commission monitor and evaluate national and EU drug policies respectively.

Another key aspect of the new remit is closer co-operation with the law enforcement body, Europol, to attain maximum efficiency in monitoring the drugs problem. Among other things, the two bodies will continue to work together in monitoring new psychoactive substances appearing on the European illicit drug market.

The EMCDDA may also be called on to transfer its know-how to certain non-EU countries, such as official candidates for EU accession and countries in the Western Balkans. This is likely to entail creating and reinforcing links with the European Information Network on Drugs and Drug Addiction (Reitox) and assisting in the building and strengthening of national drug observatories (national focal points).

For further information, visit www.emcdda.europa.eu

European drug policies – extending beyond illicit drugs?

It is difficult to differentiate between users of licit and illicit substances due to the increasing prevalence of polydrug use.

The inclusion of licit substances in European drug policies is discussed in the EMCDDA annual report selected issues 2006.[1] This report analyses the current approach advocated by EU countries to their drugs strategies, the rationale behind extending the scope of drugs strategies and the potential repercussions an extended drugs strategy would have on drugs services and responsible bodies at operational level.

The *EU Drugs Strategy 2005–2012* adopted in 2004 is directed at illicit drug use, although it does acknowledge the health-related and social problems caused by the use of illicit drugs in combination with legal psychoactive substances such as alcohol, tobacco and medicines. However, there is an increasing body of opinion which believes that the scope of drugs strategies should be broadened to encompass licit addictive substances such as alcohol, tobacco and medicines, as well as illicit drugs.

Of the 27 countries surveyed for this report, 24 reported the existence of a national drugs strategy but just eight countries reported that their strategies included both drugs and alcohol (Table 1). The basis for the inclusion of both substances within a single strategy differs across countries. In some countries the justification comes from a public health perspective which considers the distinction between licit and illicit substances to be irrelevant – licit substances can cause addiction and consequently pose a major health and social problem. It is difficult to differentiate between users of licit and illicit substances due to the increasing prevalence of polydrug use. Another reason for broadening national strategies is based upon a medico-scientific consensus that takes into account the causes and consequences of addictive behaviours, regardless of the legality of the substance. This approach places greater emphasis on common behaviours than on substances.

In practice, prevention programmes address licit and illicit substances together.

Ireland is identified as one of 11 countries with a drugs strategy that addresses only illicit drugs but which includes links to licit substances in the context of prevention and treatment. While the Irish National Drugs Strategy *Building on experience: National Drugs Strategy 2001–2008* refers mainly to illicit drugs there are links between it and the national alcohol policy in terms of prevention approach. These links aim 'to ensure complementarity between the different measures being taken'[2] in the field of prevention.

The possibility of developing a combined alcohol and drugs strategy in Ireland is being examined. One of the recommendations of the steering group responsible for overseeing the mid-term review of the National Drugs Strategy was that 'a working group involving key stakeholders of both the alcohol and drugs areas should be established to explore the potential for better co-ordination between the two areas and how synergies could be improved. The working group should also examine and make recommendations on whether a combined strategy is the appropriate way forward'.[3]

The field of prevention is the area where extending the remit of national drugs policies is most often apparent. In practice, prevention programmes address licit and illicit substances together. Prevention of drug use is associated with prevention of addictive behaviours which involve both licit and illicit substances. The main objective of prevention programmes is to delay or prevent the introduction into the use of legal drugs as it is now recognised that the early use of licit substances is the most important risk factor for progression to illicit drug use. This is particularly evident among programmes targeting young people which focus first on alcohol and tobacco as the longer that initiation to tobacco and alcohol can be delayed, the greater the reduction in later substance abuse problems.

