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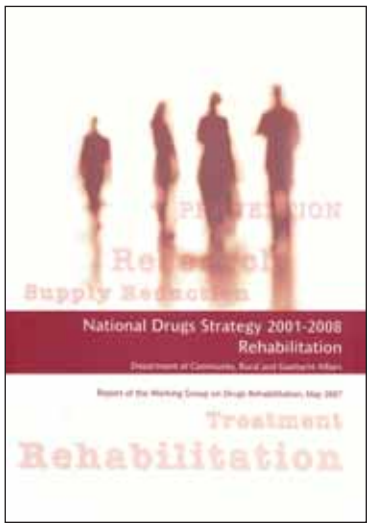

Rehabilitation: the fifth pillar of the National Drugs Strategy

The mid-term review of the National Drugs Strategy (2005)[1] recommended that rehabilitation become the fifth pillar of the Strategy and that a working group be established to develop an integrated rehabilitation provision. The report of the Working Group on Drugs Rehabilitation was launched on 7 June 2007.[2] The report makes a number of key recommendations and sets out the structural arrangements required to implement them. The overall goal is to provide an integrated rehabilitation service to current, stabilised and former drug users. This article summarises the main structural arrangements and recommendations in the report.

Structures for the delivery of rehabilitation services

National Drug Rehabilitation Implementation Committee and rehabilitation co-ordinators

A key proposal is to add to the existing structures of the drug strategy by establishing a National Drug Rehabilitation Implementation Committee (NDRIC), chaired by a senior rehabilitation co-ordinator (new post). The committee will be made up of representatives of the Health Service Executive (HSE), the National Drugs Strategy Team (NDST), the National Advisory Committee on Drugs (NACD), the community and voluntary sectors, rehabilitation and healthcare professionals, problem drug users and families of problem drug users. In addition, it is proposed that 10 rehabilitation co-ordinators and appropriate numbers of support staff be appointed. These co-ordinators will contribute to the development of local protocols, service-level agreements, (SLAs) quality standards and care plans, and to the overall tracking of client progression. The report recommends that the co-ordinators join the treatment and rehabilitation sub-committees of local drugs task forces and take the lead in overseeing the implementation of the recommendations of the Working Group in their respective geographical areas.

Recommendations

Protocols, service-level agreements and quality standards

The Working Group recommends that the NDRIC develop broad national protocols to facilitate inter-agency working, which, when approved by the Cabinet Committee on Social Inclusion and the Inter-Departmental Group on Drugs, will form the basis for the development of local protocols (that will require final approval by the NDRIC). The Group envisages that the protocols will cover issues such as confidentiality, common assessment tools, referral procedures and conflict resolution between agencies. It also recommends the development of SLAs at national and local level, to give clarity on the roles of each agency. The development of national and local SLAs will follow the same procedures as indicated for the development of inter-agency protocols.

A quality standards framework should be developed for service providers, to include enhanced case management procedures. The framework will be set out by the NDRIC and will follow procedures similar to those proposed for the development of the protocols and SLAs. The framework will help to identify the core competencies required by service providers to enable them to deliver rehabilitation programmes.

Case management, care plans and key workers

The HSE will be responsible for case management, for ensuring that this service is carried out by the responsible agency, and for tracking the progression of service users through the system. Case managers will liaise with key workers who will deal directly with clients receiving specific services. Client-centred care plans based on assessment, with negotiated and agreed goals, will form the basis of case management and progression. Care plans will be holistic and will address a range of personal, educational, housing and employment needs.

Medical support

The report recommends an expansion in the range of treatment options, an increase in the number of local GPs and pharmacies, and an increase in the number of residential detoxification beds from 23 to 48 (HSE lead), pending the outcome of the report on residential treatment/rehabilitation.[3] Building on the work of the Research Outcome Study in Ireland (ROSIE),[4] research should be undertaken to examine the outcomes of methadone maintenance programmes.

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Rehabilitation report *(continued)*

Community Employment (CE) (vocational rehabilitation)
The health requirements (HSE lead) and educational requirements (Vocational Education Committee (VEC) lead) of CE participants should be addressed while they are on the scheme, with the help of service-level agreements. The number of drug-specific CE places should be increased from 1,000 to 1,300 to reflect demand and the settling down of the regional drugs task forces (FÁS lead). A pre-stabilisation initiative, focusing on preparation for CE, should be developed (HSE lead).

Employment
Stronger links with employers, employer organisations and trade unions need to be established to facilitate ease of access to the workplace for recovering drug users (Department of Enterprise, Trade and Employment lead), while access to ongoing support for employers of drug users and for recovering drug users in employment is recommended (Case managers and rehabilitation co-ordinators lead). The report recommends that research on progression pathways to employment should be undertaken (NACD lead).

Access to education
Factors that make it difficult for recovering drug users to access education should be identified and removed where possible and an education fund for drugs rehabilitation should be established (Department of Education and Science lead). An outreach approach should be developed by the Vocational Education Committees to identify and develop responses to the adult educational needs of problem drug users in rehabilitation.

Housing
Local authorities should liaise with local drugs task forces to facilitate recovering drug users who wish to return to or move into local authority housing in the community. Dedicated supported accommodation, staffed appropriately, should be provided to cater for clients who have difficulties with an independent living environment. The provision of transitional/half way housing for recovering drug users should continue to be expanded. The long-term housing needs of problem drug users who are capable of independent living should be addressed, for example, through the rental accommodation scheme. (Department of Environment, Heritage and Local Government lead).

Rehabilitation of offenders
Drug treatment and rehabilitation programmes should be made available to all problem drug users in prison in the context of mandatory drug testing and drug-free prisons, and a continuum of care put in place for when they leave prison. A review of the operation of the local prison liaison groups should take place (Irish Prison Service and the Probation and Welfare Service lead).

Childcare
The HSE, in conjunction with the Office of the Minister for Children should decide on how best to integrate childcare facilities with treatment and rehabilitation services and subsequently progress the matter. Research is recommended to inform this process (HSE lead). Childcare services for children of problem drug users should adopt an approach focused on the development of the children (Office of the Minister for Children lead).

Role of families in the rehabilitation process
Service providers should actively encourage family reconciliation, where appropriate. Families should be seen as service users and involved in the recovery of drug using family members (Case managers, HSE and service providers lead). A pilot short-stay respite programme for families of drug users should be developed (HSE lead).

Conclusion

This report sets out a sound structural framework with key relevant recommendations to advance the strategic response to the rehabilitation needs of current, stabilised and former drug users. The report provides a real challenge to Government departments and agencies already involved – and those newly involved – in the delivery of the National Drugs Strategy to combine their expertise and energy towards delivering much needed rehabilitation services. In this regard, the development of inter-agency protocols and service-level agreements are vital to enable these different agencies to develop agreed strategic and operational goals. The development of a quality standards framework identifying the core competencies and associated training needs of service providers will add to the quality of services being provided.

The recommendations in this report for the delivery of an expanded service, in terms of treatment options, educational and vocational training options, and employment supports, are a welcome addition to the National Drugs Strategy. These services should build on the achievements of the strategy thus far and contribute to the social reintegration of current, stabilised and former drug users. Finally, the appointment of rehabilitation co-ordinators and the establishment of the NDRIC will be followed by the development of an agreed action plan, with key performance indicators to assess outputs and measure outcomes.

(Martin Keane)

1. 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.
2. Working Group on Drugs Rehabilitation (2007) *National drugs strategy 2001–2008: rehabilitation. Report of the working group on drugs rehabilitation, May 2007*. Dublin: Department of Community, Rural and Gaeltacht Affairs.
3. This report is being finalised by the HSE Working Group on Residential Treatment & Rehabilitation (Substance Users) and will be published in due course.
4. See article on ROSIE Findings 4 on p. 9 of this issue.

Outgoing government reports on drug initiatives

In April 2007 the final departmental reports on the completion of *An agreed programme for government*, which set out the priorities of the Fianna Fáil–Progressive Democrats coalition government 2002–2007, were released.[1] They include updates on the five drug-related initiatives not included in the National Drugs Strategy 2001–2008.

We will provide for compulsory drugs testing of prisoners where appropriate.
The Department of Justice, Equality and Law Reform stated: 'Section 35 of the Prisons Act 2007 provides that the Minister may make rules for the regulation and good government of prisons. In line with this provision, the Prison Rules 2007 are currently in the final stages of being drafted. It is envisaged that the new rules will come into effect approximately three months after the enactment of the Bill. … Amongst other things, the new Rules will provide for the compulsory testing and searching of prisoners for drugs and other contraband. Under the Rules it shall be a breach of prison discipline for a prisoner to be found in possession of any controlled drug or medicinal product other than that which has been prescribed by the prison medical authorities. A prisoner shall also, if requested by a person acting on the authority of the prison governor, provide samples of urine, saliva, oral buccal transudate or hair for the purpose of detecting the presence of intoxicating liquor, controlled substances or medicinal products.'

Where a person has been found to be involved in the supply of drugs to a prisoner we will introduce a stiffer penalty.

We will require convicted drug dealers to register with the Gardaí after leaving prison.
The Department of Justice, Equality and Law Reform reported that relevant provisions in respect of both these initiatives had been included in the Criminal Justice Act 2006, and Commencement Orders made.

We will ensure that an early warning system, involving all key agencies, is in place to track the potential spread of heroin into new areas.
The Department of Community, Rural and Gaeltacht Affairs reported, '… the National Advisory Committee on Drugs (NACD) has sought expressions of interest from appropriate bodies to develop a Drug Trend Monitoring System (DTMS) as part of its current work programme and these are due in April 2007. If progressed, such a system will collect primary data, as well as analysing secondary data on a range of drug use indicators in order to identify nationwide trends in drug use, including the spread of heroin use outside of Dublin.'