In most countries, the extension of treatment programmes to include both licit and illicit substances is due to the increasing prevalence of polydrug use. Polydrug use presents challenges to drug monitoring systems that traditionally have focused on the use of individual substances. In Ireland there are no official

Table 1 Substances or behaviours targeted in national drugs strategies

	Illicit drugs	Alcohol	Tobacco	Medicines	Other substances or addictions
Belgium	+	+	+	+	+
Czech Republic	+	+	+		
Germany	+	+	+	+	+
Spain	+	+	+	+	
France	+	+	+	+	+
Cyprus	+	+	+	+	
Romania	+	+	+	+	
Norway	+	+		+	

Sources: *Reitox national focal points*

European drug policies *(continued)*

links between alcohol and drug treatment services, but in practice many drug services also treat clients with problem alcohol use. The reason for this is that one-fifth of those treated for problem alcohol use also misuse drugs. The trend towards integrating treatment centres or establishing joint treatment centres for licit and illicit substances is particularly common in countries which have extended their drugs strategies to include licit substances.

While the majority of countries have established drugs strategies, the scope of these can vary greatly. However, a number of trends appear to be developing which seem to support the integration of licit and illicit substances in some respects. These mainly include prevention programmes and, increasingly, treatment programmes which are now taking into account both licit and illicit substances. *(Deirdre Mongan)*

1. EMCDDA (2006) *Annual report 2006: selected issues.* Luxembourg: Office for Official Publications of the European Communities.
2. Department of Community Rural and Gaeltacht Affairs (2001) *Building on experience: National Drugs Strategy 2001–2008.* Dublin: Department of Community, Rural and Gaeltacht Affairs.
3. Steering group for the mid-term review of the National Drugs Strategy (2005) *Mid-term review of the National Drugs Strategy 2001–2008.* Dublin: Department of Community, Rural and Gaeltacht Affairs.

EU research funding and the drugs issue

Launched in December 2006, the 7th Framework Programme for Research and Technological Development (FP7) is the EU's main instrument for funding research in Europe. It will run from 2007 to 2013.

In February the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published information on FP7 relevant to drug researchers under two main headings – Health, and Socio-Economic Sciences and Humanities.

For the full EMCDDA analysis of FP7, visit www.emcdda.europa.eu. For more information about FP7 as a whole, visit http://cordis.europa.eu/fp7/home_en.html

New Directory of training courses for 2007

The National Documentation Centre on Drug Use has published a new edition of the Directory of courses and training programmes on drug misuse in Ireland. Thirty-six providers sent us information about 100 courses for this second edition – a 45% increase in submissions from last year. We would like to thank all of those who made contributions.

The Directory lists a range of training available, from single sessions to courses lasting up to two years. A wide variety of training standards, methods and approaches are represented. Some courses do not refer directly to drugs or addiction but aim to develop broad skills, such as supervision, facilitation and counselling techniques, which may be of interest to those working in this area.

Most courses are targeted at a specific audience. In particular, a large number of courses and training programmes have been designed for workers in the area of drug misuse and for parents. Many are offered at both in-house and external locations. This year there is just one course specifically for young people.

Perhaps the most significant feature of this edition is the increased opportunities for those who wish to study aspects of drug misuse or addiction at certificate, diploma and degree level. We do not assess the quality of courses listed; we present information as supplied by the course co-ordinators on course length, assessment, qualifications and accreditation.

Most course providers are based in Dublin (64%), although counties outside Dublin are better represented than in the first edition. There are course providers in Wexford, Waterford, Tipperary, Cork, Kildare, Meath, Offaly, Cavan, Donegal and Mayo. Although many cater specifically for people in their locality, some also offer courses on a regional or national basis.

We make every effort to include all relevant courses in the Directory but, inevitably, some agencies providing courses and training in drug misuse were overlooked, while others were unable to respond in time. We hope, therefore, to update this directory annually. *(Mary Dunne)*

Course co-ordinators who wish to revise an existing entry or include a new course in the next edition of the Directory may request an application form from mdunne@hrb.ie

Changes at the HRB

Change in HRB management structure

The **Health Research Board (HRB)** has changed its management structure from a two-layer one (the chief executive and eight divisions) to a three-layer one (the chief executive, three directorates and eight units). The change in structure came into effect on 1 January 2007, following an organisational review. The directorate layer was introduced to combine units (formerly 'divisions') with similar or linked functions into three groups (directorates) in order to enhance the effectiveness and efficiency of these functions throughout the organisation.