We will continue to prioritise heroin and cocaine for intervention, and will publish separate national targets for supply reduction for each major type of drug.
The Department of Community, Rural and Gaeltacht Affairs reported, 'The increased use and spread of cocaine has emerged as a particular threat, and in late 2006, the National Advisory Committee on Drugs (NACD) and the National Drugs Strategy Team (NDST) compiled a briefing paper on cocaine and a presentation covering this and other drug related issues was made to the Cabinet Committee on Social Inclusion. Implementation of the recommendations in the cocaine paper are being progressed with the relevant Departments and agencies.' (In its 2005 Progress Report, the government reported that it had accepted the existing key performance indicators in the National Drugs Strategy, and would not specify separate targets for each major type of drug.)

The drugs issue and social inclusion
In its Agreed Programme, under the heading 'Building an inclusive society', the government included an action to promote and pilot local corporate social responsibility initiatives, for example, in areas affected by drugs and social or rural disadvantage. In its final progress report in respect of this action, the Department of Community, Rural and Gaeltacht Affairs stated, 'Government has established a Forum on Philanthropy to examine ways of facilitating greater levels of philanthropic activity within Ireland. The Department has provided funding of €100,000 per annum to Philanthropy Ireland in support of this initiative.'

Under the heading 'Regenerating urban communities', the government pledged to continue the Young People's Facilities and Services Fund (YPFSF) and complete a comprehensive survey of the availability of recreation facilities in disadvantaged areas. In its final report, the Department of Community, Rural and Gaeltacht Affairs stated: 'To date, the focus of the YPFSF has been in the 14 LDTF areas, as well in the four urban centres of Limerick, Waterford, Galway and Carlow. Overall to date, approximately €109m has been allocated to support projects employing around 330 people. … 108 services projects, with an annual cost of approximately €7.6m, were evaluated and mainstreamed to the Department of Education and Science between 2004 and 2006. They continue to receive annual funding directly from that Department. Expenditure under the YPFSF in 2006 amounted to just over €15.5m (€5.8m capital; €9.7m current).'

(Brigid Pike)

1. Fianna Fáil and the Progressive Democrats (2002) *An agreed programme for government between Fianna Fáil and the Progressive Democrats*. Dublin: Fianna Fáil and the Progressive Democrats. See *Drugnet Ireland*, Issues 8, 12 and 16 for updates on the annual Progress Reports for 2003, 2004 and 2005. No progress report was released in 2006. The final departmental progress reports are available on the website of the Department of the Taoiseach www.taoiseach.gov.ie. Retrieved on 15 June 2007.

RDTF strategies and supply reduction

The regional drugs task forces (RDTFs) are tasked with co-ordinating the implementation of drug policy, as set out in the National Drugs Strategy, in the regions. In 2006 the first round of RDTF strategies and/or action plans was released. Previous issues of *Drugnet Ireland* have looked at the overall approach taken by the RDTFs and at their responses to the need for co-ordination.[1] Starting with supply reduction, this and the following three issues of *Drugnet Ireland* will consider the RDTFs' responses to each of the four pillars of the National Drugs Strategy.

The RDTFs acknowledge that national statutory bodies – An Garda Síochána, the Probation and Welfare Service, the Courts, the Prison Service, Customs and Excise, the Naval Service – have the lead roles in reducing illicit drug supply throughout the country. Understanding of the roles of these agencies, however, varies. Some RDTFs are familiar with the national criminal justice policy and legislative frameworks, but one observes that it is 'aware only in general terms' of the services provided.

The RDTF strategies[2] reveal three main approaches to addressing supply reduction in the regions:

1. *Facilitating the formation of partnerships between statutory and local bodies*, for example, supporting closer liaison between the Gardaí, Customs and Excise, the fishing community, all seafarers, local authorities and the Naval Service, and coastal communities on how they can best contribute to the reduction in the trafficking of drugs; and supporting the development of shared initiatives, services or protocols between health service providers and law enforcement agencies. RDTFs propose measures to ensure that effective channels of communication between themselves and the gardaí are maintained and enhanced.

2. *Strengthening community participation in supply-reduction activities* through means such as fostering estate management programmes in at-risk communities; establishing joint policing committees; promoting the development of community fora; and encouraging An Garda Síochána to engage with community groups to discuss the policing plan for the area, including deployment at peak times, such as week-ends/closing times. One RDTF observes that, 'dealing effectively with the underlying causes of crime and anti-social behaviour will require approaches that have a combined focus on the needs of individuals at risk, building communities, appropriate community policing, and measures to tackle social, economic and educational disadvantage. Local policing partnership, properly resourced, would allow the Garda to adopt a more pro-active approach in aw enforcement and community policing' (WRDTF: 57).

3. *Advocating or lobbying for increased resources for policing activities in the region, and lobbying for policy changes at national level.* Possible policy changes include channelling confiscated assets derived through drug-dealing to communities; extending the Drug Courts model outside Dublin; encouraging and supporting the prosecution of licensed and off-licence premises and adults when charged with supplying alcohol to under-18s; implementing harm-reduction measures within the criminal justice system; considering alternatives to prison; and stronger enforcement of existing legislation, e.g. underage drinking laws and consistency of court penalties.

One RDTF identifies a tension between the nationwide role of the statutory agencies in intercepting smuggling and trafficking activities, and their regional and local roles in interrupting local drug markets:

> …the national brief asked of the Customs and An Garda Síochána, while essential, may actually be distractive to the implementation of initiatives in the context of the LDTFs and RDTFs …. The resources available to the Customs and Excise and An Garda Síochána are insufficient to address levels of drugs supply despite the very significant hauls of both drugs and alcohol at Rosslare and Waterford ports. It is suggested that the supply reduction committees of the Regional DTF and the Local DTFs are restructured to re-focus supply analysis and action at local community level rather than national level as at present. (SERDTF: 53)

A further tension peculiar to the RDTFs is the need to police drug markets across urban and suburban areas and rural hinterlands, where the market dynamics can alter very rapidly. One RDTF notes that drug market activity depends on where there is a local Garda station: '… it is often the case that these rural stations are shared among a wide number of small towns and villages and therefore service provision is diluted' (SWRDTF: 35). In another region, the consultation process brought forth the observation that drugs were being brought into the country through small regional fishing ports, but 'there was a reluctance to name this as it might be detrimental to the image of these places and negatively impact on their tourist potential' (SRDTF: 59). One RDTF calls for exploration of policing models such as the UK Participatory Drugs Profiling (PDP) model, 'to determine whether such approaches could have benefits for community policing, supply reduction and crime prevention efforts in the rural West of Ireland' (WRDTF: 57–8), and another suggests 'augmented policing activity which could include cross-regional work to tackle middle market supply and the strengthening of local policing to disrupt supplies on the streets' (SERDTF: 56). RDTFs operating near active centres of drug-related activities, e.g. Dublin or Derry, call for special responses. The NWRDTF, operating in close proximity to Northern Ireland, and Derry in particular, calls for partnerships with cross-border agencies to address illicit drug use and underage drinking in the region.

(Brigid Pike)

1. Pike B (2006) RDTF strategies push out the boundaries. *Drugnet Ireland*, Issue 20: 11–12; Pike B (2007) Tools for co-ordinating drugs initiatives in the regions. *Drugnet Ireland*, Issue 21: 6–7.
2. The RDTF strategy and action plan documents are held in hard copy in the National Documentation Centre, and are available online at www.hrb.ie/ndc.

Where do illicit drugs fit in the new social inclusion policy framework?

Published in the last 12 months, the new social partnership agreement,[1] national development plan[2] and action plan for social inclusion[3] have all reflected the emergence of a new social inclusion policy framework in Ireland. While not altering the direction of drug policy, the new framework has changed the way in which the drugs issue is presented.

In 2001 the Review Group that drafted the National Drugs Strategy 2001–2008 welcomed the situating of illicit drug policy within the context of social inclusion: 'The Group fully recognises that, notwithstanding the obvious benefits for communities affected by the drugs problem of having a specific drugs strategy, the best prospects for these communities, in the longer term, rest with a social inclusion strategy which delivers much improved living standards to areas of disadvantage throughout the country.'[4] At that time the illicit drugs issue was dealt with in social inclusion policy documents such as the national development plan 2000–2006, the social partnership agreement for 2000–2003 and the national anti-poverty strategy, under functional headings including healthcare, education and training, regenerating disadvantaged communities, tackling homelessness, and tackling crime.

In 2005 the National Economic and Social Council (NESC) published a report, *The developmental welfare state*, which proposes a new streamlined and comprehensive approach to tackling poverty and social exclusion in Ireland.[5] Acknowledging that serious social deficits remain despite Ireland's economic progress, the NESC report calls for a recasting of the social debate in a way that does not distinguish between the economic and the social, suggesting that this will help to build consensus across the social partners, government and wider society. It proposes two innovations in the way in which social inclusion interventions are presented:

- Interventions should be organised according to a lifecycle framework, comprising four categories – children, people of working age, older people, and people with disabilities. This arrangement both places the individual at the centre of policy making and encourages a more joined-up and multi-disciplinary approach to policy making.
- Greater recognition and weight should be given to the role of services in providing protection against risks and to activist measures, or innovative social policy initiatives, in meeting unmet needs and pre-empting problems, as opposed to focusing entirely on income transfers.

In the suite of new social inclusion policy documents mentioned in the opening paragraph, the illicit drugs issue is now placed within the childhood, youth and people of working age stages of the lifecycle framework, and interventions are listed under either 'Services' or 'Innovative Measures'. Details of the most recent social partnership agreement, *Towards 2016*,[1] and the *National development plan 2007–2012* [2] have been described in previous issues of *Drugnet Ireland*.[6] In this issue the presentation of the illicit drugs issue in the *National action plan for social inclusion 2007-2016* (NAPincl), published in February 2007,[3] is described. NAPincl includes an additional category – Communities – which the NESC report acknowledges as an important source of activist or innovative measures.