Change of name and increase in role

The Drug Misuse Research Division considered this an opportune time to change its name to the **Alcohol and Drug Research Unit (ADRU),** to reflect the expansion of its work activities to include alcohol-related research. This change came into effect on 1 January 2007. The ADRU is one of four units in the Health Information and In-House Research Directorate.

The ADRU is a multi-disciplinary team of researchers and information specialists who provide objective, reliable and comparable information on the drug and alcohol situation, its consequences and responses in Ireland. The ADRU maintains two national drug-related surveillance systems and is the national focal point for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The Unit also manages the National Documentation Centre on Drug Use. The ADRU disseminates research findings, information and news in Occasional Papers, in the Overview series, and in this quarterly newsletter, *Drugnet Ireland.* Through its activities, the ADRU aims to inform policy and practice in relation to drug and alcohol use.

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e adru@hrb.ie

Recent publications

Books

How to read a paper: the basics of evidence-based medicine (3rd edition)

Greenhalgh T
Blackwell Publishing 2006,
229 pp.
ISBN -13: 978 1 4051 3976 2

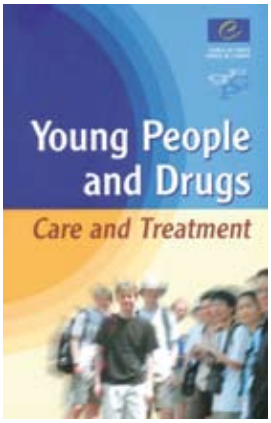
This book is intended for anyone, whether medically qualified or not, who wishes to find their way into the medical literature, assess the scientific validity and practical relevance of the articles they find and, where appropriate, put the results into practice. These skills constitute the basics of evidence-based medicine.

This is what the author said in 1996 in the preface to the first edition of this book, which has since become a standard reader in many medical nursing schools, much reprinted and translated into eight languages. This third edition maintains the clarity and directness – and humour – of the original in its 'no frills' introduction to evidence-based medicine (EBM). Many of the chapters in this edition are essentially unchanged, apart from adding illustrations and updating the reference lists. Some chapters – notably those on searching, qualitative research, systematic review and implementing evidence-based practice – have been fundamentally revised because the fields have moved on significantly since the previous edition.

The chapter titles reflect the book's unpretentious approach. The first five chapters are: Why read papers at all?; Searching the literature; What is this paper about?; Assessing methodological quality; and Statistics for non-statisticians. The author makes the point that it is only when the questions raised in these early chapters have been addressed that one should proceed to the next stage in the EBM process – critical appraisal. Chapters 6–12 describe how to critically appraise papers that report drug trials, diagnostic or screening tests or questionnaire research, those that summarise other papers (systematic reviews), that tell you what to do (guidelines), that tell you what things cost (economic analyses), and those that go beyond numbers (qualitative research).

The final chapter, Getting evidence into practice, questions why health professionals are slow to adopt evidence-based practice and discusses how their behaviour might be influenced. It attempts to identify what an evidence-based organisation looks like, and what interventions exist for achieving organisational change. An appendix has 13 checklists, each linked to a chapter, for finding, appraising and implementing evidence. There is a second, one-page appendix giving a formula for calculating the effects of an intervention.

Recent publications *(continued)*



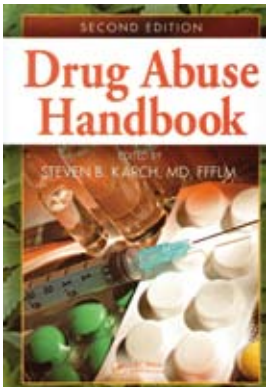
Young people and drugs: care and treatment
Council of Europe Pompidou Group 2006, 252 pp.

The Pompidou Group's Working Group on Treatment focused on the treatment of young drug users (aged up to 25 years) and adopted a series of recommendations and orientations to improve practice in this domain. As a result, this book, containing contributions from some 15 members of the Group, was published in November 2006. It is intended for people who deal directly with young people with problematic drug use, such as physicians (GPs), psychologists, pedagogues, addiction-care specialists and teachers.