Children: NAPincl sets targets for the provision of health services for children that include access to treatment for 100% of problematic drug users aged under 18 years within one month of assessment; the introduction of substance abuse policies in 100% of schools by 2008; and the use of results from various surveys to inform policy making and service planning (p. 34). Under the heading of Innovative Measures, NAPincl endorses the Young Peoples Facilities and Services Fund (YPFSF). It notes that the Fund may be extended to other disadvantaged urban areas (p. 37).

People of working age: Under Services, NAPincl emphasises the link between access to a quality health service and participation in the social and economic life of society. Working to improve the health status of vulnerable groups such as those with mental illness, drug users, the homeless and Travellers is seen as 'an essential element of social inclusion'. Actions include ensuring that people who are not able to meet the cost of GP services for themselves and their families are enabled to do so (p. 45).

Communities: Within this category, NAPincl itemises a number of Innovative Measures in areas such as arts, sport, and active citizenship which are expected to have an impact on the illicit drugs issue. NAPincl also lists a series of community-based programmes which will have an impact on the illicit drugs issue, including the Local Development Social Inclusion Programme, the Community Development Programme, the RAPID Programme, the Community Services Programme, Joint Policing Committees, and Family Support Services. The National Drugs Strategy is included in this grouping.

(Brigid Pike)

1. Department of the Taoiseach (2006) *Towards 2016: ten-year framework social partnership agreement 2006–2015*. Dublin: Stationery Office.
2. Government of Ireland (2007) *National development plan 2007–2013: transforming Ireland – a better quality of life for all*. Dublin: Stationery Office.
3. Government of Ireland (2007) *National action plan for social inclusion 2007–2016*. Dublin: Stationery Office.
4. Department of Tourism, Sport and Recreation (2001) *Building on experience: national drugs strategy 2001–2008*. Dublin: Stationery Office. Para. 6.1.9.
5. National and Economic Social Council (2005) *The developmental welfare state*. Dublin: NESC
6. Pike B (2006) New social partnership agreement addresses drugs and alcohol. *Drugnet Ireland*, Issue 19: 7; Pike B (2007) The National Development Plan and the drugs issue. *Drugnet Ireland*, Issue 21: 23–25.

Civil society calls for new directions for UK drug policy

2008 will see the expiry not only of Ireland's national drugs strategy but also of the United Kingdom's (UK) drugs strategy and the United Nations' (UN) 10-year action plan on drugs. Debate around the future direction of UN drug policy was described in the last issue of *Drugnet Ireland*.[1] This article describes recent contributions to the debate about UK drug policy. Three separate new entities have been formed within the civil society sector to kick-start this debate.

In April 2007 the **United Kingdom Drug Policy Commission (UKDPC)** was launched with the release of a 108-page monograph on UK drug policy.[2] Reviewing the available evidence, the authors outline the nature of Britain's drug problem, the population pattern of use of various illicit drugs, how these patterns have changed over time, and the associated harms (including death, health problems, and crime). Against this background, they analyse the impact of current policies in the areas of enforcement, prevention, treatment and harm reduction. They conclude:

> Government policies have only limited impact on rates of drug use itself. However, policies are highly relevant because they can have significant impact on the levels of drug-related harm. …[the government] could make better use of available evidence to choose policies that more effectively reduce drug-related death, crime, physical and mental health problems and other harms to the communities that currently suffer the consequences of drug use. (pp. 82–3)

The authors call for further research on the consequences of drug enforcement efforts, and for the strengthening of the Drug Harm Index,[3] and more transparent drug budgeting, all of which will lead to a greater capacity to measure what is currently being spent.

In May 2007 the **Drugs and Health Alliance (DHA)**, a new alliance of drug charities, was launched.[4] The DHA calls on the UK government to put public health, harm reduction and tackling poverty and exclusion at the heart of UK drug policy. Specifically, it calls on the government to:

- prioritise public health goals;
- implement a truly cross-departmental, public-health-led strategy and place the lead role in the relevant health agencies;
- commission an independent audit of outcomes against expenditure, comparing public health with criminal justice approaches;
- hold an official cross-departmental consultation on the efficacy of criminal justice and public health approaches; and
- reallocate drug strategy expenditure from criminal justice to public health.

The DHA was launched at the RSA (Royal Society for the Encouragement of Arts, Manufactures & Commerce) on 3 May 2007. Two months previously, the **RSA Drug Commission on Illegal Drugs, Communities and Public Policy** published its 300-page report on illegal drugs, communities and public policy.[5] The RSA Drug Commission did not conduct research or hold public hearings but it made extensive use of the existing literature, consulted widely and took advice from a range of experts in the drugs field. Among its many observations and recommendations were the following:

- Illegal drugs, alcohol, tobacco and other psychoactive substances should all be brought within a single regulatory framework, one capable of treating substances according to the amount of harm they cause.
- The success of drugs policy should be measured not in terms of the amount of drugs seized or the number of dealers imprisoned but in terms of the amount of harms reduced. The fight against illegal drugs should not stop, but it should be refocused so that it concentrates on organised criminal networks.
- Drug treatment should be set in a public health framework that includes both clinical treatment and 'wrap-around' services such as housing and employment. There should be easier access to treatment through primary care, and GPs should not be allowed to opt out of providing drug treatment.
- The Misuse of Drugs Act 1971, now over 30 years old, should be repealed and replaced by a comprehensive Misuse of Substances Act.

(Brigid Pike)

1. Pike B (2007) Civil society joins international debate on drug controls. *Drugnet Ireland*, Issue 22, p. 3:
2. Reuter P and Stevens A (2007) *An analysis of UK drug policy. A monograph prepared for the UK Drug Policy Commission*. London: UKDPC. Retrieved 25 July 2007 from www.ukdpc.org.uk. The UKDPC was established to provide independent and objective analysis of drug policy and find ways to help the public and policy makers better understand the implications and options for future policy. Composed of a group of independent experts, the UKDPC is chaired by Dame Ruth Runciman.
3. MacDonald Z, Tinsley L, Collingwood J, Jamieson P and Pudney S (2005) *Measuring the harm from illegal drugs using the Drug Harm Index*. Home Office Online Report 24/05. London: Home Office.
4. For further information on the DHA, visit www.drugshealthalliance.net. The charities forming the DHA include the Beckley Foundation, the International Harm Reduction Association, the Kaleidoscope Project, Release, Transform Drug Policy Foundation and the UK Harm Reduction Alliance.
5. RSA Commission on Illegal Drugs (2007) *Drugs – facing facts. The report of the RSA Commission on Illegal Drugs,Communities and Public Policy*. London: RSA Commission on Illegal Drugs. Retrieved 25 July 2007 from www.rsadrugscommission.org. The Commission was appointed in January 2005 as an independent body under the auspices of the RSA. Its members were drawn from various fields and disciplines in the drugs area, and also from business, local government, health and social services, parliament, the professions and academia.

MQI annual review 2006

The Merchants Quay Ireland (MQI) annual review for 2006, and its re-designed website, were launched by Minister of State with responsibility for the National Drugs Strategy Mr Pat Carey TD on 31 August 2007.[1] The Minister spoke of the growing need for needle exchange services to be made available nationally.

More than 39,460 visits were recorded at MQI's needle-exchange service, of which 1,754 were by new clients. While the majority were heroin users, 20% were also using cocaine. Chief executive Mr Tony Geoghegan said that people tended to inject drugs for a year or more before they sought treatment and that during this period they were at risk of contracting hepatitis C or HIV. He highlighted the lack of localised harm-reduction services, saying that, while media attention had focused on problem cocaine use, heroin remained a major issue throughout the country.

The review also highlights the increasing demand for MQI's homeless services, particularly from people from the new EU member states. By October 2006 over 50 eastern Europeans were availing of the services every day. MQI has produced information leaflets in Polish and Russian (available on the new MQI website), and some staff have taken language classes. Mr Geoghegan called for some relaxation of the Habitual Residence Condition to allow non-nationals greater access to social welfare services.

The types of service offered by MQI and the numbers of people accessing them in 2006 are shown below.

Service	Type of intervention	No. of participants	Outcomes
Needle exchange and health promotion services	Promoting safer injecting techniques HIV and hepatitis prevention Safe sex advice Information on overdose	39,460 (including 1,754 new clients) 308 safer injecting workshops	Not available
Stabilisation services	Methadone substitution	30	Not available
	Supportive day programmes	18	Not available
	Gateway programme	16 (monthly average)	Not available
	Counselling	Not available	Not available
Settlement service	Assist service users to access interim and long-term accommodation	An average of 52 a month	An average of 25 a month availed of the Tenancy Sustainment Service
Integration programmes	Access to transitional accommodation (Ballymount House) for up to 24 weeks Group and one-to-one therapeutic sessions	6	Not available
Training and work programmes	FÁS Community Employment scheme	130	70 secured permanent employment or moved to further education
	Catering training programme	21	10 awarded FETAC Certificate
High Park	17-week, drug-free residential programme including individual counselling, group therapy, educational groups, work assignments and recreational activities	73 (of whom 27 were admitted for detoxification)	19 completed detox
St Francis Farm	Therapeutic facility offering a 6–12-month programme	30	17 completed three months or more

(Vivion McGuire)

1. Merchants Quay Ireland (2007) *Annual review 2006*. Dublin: MQI.

MQI annual review 2006 *(continued)*

From left: Fergus McCabe, community worker and former community sector representative on the National Drugs Strategy Team, and David Connolly, chair of the Ballyfermot LDTF, at the MQI launch (photo: Jim Berkeley)

The new MQI website

Along with its annual review, Merchants Quay Ireland launched its re-designed website (www.mqi.ie). MQI has had an online presence for some years but the new site is a significant development in terms of design, content, navigation and accessibility. The site is rich in content that is clearly and logically organised; all parts of the site are within the maximum '3 clicks' recommended in contemporary web design. Navigation is further aided by the high level of consistency in navigation devices, font styles and headings, colour and page structure across all parts of the site.