The publication contains the following chapters, each with its own references, which comprise an independent whole but can be read separately:

- Definitions of dependency and recreational, regular, problematic, harmful drug use
- Epidemiological basis
- Risk and protective factors in adolescent and youth drug use
- How to establish contact with young people who use drugs
- Screening and assessment
- Treatment and treatment planning
- Co-morbidity of substance abuse: diagnosis and treatment implications in adolescents
- Treatment considerations for pregnant drug users

The first of two final chapters draws conclusions and recommendations from the eight chapters above, while the last chapter summarises the main points made in the book.



Drug abuse handbook (2nd edition)
Karch S (ed.)
CRC Press 2007, 1267 pp.
ISBN-13: 13 978 0 8493 1690 6

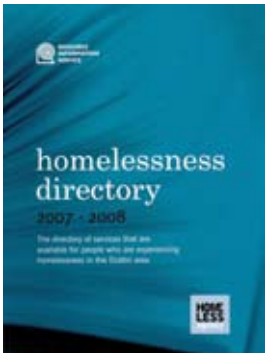
This handbook is a comprehensive guide to the pharmacology and pharmacokinetics of abused drugs, and offers an extensive overview of the pathology of drug abuse. The first edition was published in 1998. Acknowledging the advances in knowledge about drug abuse in the past decade, largely in the fields of molecular biology and neurochemistry, the editor argues that progress in understanding its effects has been slow in the field of pathology and in other medical specialities.

Most of the book is concerned with forensic science, the clinical management of toxic patients and the management of addicted patients, with authoritative contributions from experts in the legal, medical and treatment fields. The editor believes that at some point there must be a convergence of these fields, bringing all of these different disciplines together to form an evidence-based field.

The book examines criminalistics, pathology, neurochemistry, alcohol, drug testing, treatment, medical complications, drug-related death investigation, and the ethical, legal and practical issues involved. New material in this edition includes:

- advances in DNA research on forensic investigation
- the genetics behind sudden cardiac death and other 'invisible' diseases
- drug-testing methods, protocol, practicality and applications in the workplace and in criminal justice systems
- the neurochemistry of drugs of abuse, including nicotine
- the effects of blood doping and the future of genetic performance enhancement.

Each of the fourteen chapters opens with a detailed contents list and ends with a bibliographic reference list. Appendices include a glossary of terms in forensic toxicology, a list of common abbreviations, references for methods of drug quantitative analysis and sample calculations. The book has a 43-page index.



Homelessness directory 2007/2008: the directory of hostels, supported housing and other services in Dublin
Homeless Agency 2006, 100 pp.

This is the fourth edition of the directory of services for people who are experiencing homelessness in Dublin. The Homeless Agency produced and published the directory in conjunction with the Resource Information Service, a London-based charity. This edition includes a comprehensive listing of all specialist homeless services – for adults, families and young people – and includes information on support available from mainstream and general services. It provides details on access criteria and referral procedures, and information on rights and entitlements.

The directory is divided into three main sections. The first section has maps of Dublin city and surrounding council areas, and provides general information about the kinds of services available, how they are currently organised and delivered, and their statutory responsibilities. The second section contains alphabetical lists of hostels and housing projects in four subsections: emergency hostels, domestic violence, transitional housing and long-term supported housing. Each entry contains information on the service, the target group, the facilities provided and public transport

Recent publications *(continued)*

access. Location maps are included in the case of emergency hostels. The third section covers advice and support services, with subsections listing food and day centres providing practical support, housing advice agencies, street services, health and mental health, alcohol and drugs, education and training, and counselling services, among others. The directory has five indexes, allowing the reader to find out-of-hours services, young peoples' projects and women's projects, and to search for services alphabetically or by local authority area.