Photos of anonymous figures in various parts of Dublin used as background to the main pages work well aesthetically and reflect the nature of the site's content. Thumbnails of these portraits are used to form an alternative menu on the home page, which has the effect of softening an otherwise busy and content-heavy page. Images are used to highlight both the news stories and items selected for display on the front page, which reduces the crowding and noise often found on sites that use contemporary content-management systems.

The website's contents menu neatly delineates the various aspects of MQI's work. The organisation's extensive and diverse research output over the past ten years is available to download and the research page also contains links to many other organisations' publications on drugs and homelessness. The site also has a short guide to MQI services in Polish and Russian translation. The Media page is a very useful source of concise factual information on drug use, homelessness and the work of MQI for those who need information quickly and who may not be familiar with these subjects.

The new MQI website is an impressive addition to the growing collection of online resources available to those interested in the drugs area. It manages to present a considerable amount of documentation and other information in an attractive and easily-navigable resource.

(Brian Galvin)

ROSIE Findings 4: summary of methadone treatment outcomes

The Research Outcome Study in Ireland (ROSIE) is a national multi-site drug treatment outcome study which is being conducted 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 treatment outcomes presented in the first three papers in the ROSIE Findings series have been reported in previous issues of *Drugnet Ireland*. The fourth paper in the series, ROSIE Findings 4,[1] provides a summary of the outcomes for people in the methadone modality one year after treatment intake.

The provision of methadone, a long-acting opiate agonist, under medical supervision is the main pharmacological substitution intervention for opiate users in Ireland. Initially, a low commencing dose (usually 10–40 ml) is prescribed, aimed at achieving a level of comfort while reducing the likelihood of overdose. By the end of six weeks' treatment, the individual is usually stabilised on an appropriate therapeutic dose. Methadone maintenance is a long-term treatment option of no fixed duration and there are different models of maintenance prescribing, ranging from highly structured regimes to low-threshold programmes.

The ROSIE study methadone cohort (n=215) was recruited from health board clinics (50%, n=108), general practitioners (25%, n=54), community-based clinics (22%, n=48) and prison (2%, n=5). The analysis presented in Findings 4 is based on the 167 (78%) participants who provided valid answers to each individual question during their treatment intake and one-year follow-up interviews.

Participants in the methadone modality were typically male (68%), with an average age of 28 years, and were largely dependent on social welfare payments (81%). The majority (64%) had children aged under 18 years. Sixty per cent had spent time in prison and 17% had been homeless in the 90 days prior to treatment intake interview.

Treatment completion rates

Methadone is a long-term treatment option and, at one year, 3% (n=5) had completed treatment. The retention rate was high: 79% (n=132) were still receiving methadone treatment at one year, 6% (n=10) had transferred to another treatment modality and 12% (n=20) had dropped out of treatment.

One year after treatment intake, 90% (n=151) reported being in some form of drug treatment. Eighty-four per cent (n=141) were in methadone treatment, 26% (n=44) were attending one-to-one counselling, 15% (n=25) were in group work (Narcotics Anonymous meetings, aftercare programmes, and Community Employment schemes), and 1% (n=2) were in a structured detoxification programme.

Drug use outcomes

The number of participants who reported using heroin, non-prescribed methadone, non-prescribed benzodiazepines, cocaine powder or crack cocaine in the 90 days prior to interview decreased between treatment intake and one-year follow-up. The most substantial reduction was in opiate use (heroin and non-prescribed methadone) both in terms of the proportion of participants using the drug and the frequency of use. Heroin use decreased from 84% at treatment intake to 53% at one year, while non-prescribed methadone use decreased from 48% to 16%. The frequency of heroin use decreased from 50 days out of 90 at treatment intake to 15 days out of 90 at one year, while the frequency of non-prescribed methadone use decreased from 16 days out of 90 at treatment intake to 4 days out of 90 at one year.

Polydrug use in the 90 days prior to interview also reduced, from 78% (n=131) at treatment intake to 56% (n=94) at one year. At one-year follow-up, 16% (n=27) of participants reported that they had not used any illicit drugs in the 90 days prior to interview.

Crime outcomes

Overall, the proportion of participants who reported involvement in crime had decreased from 49% at treatment intake to 27% at one year. There was a reduction in the percentage of participants involved in acquisitive crime, from 28% at treatment intake to 15% at one year.

Risk behaviour outcomes

There was a significant reduction in the number of participants who reported injecting drug use. At treatment intake, 44% (n=73) had injected a drug in the 90 days prior to interview, compared with 32% (n=53) at one year. There were no changes in participants' injecting-related risk behaviours. There was a non-significant reduction in the proportion of participants who reported an overdose in the 90 days prior to interview, from 8% (n=12) at treatment intake to 6% (n=9) at one year.

Health outcomes

Ten symptoms were used to measure the physical health of participants (see paper for details). The number of participants who reported nine of the ten physical health symptoms increased between treatment intake and one year, with a significant increase observed in the proportion reporting stomach pains.

Ten symptoms were also used to measure the mental health of participants (see paper for details). There was an increase in the number of participants who reported suffering from any six of the ten mental health symptoms.

ROSIE Findings 4 *(continued)*

Service contact

ROSIE Findings 4 reports an increase in participants' contact with GPs, employment/education services and housing/homeless services.

The authors state that the findings presented in this paper demonstrate that retention in methadone treatment is high, and continued participation in a methadone programme substantially reduces opiate use, injecting drug use and involvement in crime. The outcomes for ROSIE participants in the methadone modality compare favourably with international outcome studies. Although rates of improvement in physical and mental health were disappointing, it is hoped that results from the ROSIE three-year follow-up will provide evidence of a positive association between long-term treatment and improvements in physical and mental health.

(Deirdre Mongan)

1. Cox G, Comiskey C and Kelly P (2007) *ROSIE Findings 4: summary of 1-year outcomes: methadone modality*. Dublin: National Advisory Committee on Drugs. Available at http://www.nacd.ie/publications/treatment_rosie4.html

Evaluation of a cocaine training programme

In 2004, the National Drugs Strategy Team funded Merchants Quay Ireland to co-ordinate training programmes for two levels of service providers who come in contact with cocaine users – front-line staff and key or case workers supporting active cocaine users. The training programme outlined in the table below was implemented in May 2005.

Wendy Crampton[1] evaluated the training, using:

- participant self-assessment and evaluation
- tutor evaluation
- participant follow-up questionnaire
- work supervisors' feedback.

The evaluation of the level-one course indicated that the participants' level of knowledge had increased considerably, from an average of 50% per participant to 80%. While each individual's knowledge about cocaine increased during the course, many wanted more knowledge and practical experience with clients. Participants rated the course content at 79%, the training style at 85% and the venue at 81%. The trainer rated two of the three groups of participants as having beginner-level knowledge and one group as having medium level. The trainer noted that the participants were open to learning, asked lots of questions and were willing to share their knowledge.

Because of issues that arose during Course 1 of the level-two course, some adjustments were made to the plans for Course 2, and the two courses were evaluated separately.

The evaluation of Course 1 indicated that the participants' level of knowledge had increased by 33%, from an average of 58% per participant to 77%. Participants rated the course content at 64%, the training style at 67% and the venue at 57%. The trainer reported that some participants were inexperienced and this resulted in 'lecture style' training. Based on this and other feedback from Course 1, MQI requested that the tutor introduce interactive training methods in Course 2. They also changed the training venue and requested a list of participants in advance of the course.

The evaluation of the level-two Course 2 indicated that the participants' level of knowledge increased by 43%, from an average of 59% per participant to 84%. Participants rated the course content at 78%, the training style at 86% and the venue at 78%. The feedback from Course 2 was positive and demonstrated that it is important to learn from participants' evaluations.

(Jean Long)

1. Crampton W (2005) *An evaluation of a cocaine training programme*. Dublin: Merchants Quay Ireland. Available on the National Drugs Strategy page at www.pobail.ie.

Training type	Target group	Trainers	Expected learning outcomes	Number of attendees
A one-day, level-one course, run for three separate groups Providing basic knowledge of cocaine and related issues and skills to support cocaine users	Front line staff and agencies	Piper Projects: same facilitator for each of the three groups	Know: ■ facts about cocaine, dopamine and adrenaline ■ methods of cocaine consumption ■ effects of polydrug use ■ trigger factors associated with cocaine use ■ signs and symptoms of cocaine use ■ role of and types of harm reduction and complementary therapy Skills to support cocaine users	Expected: 60 Attended: 55 Completed: 53
A three-day, level- two course, run for two separate groups (Course 1 and Course 2) Providing basic assessment and motivational counselling techniques to support cocaine users through treatment	Key or case workers	Piper Projects: different facilitator for each of the two groups	Know: ■ facts about cocaine ■ about motivation and the wheel of change ■ appropriate treatment interventions ■ risks and benefits of interventions ■ how to prevent relapse Ability to: ■ identify signs and symptoms of cocaine use ■ assess client needs ■ develop care plans ■ counsel using motivational interviewing	Expected: 40 Attended: 49 Course 1 – 24 Course 2 – 25 Completed: 38 Course 1 – 20 Course 2 - 18

Conference on cocaine intervention and rehabilitation

Mr Pat Carey TD, Minister of State with special responsibility for drugs strategy and community affairs, speaking with Tony Geoghegan of MQI at the cocaine conference (photo: Jim Berkeley)

Cocaine Response: Sharing Good Practice, a conference hosted by SAOL and the National Drugs Strategy Team (NDST) and attended by 280 delegates, was held in Croke Park, Dublin, on 28 June 2007. The aim of the conference was to further collaboration and knowledge sharing between the various agencies involved in the field of cocaine intervention and good practice. A consistent theme throughout the conference was that progress depended on continued co-operation and partnership between community and voluntary services and statutory agencies. Minister of State with responsibility for drugs strategy, Mr Pat Carey TD, opened the conference. The Minister acknowledged that cocaine presented a serious issue for communities and drug services throughout the country and that an effective response needed continued planning and proper resources. He welcomed SAOL's initiative in developing a resource pack and organising the conference. These were examples, he said, of the important contribution that the community and voluntary sector makes in the area of problem drug use. He said that he strongly believed that treatment, particularly in the form of counselling, can and does work, and he noted the commitment to cocaine-specific clinics in the section on drugs in the new Programme for Government.