Journal articles

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

Alcohol problems, marriage, and treatment: developing a theoretical timeline

Loughran H
Journal of Social Work Practice in the Addictions 2006; 6(1–2):31–48

While research findings over the past twenty years have consistently supported the efficacy of couples work with people experiencing alcohol related problems, in the field of practice in Ireland there is little evidence of the development of interventions based on a couples/marital perspective. This paper examines the place of marital work in the alcohol field through a review of the literature from the 1950s to the present in order to discover the limitations in theory and research that might explain the reluctance of practitioners to adopt this method of intervention.

Violence and aggression in the Drug Treatment Centre Board

Whitty P and O'Connor JJ
Irish Journal of Psychological Medicine 2006; 23(3): 89–91

In this study, the authors sought to determine the prevalence of and the factors associated with violent and aggressive incidents among clients attending an out-patient methadone stabilisation and detoxification programme in Dublin. Incident reports from a two-year period were retrospectively examined. The authors also obtained information on demographics, main drug of abuse, timing and location of the incident as well as psychiatric and physical co-morbidity among the perpetrators from case note review.

A total of 295 incidents occurred over the study period. The overall rate of violence and aggression was 85 per 1,000 clients attending the centre per year. Most incidents involved verbal abuse. Females were significantly more likely than males to be involved in assaults. A high proportion of clients (80%) who were physically aggressive tested positive for benzodiazepine medication. The authors concluded that levels of recorded violence have remained stable but that racial abuse has increased in recent years. The relatively low overall rate of violence suggests that existing measures have helped reduce the number of aggressive and violent incidents in the centre. Most of the victims were doctors, nursing staff or general assistants. This finding reflected their respective roles in the centre, which included limit setting and dealing with positive drug screens among clients.

Zopiclone misuse: an update from Dublin

Bannan N, Rooney S and O'Connor J
Drug and Alcohol Review 2007; 26(1): 83 –85

The prevalence of zopiclone misuse in clients attending a methadone maintenance programme in Dublin through detection of its degradation product, 2-amino-5-chloropyridine (ACP) on urinalysis is outlined. Urine samples from all 158 clients were tested for the presence of ACP, opiates, benzodiazepines, cocaine, alcohol and cannabis. Of the 37 (23%) clients who tested positive for ACP, 23 (62%) were interviewed. A profile of zopiclone misusers is outlined, including details of demographics, drug history, viral status, recent urinalysis results and opinions on zopiclone. Of the 14 (38%) clients who were not interviewed, information was obtained from their clinical casenotes and documented urinalysis results. The prevalence of zopiclone misuse was reported as 23%. Benzodiazepines were the most popular drug of misuse, with zopiclone followed by heroin/opiates. Zopiclone is being misused by drug users in Dublin in the context of many other drugs. Prescribing of zopiclone should be restricted, especially among drug misusers.

Introducing safer injecting facilities (SIFs) in the Republic of Ireland: 'chipping away' at policy change

O'Shea M
Drugs: education, prevention and policy 2007; 14(1):75–88

Safer injecting facilities (SIFs) have been introduced in many countries throughout Europe over a number of years, and more recently have been established in Canada and Australia. This study conducted in Dublin sought to examine the policy implications of introducing safer injecting facilities in Ireland as a logical development of harm-reduction policy. A triangulation method of data collection was adopted that comprised semi-structured interviews with 16 drug users and structured interviews with key personnel and policy makers in the drug field. The study revealed that the majority of drug users were injecting in public places, had a surprising level of knowledge of SIFs, and indicated a willingness to use such facilities. The findings of the study also revealed very mixed feelings among policy makers and key personnel and showed that, among those in favour of such an innovation, there was a preference for doing so with the maximum of discretion. The study concludes that it is perhaps 'a bridge too far' in the current political climate.