Two recurring themes were the dangers of cocaine use and the value of partnership as an approach to dealing with drug problems. Patricia O'Connor, director of the National Drugs Strategy Team (NDST), emphasised both of these points. She stressed that cocaine use can, and often does, result in significant health problems and death. In view of these risks, the challenge is to get this message across to all age groups, all sections of the workforce and to those communities already most affected by heroin use. She appealed to the media to play a supportive role in this task and to keep publicising the risks. Joan Byrne, director of the SAOL project, spoke of the challenge facing services in turning a predominantly opiate-focused treatment system into one that meets the needs of cocaine and polydrug users. She emphasised the importance of information on drug trends and noted the limited role that the experience of local communities has in informing official drug policy. She praised the work and the partnership approach of the NDST.

The conference also heard an overview of the recent NACD cocaine report presented by Mairead Lyons, NACD director. Siobhán Cafferty outlined the tools which comprise the Cocaine Resource Pack: a CD for low-threshold, chaotic users who are unable to commit to attending a project on a regular basis; Relapse Worksheets, for those who can attend projects or services on a more regular basis and who have an established relationship with a key worker; and Reduce the Use, a booklet for those in the contemplation stage who are linked in with a project/service on a more regular basis. Tony Duffin of the Ana Liffey Drug Project described a

Anna Quigley of CityWide speaking at the cocaine conference (photo: Progression Routes)

new, joint community/statutory harm reduction campaign targeting injecting cocaine users. The conference also heard a report from the HSE on plans for addressing cocaine use and examples of effective responses in Tallaght with a client group not traditionally engaged with drug services. The role of holistic treatments in dealing with problem drug use was described, and was a theme of one of the conference workshops.

(Brian Galvin)

Copies of the report on the conference are available from SAOL. Contact progressionroutes@saolproject.ie.

Siobhán Cafferty of SAOL talking about their Reduce the Use programme at the cocaine conference (photo: Jim Berkeley)

Overdose data from the HIPE scheme

Data used in the following analysis were extracted from the database of the Hospital In-Patient Enquiry (HIPE) scheme maintained by the Economic and Social Research Institute.[1] HIPE is a computer-based health information system designed to collect medical and administrative data regarding discharges and deaths from acute hospitals.[2] Each HIPE discharge record represents one episode of care; each discharge of a patient, whether from the same or a different hospital, or with the same or a different diagnosis, gives rise to a separate HIPE record. The records therefore facilitate analyses of hospital activity rather than of the incidence of disease. HIPE does not record information on cases that attend accident and emergency units but are not admitted as inpatients.

Number of deaths from overdose

The total number of overdose cases for the period 1996 to 2004 inclusive was 46,539. Eighty of these cases died and have been excluded from this analysis.

Age group

Cases aged between 15 and 65 years inclusive are included in this analysis. Figure 1 shows that the 20–24-year age group is at highest risk, with the incidence of overdose decreasing with age. It is important to note the significant number of cases in the 15–19-year age group.

Area of residence

From 1999 to 2001 a steady increase in overdose cases was recorded among persons resident outside Dublin. In 2002 there was a slight decrease among this population, followed by an increase in 2003 and then a significant decrease (18%) in 2004. Reported overdose cases among persons resident in Dublin decreased steadily between 2000 and 2004.

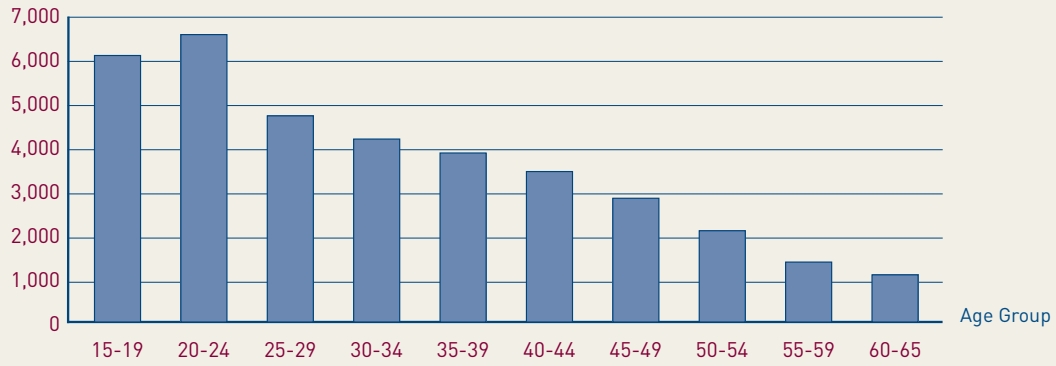
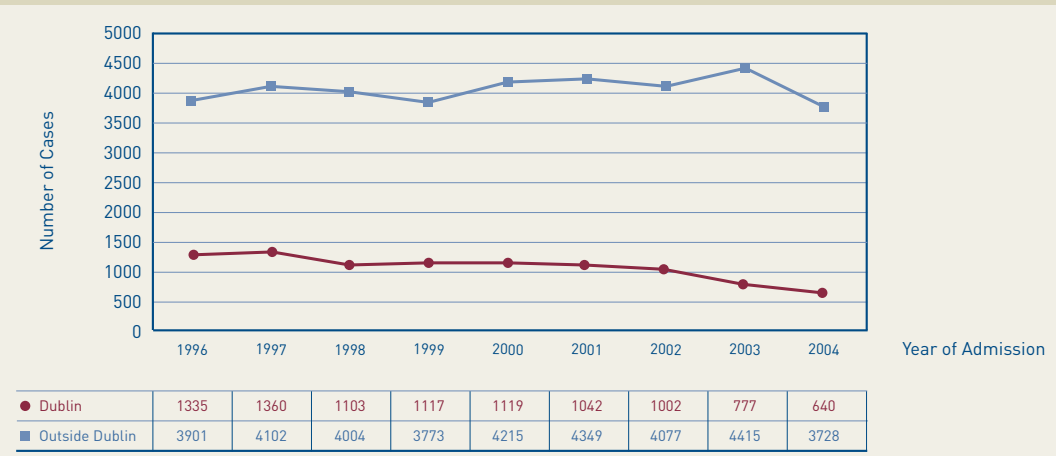


Figure 1 Incidence of overdose by age group, 1996 to 2004

Most common drug category by type of overdose

Attempted suicide accounted from the majority (81%) of overdose cases reported through HIPE for the years 1996 to 2004 inclusive. Of these cases, 42% related to the use of a tranquilliser or other psychotropic-type drug and 39% related to intentional overdose with analgesics. According to the 2005 annual report of the National Registry of Deliberate Self Harm, 41% of all drug overdoses involved a minor tranquilliser, 32% involved paracetamol and 23% involved anti-depressants.[2]



	1996	1997	1998	1999	2000	2001	2002	2003	2004
Dublin	1335	1360	1103	1117	1119	1042	1002	777	640
Outside Dublin	3901	4102	4004	3773	4215	4349	4077	4415	3728

Figure 2 Area of residence of overdose cases, 1996 to 2004

Overdose data *(continued)*

Gender

There were more overdose cases among females than among males. A significant decrease in reported incidence of overdose among females (17%) and among males (15%) is evident between 2003 and 2004.

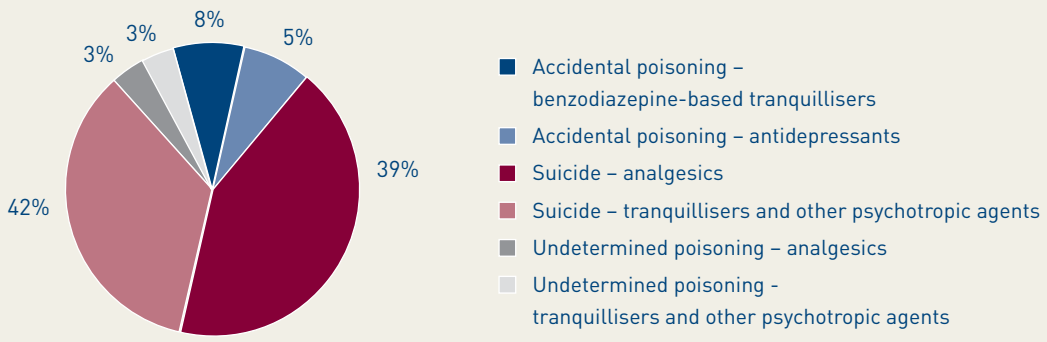
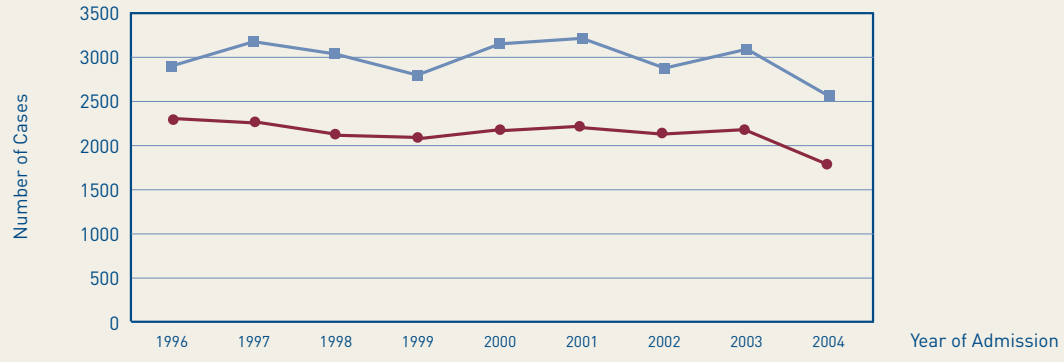