The cost of drug use in adolescence: young people, money and substance abuse

McCrystal P, Percy A and Higgins K
Drugs: education, prevention and policy
2007; 14(1): 19–28

It is now common for young people in full-time compulsory education to hold part-time jobs. However, while the 1990s

Recent publications *(continued)*

experienced a rise in illicit drug use particularly among young people and an increase in the level of interest in identifying factors associated with drug use, little attention has been paid to the influence of the money young people have to spend and its potential links with drug use. In this study, 4,524 young people living in Northern Ireland completed a questionnaire in school year 10 (aged 13/14 years). The findings suggested that there was a positive association between the amount of money young people received (and its source) and higher rates of drug use. The study concludes that money, and how it is spent by young people, may be important factors for consideration when investigating drug use during adolescence. The findings may help inform drug prevention strategies, particularly through advice on money management, and taking responsibility for their own money.

(Compiled by Louise Farragher and Joan Moore)

Upcoming events

(Compiled by Louise Farragher – lfarragher@hrb.ie)

March

26–28 March 2007
Drugs, Alcohol and Criminal Justice – the shape of things to come
Venue: University of Warwick
Organised by / Contact: Michelle Vatin, The Conference Consortium
Email: michelle@conferenceconsortium.org
www.conferenceconsortium.org

This conference is an opportunity for those working in the closely related fields of drugs, alcohol and criminal justice to discuss and debate major challenges facing services and service users. Participants will hear and learn about current models of good practice, linked with sessions aimed at influencing the shape of policy and practice in the future. Sessions include:

- Motivating the coerced – what do we mean by motivation?
- All I want is a room somewhere – the role of housing and residential rehabilitation in addressing drug and alcohol use/misuse
- What's happening in the world of alcohol?

April

17 –25 April 2007
Cork Drug Awareness Week 2007
Organised by / Contact: Aoife Ní Chonchúir or Mella Magee
Community Outreach Drug Awareness Project, Cork City Partnership, Sunbeam Industrial Estate, Millfield, Mallow Road, Cork
Tel: +353 (021) 4302310
Email: anichonchuir@partnershipcork.ie or mmagee@partnershipcork.ie

Cork Drug Awareness Week aims to raise awareness and signpost information so that communities, families and professionals know where to go for assistance and information on drug and alcohol services. Each day of the week targets groups / areas affected by substance use.

Tuesday, 17 April 2007
'Families, Friends and Addiction'
Time: 7:30pm – 9:30pm
Venue: Jury's Hotel, Western Rd. Cork

Thursday, 19 April 2007
Conference: 'Addiction – Treatment and the 4 Tier Model'
Time: 9:30am – 2:00pm
Venue: Clarion Hotel, Lapp's Quay, Cork

24–25 April 2007
Information Day
Time: 9:30am – 2:00pm on both days
Venue: to be confirmed

Information: Various stands and groups will present on the day, providing a broad range of information on drug and alcohol services in Cork. The target audience includes school-going students, young people, teachers, parents etc. The day will be informative and enjoyable and will include light entertainment, i.e. competitions, music, drama, DVD, refreshments and presentations by several well-known Cork personalities!

19–20 April 2007
Management of Drug Users in Primary Care
Venue: Hilton Birmingham Metropole Hotel
Organised by / Contact: The Royal College of General Practitioners, and Healthcare Events
www.healthcare-events.co.uk

Information: The conference is the largest event in the UK for GPs, shared care workers, drug users, nurses and other primary care staff, specialists, commissioners, and researchers interested and involved in the management of drug users in primary care. This year's conference aims to address that 'whole systems approach', and how healthcare professionals can all work more effectively together to provide the best care for patients who use drugs and/or alcohol.

May

1 May 2007
Drugs and Alcohol Today London
Venue: Business Design Centre, London
Organised by / Contact:
Tel: +44 (0)870 890 1080
Email: exhibitions@pavpub.com
www.drugsandalcoholtodayexhibition.com

Information: This one-day event, comprising a full and comprehensive seminar programme and a large exhibition, will provide a unique opportunity for professionals and managers involved in preventing and treating substance misuse, service users and those interested in joining the profession to come together to debate the big issues, share best practice and network.