Figure 3 Most common drug category, by type of overdose, 1996 to 2004

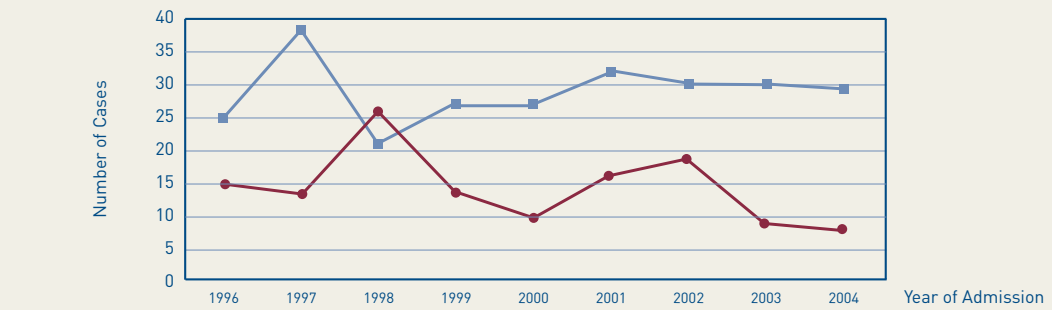
Opiates

Opiate-type drugs were involved in less than 1% of cases reported for each year between 1996 and 2004. Since 2002, the trend in accidental poisoning by opiates other than heroin has stabilised. The number of cases of accidental poisoning by heroin decreased by 58% in the same period, from 19 in 2002 to 8 in 2004.



	1996	1997	1998	1999	2000	2001	2002	2003	2004
Male	2327	2300	2141	2132	2244	2280	2139	2146	1831
Female	2951	3211	3011	2810	3150	3167	2987	3074	2558

Figure 4 Incidence of overdose by gender, 1996 to 2004



	1996	1997	1998	1999	2000	2001	2002	2003	2004
Accidental poisoning by heroin	15	13	26	14	10	16	19	9	8
Accidental poisoning by other opiates	25	38	21	27	27	32	30	30	29

Figure 5 Incidence of overdose involving opiate-type drugs, 1996 to 2004

Overdose data *(continued)*

Thirteen per cent more males than females overdosed using opiate-type drugs during the period 1996 to 2004. A significant number (16%) of those who overdosed using opiate-type drugs were in the 15–19-year-old group; however, the majority (27%) were in the 20–24-year-old group, and the incidence decreased in successive age groups between 25 and 54 years. Thirty-eight per cent of overdose cases involving an opiate-type drug occurred in the Dublin region.

(Ena Lynn)

1. I would like to thank the ESRI for providing the data for the analysis included in this article.

2. The coding scheme used to code diagnoses for the years presented in this analysis was the International Classification of Diseases, 9th Revision, Clinical Modification, known as ICD-9-CM. Further information and reports on HIPE can be found on the Economic and Social Research Institute website at www.esri.ie
3. National Registry of Deliberate Self Harm Ireland (2005) *Annual report 2005*. Cork: National Suicide Research Foundation.

Drug users' experiences of overdose

A study which aimed 'to explore drug users' experiences and perspectives of overdose' was carried out in Dublin in 2006.[1] The main objectives were to investigate drug users' personal perspectives and experiences of overdose, their experiences of witnessed overdoses, and their views on possible strategies to prevent or reduce the incidence of overdoses.

The inclusion criteria were as follows: all participants in the study must be receiving methadone maintenance therapy in the Drug Treatment Centre Board for treatment of opiate addiction, all participants must have overdosed in the preceding year, all participants must have voluntarily agreed to participate in the study and signed a consent form, and all participants must be fluent in English. A convenience sampling method was used and the first 10 participants who volunteered and met the inclusion criteria were selected to take part in in-depth semi-structured interviews, which lasted between 30 and 60 minutes. Participants ranged in age from 22 to 46 years; seven were male and three were female. All 10 had hepatitis C and four had HIV.

The researcher asked participants questions about their own overdose experiences, including: what drugs they had used; their method of drug taking; their actual experience of overdose; whether the overdose was accidental or intentional; their perceived reasons and/or precipitating factors for accidental overdose; trigger factors for intentional overdose; their knowledge of medical treatment for overdose; and possible strategies to prevent or reduce future overdoses.

The numbers of personal overdoses among the participants ranged from two to 30. The most recent overdose was accidental in six cases and intentional in four cases. All 10 had engaged in polydrug use in their most recent overdose. Five of the six participants who had accidentally overdosed had used heroin, and one of the four who had intentionally overdosed had used heroin. The most common drug used was methadone and all 10 participants had consumed methadone in their most recent overdose. Three of the participants reported intentionally overdosing on a combination of prescribed methadone and other prescription medication. Trigger factors for intentional overdoses included sexual abuse, physical abuse, depression and recent bereavement. Perceived reasons for accidental overdoses included reduced tolerance to drugs following a period of abstinence, variation in the quantity and quality of heroin used, and polydrug use, especially of benzodiazepines or alcohol in conjunction with heroin. Four participants were hospitalised as a result of their most recent overdose (two from intentional overdoses, two from accidental overdoses).

Participants showed a lack of knowledge about medical treatment of overdose. Those hospitalised did not know how they had been treated, and only one of the 10 participants was able to name the heroin antidote given to overdose victims.

All 10 participants had witnessed another person overdosing. They were questioned about their knowledge of overdose intervention, how they had intervened and, if they had not done so, why they had not. Interventions such as slapping the victim, walking them around, dousing them with water, using mouth-to-mouth resuscitation and placing them in the recovery position were implemented before an ambulance was called. In general, an ambulance was called only in cases where there was serious danger, and only then after a delay of at least 10 minutes. In cases where the participants witnessed an overdose and did not intervene, the most common reason given was fear of police involvement.

Participants were asked whether they thought training in overdose prevention should be available to drug users. All 10 agreed that such training should be available to all drug users and two stated that it should be made compulsory.

The study makes a number of recommendations for reducing drug overdoses and deaths:

- a training programme on drug overdose prevention
- tighter legislation and caution when prescribing medication to drug users
- improvements in initial and ongoing psychiatric assessment of drug users
- frequent drug analysis screening of street heroin
- decreased police presence at overdose situations
- pilot studies on naloxone distribution among peers
- supervised drug injecting facilities.

(Lorraine Coleman and Ena Lynn)

1. Bolger A (2007) Drug users' experiences and perspectives of overdose: an exploratory study. MSc thesis submitted to Dublin City University.

New data on the incidence of HIV

HIV (subsequently known as HIV1) was identified in 1981 and HIV2 was identified in 1986. The virus attaches itself to the CD4 particle of the T-lymphocytes. These T-lymphocytes co-ordinate the body's immune response. HIV may lead to a condition known as acquired immunodeficiency syndrome (AIDS). This condition generally occurs when the CD4 count is below 200 per millilitre and is characterised by the appearance of opportunistic infections. Such infections take advantage of a weakened immune system. The HIV virus is found in all body fluids and is transmitted via sexual intercourse (both heterosexual and homosexual), mother to foetus and baby, infected blood and blood products and procedures with unsterile needles, syringes and skin-piercing instruments. Best evidence available to date indicates that once an individual is infected he or she remains infected for life.

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1985. According to the most recent report of the Health Protection Surveillance Centre (HPSC), at the end of 2006 there were 4,419 diagnosed HIV cases in Ireland, of which 1,327 (30%) were probably infected through injecting drug use.[1]

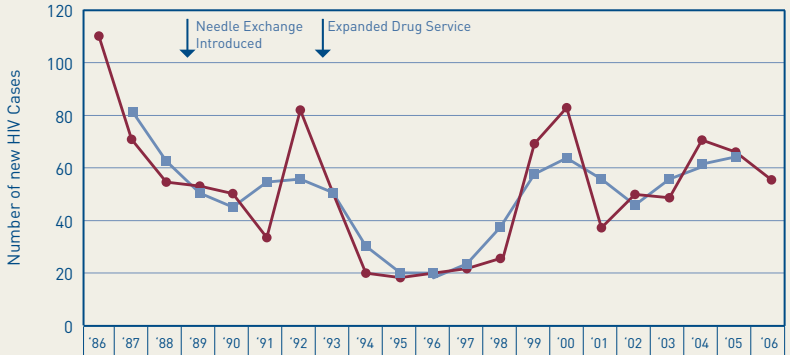
Figure 1 presents the number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland; data from 1982 to 1985 were excluded from the figure as these four years were combined in the source records. Figure 1 is based on data reported to the Department of Health and Children, the National Disease Surveillance Centre and its successor, the HPSC. There was a fall in the number of HIV cases among injecting drug users between 1994 and 1998, with about 20 cases per year compared to about 50 cases each year in the preceding six years. In 1999, there was a sharp increase in the number of cases among injecting drug users, which continued into 2000, with 69 and 83 new cases respectively. Between 2001 and 2003 there was a decline in the number of new injector cases (38, 50 and 49 respectively) when compared to 2000 but the number was higher than in 1998. In 2004, once again, there was an increase (to 71 cases) in the number infected through injecting drug use compared to the preceding three years. In 2006 there were 57 cases infected through injecting drug use. It was difficult to interpret the trend due to the relatively small numbers diagnosed each year, so a smoother curve (red plot line in Figure 1) was calculated using a rolling centred three-year average. This curve presents an increase in the annual number of HIV cases in 1999; this higher number of cases was sustained between 2000 and 2006. This indicates a true increase in the number of cases.

Of the 57 new HIV cases among injecting drug users reported to the HPSC in 2006, 41 were male and 16 were female and the average age was 32 years. Of the 39 cases for whom place of residence was known, 37 lived in the HSE Eastern Region.