9–11 May 2007
Unhooked Thinking 2007 – Love and Baggage
Venue: The Guildhall, Bath
Organised by / Contact: Unhooked Thinking
www.unhookedthinking.com

Information: Unhooked Thinking is an unusual, international and multi-disciplinary conference enquiring into the nature of addiction. This year the relationship between love and addiction is explored. Each of the three days has a theme:

- Relationships: 9 May
- Love and Conflict: 10 May
- Family: 11 May

Upcoming events *(continued)*

17–19 May 2007
Making Time for Treatment: 4th UK/European Symposium on Addictive Disorders
Venue: Millennium Gloucester Hotel, London, Kensington
Organised by / Contact: UK/European Symposium on Addictive
www.ukesad.org

Information: Learn practical techniques and cutting-edge knowledge from leading world experts – over 60 presenters sharing knowledge in over 36 presentations. Presentations and workshops will address one or more of the three core themes below, with both national and international contributions.

- therapeutic effectiveness and family-of-origin issues
- brief interventions
- policies and interventions to treat offenders

June

6–9 June 2007
11th EFTC European Conference on Rehabilitation and Drug Policy
Venue: Hotel Domina Grand Media, Ljubljana, Slovenia
Organised by / Contact: European Federation of Therapeutic Communities, Conference Secretariat: Cankarjev dom, Cultural and Congress Centre, Mateja Peric, Pre_ernova 10, SI-1000 Ljubljana , Slovenia.
Tel: +386 1 241 71 39
www.eftc-europe.com/conferentie

Information: The EFTC and the drug rehabilitation programmes of Slovenia are delighted to invite you to this conference in the lovely and historic city of Ljubljana. The overall theme for the conference is 'Working Together – Partners for Change' and there are four sub-themes:

- working with the criminal justice system
- not just addictions
- families and communities
- contributors to change.

The focus of the conference will be the role and experience of therapeutic communities within the context of overall responses to dependency.

August

26–31 August 2007
T'2007
Venue: Seattle USA
Organised by / Contact: International Council on Alcohol Drugs and Traffic Safety (ICADTS) and The International Association of Forensic Toxicologists (TIAFT)
Tel: +001 (206) 262–6000
www.t2007.org

Information: The first joint meeting of ICADTS and TIAFT will also feature the 8th Ignition Interlock Symposium. This conference will cover traditional topics of each organisation's meetings but will also provide opportunities for cross-fertilisation of ideas, and networking within and between the organisations.

September

20 September 2007
28th Annual EAP Conference: Drugs and Alcohol at Work – Complying with the Safety, Health and Welfare at Work Act 2005

Venue: Carlton Hotel, Dublin Airport, Ireland
Organised by / Contact: EAP Institute / Anita Furlong, EAP Institute, 143 Barrack Street, Waterford, Ireland
Tel: + 353 (51) 855733
Fax: +353(51) 879626
Email: anita@eapinstitute.com
Cost: €425.00 (includes conference dinner)

Information: The Safety, Health and Welfare at Work Act 2005 obliges employers to remove employees from their place of work who are under the influence of intoxicants (defined as drugs and alcohol). A finding by the Labour Court in 2006 that alcoholism is a disability will oblige employers to provide treatment and rehabilitation to employees. This one-day conference will address the following issues:

- Managing drugs and alcohol at work
- Trade union approach
- Legal risk management
- Maintaining a drug-free work place
- Employee drug testing
- Managers training

The Alcohol and Drug Unit (ADRU) of the Health Research Board is a multi-disciplinary team of researchers and information specialists who provide objective, reliable and comparable information on the drug situation, its consequences and responses in Ireland. The ADRU maintains two national drug-related surveillance systems and is the national focal point for the European Monitoring Centre for Drugs and Drug Addiction. The unit also manages the National Documentation Centre on Drug Use. The ADRU disseminates research findings, information and news through its quarterly newsletter, *Drugnet Ireland,* and other publications. Through its activities, the ADRU aims to inform policy and practice in relation to drug use.

***Drugnet Ireland* mailing list**

If you wish to have your name included on the mailing list for future issues of *Drugnet Ireland,* please send your contact details to:

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Email: adru@hrb.ie

Please indicate whether you would also like to be included on the mailing list for *Drugnet Europe.*