This HPSC report confirms the need, emphasised by the authors of the report on the 2004 data, to continue to promote the use of harm reduction measures among injecting drug users.

(Jean Long)

1. Health Protection Surveillance Centre (2007) *Newly diagnosed HIV infections in Ireland: quarters 3 & 4 2006, and 2006 annual summary*. Dublin: Health Service Executive.
2. Long J (2006) *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005*. Overview 4. Dublin: Health Research Board.



	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06
Actual Number	11	72	58	57	50	34	82	52	20	19	20	21	26	69	83	38	50	49	71	66	57
Rolling Centred 3 Year Average Number		81	62	55	47	55	56	51	30	20	20	22	39	59	63	57	46	57	62	65	

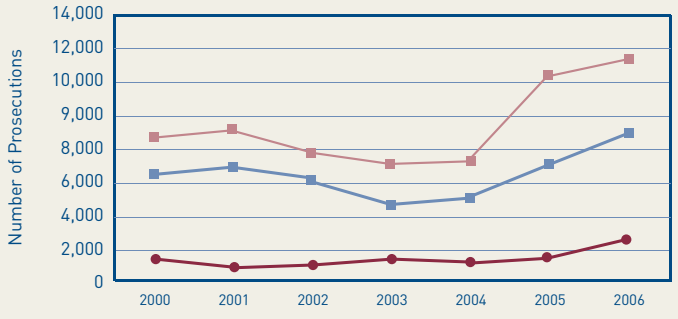
Figure 1 **Actual number and rolling average number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland, 1986 to 2006**
Source: Long (2006)[2]

Drug-crime statistics

Until 2006, the principal source of information on drug offences was the annual reports of the Garda Síochána. In 2006, responsibility for reporting crime statistics was transferred to the Central Statistics Office (CSO). The CSO has published some data on drug offences and drug seizures on a Garda divisional basis; more detailed data will be made available once the Garda data have been fully examined (CSO, personal communication, 2007).

The vast majority of drug offences reported come under one of three sections of the Misuse of Drugs Act (MDA) 1977: section 3 – possession of any controlled drug without due authorisation (simple possession); section 15 – possession of a controlled drug for the purpose of unlawful sale or supply (possession for sale or supply); and section 21 – obstructing the lawful exercise of a power conferred by the Act (obstruction). Other MDA offences regularly reported on relate to the unlawful importation into the State of controlled drugs contrary to section 21; permitting one's premises to be used for drug supply or use contrary to section 19; the use of forged prescriptions (section 18); and the cultivation of cannabis plants (section 17).

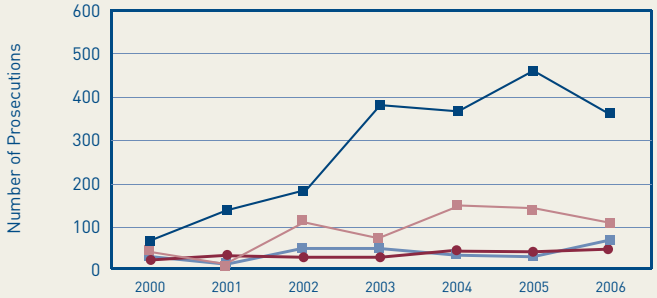
Figure 1 shows trends in the numbers of drug supply, possession and total drug offence prosecutions between 2000 and 2006. The majority of prosecutions are for drug possession, which have risen steadily since 2003 and accounted for 73.2% of the total drug offences prosecuted in 2006. The number of simple possession offences increased from 7,432 in 2005 to 8,556 in 2006. The number of supply offences leading to a prosecution in 2006 was 2,525, representing 21.6 % of the total number of offences prosecuted.



	2000	2001	2002	2003	2004	2005	2006
Drug Supply (s. 15 MDA)	1706	1520	1530	1758	1608	1928	2525
Drug Possession (s. 3 MDA)	6485	7009	6038	4805	5065	7432	8556
Total Drug Offences	8395	8768	7976	7150	7302	10,074	11,676

Figure 1 Trends in possession (s.3 MDA), supply (s.15 MDA) and total drug offence prosecutions, 2000–2006
Source: Annual reports of An Garda Síochána 2000–2005; Central Statistics Office 2006

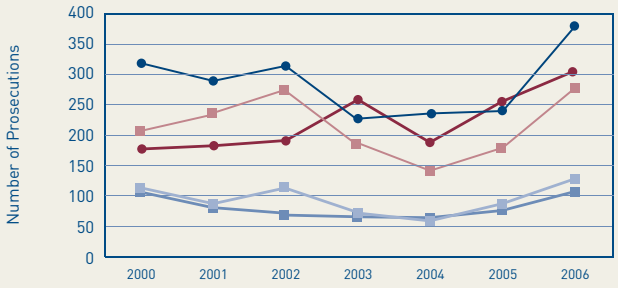
Figure 2 shows trends in prosecutions for a selection of other offences where proceedings commenced between 2000 and 2006. Prosecutions for obstruction increased by 704% between 2000 and 2005, and decreased from 479 in 2005 to 373 in 2006. Prosecutions for cultivation or manufacture of drugs increased by 200% between 2005 and 2006.



	2000	2001	2002	2003	2004	2005	2006
Importation	17	30	26	27	40	33	35
Cultivation	22	18	51	52	32	27	81
Forging a Prescription	29	16	111	80	157	134	106
Obstruction	68	138	193	392	368	479	373

Figure 2 Selected MDA offences, excluding possession and supply, where proceedings commenced, 2000–2006
Source: Annual reports of An Garda Síochána, 2000–2005; Central Statistics Office 2006

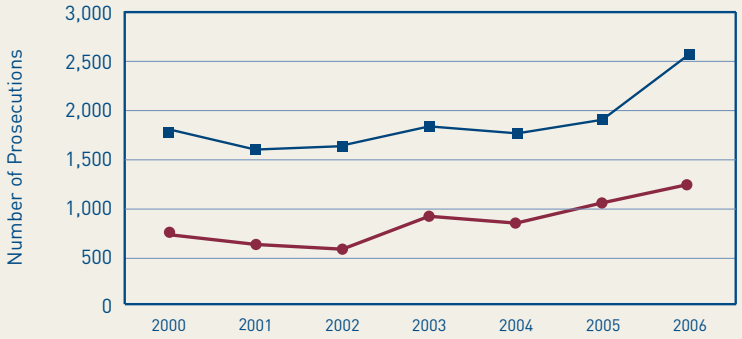
Drug-crime statistics *(continued)*



	2000	2001	2002	2003	2004	2005	2006
Eastern Region	174	183	192	259	194	256	307
Northern Region	103	81	73	68	62	72	115
South Eastern Region	207	244	274	192	148	182	278
Southern Region	329	293	322	232	236	242	378
Western Region	114	88	116	69	57	82	130

Figure 3 Drug supply (s.15 MDA) offences outside the DMR where criminal proceedings commenced, 2000–2006
Source: Annual reports of An Garda Síochána 2000–2005; CSO, personal communication, July 2006

With regard to the importation and internal distribution of drugs – the middle market – data on drug supply offence prosecutions by Garda division are a possible indicator of distribution patterns.[1] While these data primarily reflect law enforcement activities and the relative ease of detection of different drugs, they may also provide an indicator of national drug distribution trends and whether, for example, there is a concentration of prosecutions along trafficking routes. Figure 3 shows the number of prosecutions for drug supply offences in Garda regions outside the Dublin Metropolitan Region (DMR).



	2000	2001	2002	2003	2004	2005	2006
Dublin Met Region	779	631	553	938	911	1094	1317
Total	1706	1520	1530	1758	1608	1928	2525

Figure 4 Trends in total drug supply prosecutions and those in the DMR, 2000–2006
Source: Annual reports of An Garda Síochána 2000–2005; CSO, personal communication, July 2006

The upward trend since 2004 in prosecutions for drug supply continued in 2006 (Figures 3 and 4). Although the majority of such prosecutions still take place in the DMR, the proportion of the total number which take place outside the DMR has increased since 2004 (Figure 4).

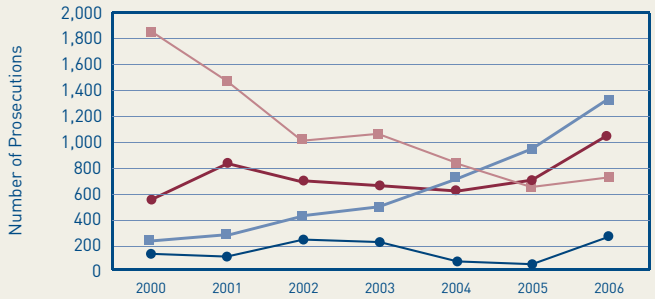
Although the number of drug seizures in any given period can be affected by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of traffickers to law enforcement activities, drug seizures are considered as indirect indicators of the supply and availability of drugs. Data presented below on trends in the number of drugs seized by drug type are derived from the annual reports of An Garda Síochána, which has retained responsibility for reporting this specific data.

Cannabis seizures account for the majority of all drugs seized. Of the 7,550 reported drug seizures in 2006, 3,853 (51%) were cannabis-related. Figure 5 shows trends in seizures of a number of selected drugs, excluding cannabis, between 2000 and 2006. We can see a continuous steady rise in cocaine seizures and a sharp rise in heroin seizures, from 725 in 2005 to 1,115 in 2006. The number of seizures of ecstasy-type substances also rose in 2006, following a steady decline since 2000.

(Johnny Connolly)

1. Connolly J (2005) *The illicit drug market in Ireland*. Overview 2. Dublin: Health Research Board.

Drug-crime statistics *(continued)*



	2000	2001	2002	2003	2004	2005	2006
Heroin	598	802	714	660	612	725	1115
Cocaine	206	300	429	566	753	968	1324
Ecstasy Type Substances	1864	1485	1027	1083	806	655	771
Amphetamines	169	162	243	211	145	119	236

Figure 5 Trends in the number of seizures of selected drugs, excluding cannabis, 2000–2006
Source: Annual reports of An Garda Síochána 2000–2006

A World Health Organization guide to health in prisons

On 25 May 2007 the World Health Organization regional office in Europe published *Health in prisons*, a guide for the provision of health care in prisons.[1] The guide outlines steps that prison services can take to reduce public health risks associated with compulsory detention and outlines internationally recommended standards for prison health. The authors provide guidelines on assessing prisoner needs and providing evidence-based prevention, care and treatment in the prison setting. A number of chapters are of interest to those working in the drugs area, such as 'drug use and services in prisons', 'substitution treatment in prisons', 'communicable diseases' and 'HIV infection and human rights in prisons'. This article highlights the steps recommended to deal with drug-related issues and infectious diseases.

Survey estimates indicate that half of the prisoners in the EU have used drugs and that many are problematic and/or injecting drug users. A number of European surveys indicate that the prevalence of blood-borne viral infections such as hepatitis B, hepatitis C and HIV is higher among prisoners than among the general population. Drug use is one of the main problems facing prison services; it leads to problems between prisoners themselves, between prisoners and their relatives and between prisoners and prison staff. The WHO guide emphasises that a wide range of drug services is required within prisons in order to deal with the demand for drugs. These services need to be linked with community drug services in order to ensure continued treatment on entry to prison and on release. Prison services need to ensure that measures to address the high risk of fatal overdose on release from prison are implemented. Prison-based drug services should participate in drug treatment monitoring systems and drug service evaluations.

According to the WHO guide, opiate substitution is part of generic drug treatment services and is the gold standard for the management of opiate-dependent individuals. Methadone (or other substitution) treatment reduces the incidence of injecting drug use and HIV. Participation in opiate substitution treatment reduces the incidence of crime and the number of admissions to prison. In Europe, the most common form of substitution treatment is methadone. The number receiving opiate substitution treatment has increased substantially within the past 10 years. Continuity of methadone is required between community drug treatment services and prison services. Before methadone substitution is started in prison, participants must be provided with information about its interaction with other medications, risks associated with multiple drug use and risk of opiate and polydrug use overdose.

The infectious disease status of prisoners (particularly in relation to HIV) is confidential information and those with access to such information should respect this principle. All prisons should have easy access to confidential voluntary testing facilities so that early diagnosis and intervention are encouraged.

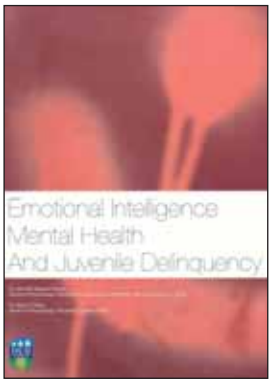
The authors report that the spread of blood-borne viral infections can be reduced through implementing universal precautions, a combination of discouraging tattooing and providing sterile tattooing services, as well as a combination of drug treatment services and needle exchange services.

In general, prison services should encourage external support for those with mental illness, substance misuse and long-term infectious diseases.

(Jean Long)

1. Moller L, Stover H, Jurgens R, Gatherer A and Nikogosian H (2007) *Health in prisons: a WHO guide to essentials in prison health*. Copenhagen: World Health Organization.

Mental illness and substance use among children in detention schools in Ireland



Emotional intelligence, mental health and juvenile delinquency,[1] the report of a study by Hayes and O'Reilly, was presented at an international conference at University College Dublin on 18 May 2007. Researchers interviewed three groups of adolescent males (average age 14.9 years): 30 participants were residing in juvenile detention schools (the offender group), 20 had been referred to an adolescent mental health service in HSE South (the mental health group), and 30 were recruited from a secondary school in County Cork (the control group). They used a number of validated instruments to determine each child's emotional intelligence and mental well-being, and obtained demographic characteristics and history of offending by means of a questionnaire.

The findings show that children in detention schools in Ireland experience very high rates of substance dependence and psychiatric disorder, engage in serious criminal behaviour and have significant deficits in emotional intelligence and cognitive ability.

Eight out of ten (83%) of the offender group met diagnostic criteria for at least one psychological disorder, with the average being 3.1 disorders per detainee, which was considerably higher than that in the mental health group. Of the offender group, 18.5% reported experiencing thoughts of suicide, and the same percentage reported that they had attempted to take their lives on at least one occasion. Over one-third (38%) met diagnostic criteria for internalising (emotional) disorders such as anxiety and depression, and 68% for externalising (disruptive) disorders such as conduct and attention deficit disorders.

Sixty-seven per cent of the offender group met the criteria for at least one substance-related disorder. Approximately equal numbers reported using cocaine (13/30), alcohol (14/30) and cannabis (14/30). Based on participants' reports of substance use in the 12 months prior to interview, researchers assigned them to one of three categories: dependency disorder (those addicted to one or more substance, n=14); use disorder (regular users

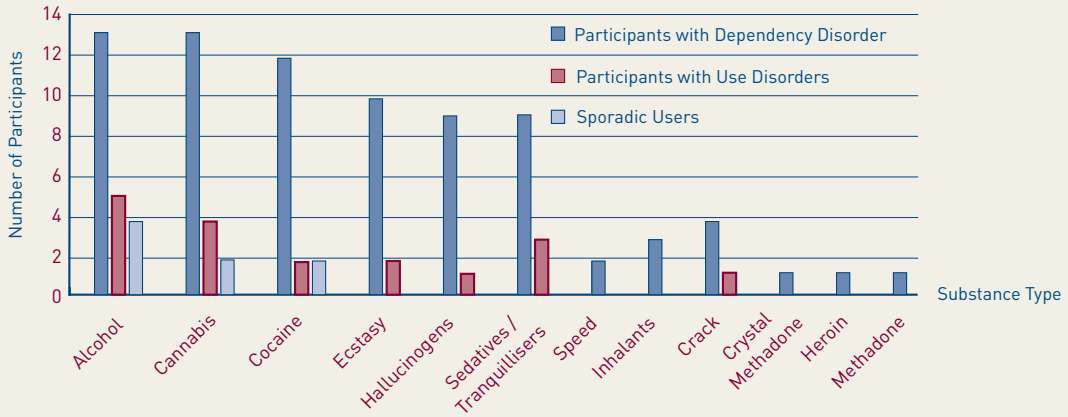


Figure 1 Substances used by young offenders in the year prior to interview
Source: Hayes and O'Reilly (2007)

of one or more drugs but who did not have a diagnosis of addiction, n=5); sporadic users (those who had used drugs in the past 12 months but not in sufficient quantities to warrant a diagnosis of dependency or use disorder, n=5) (Figure 1). One member of the offender group reported not having taken any drugs or alcohol in the previous 12 months.

Detainees with substance dependency disorders reported that they first began to use alcohol and cannabis at an average age of just nine years, and cocaine at 13 years. The majority did not receive treatment for psychiatric or substance use problems. Despite incarceration, these boys had continued access to alcohol and drugs, possibly through home leave, during family visits or during court appearances. According to the authors, this continued access to drugs and alcohol served to sustain their dependency and use difficulties.

A total of 335 crimes were committed by the 30 young detainees. These offences included acquisitive crimes, property crimes, driving offences, violent interpersonal offences, and failure to comply with a Garda/court order. Figure 2 shows the number of charges within each crime category.

The largest crime category was acquisitive crime, with 123 charges being held by 25 of the 30 young detainees. Although the majority of this group had substance-related disorders, none was detained

Detention schools *(continued)*

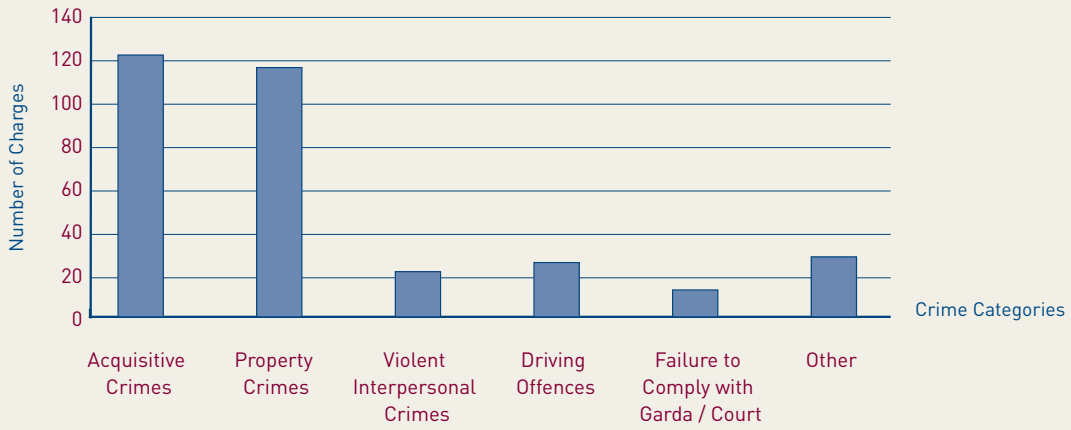


Figure 2 Number of criminal charges against respondents, by crime category
Source: Hayes and O'Reilly (2007:23)

on an alcohol-related charge, and only one held a drug-related charge (possession of a controlled substance). The results also indicate high rates of recidivism, with over three-quarters (76.7%) of the sample having been detained on at least one other occasion.

The authors conclude that the level of criminality among youths in detention schools is very serious, with about one in three detainees charged with at least one offence relating to interpersonal violent crime. They state that the emotional intelligence deficits of the detainees may make it difficult for them to fully understand how their offending behaviour impacts on others, and that 'a reduced capacity to regulate emotions could maintain offending patterns of behaviour in detainees' (p. 55).

The authors highlight the importance of addressing mental health and substance use among children in detention schools. They believe that, in addition to reducing the debilitating effect of mental health problems on a child's functioning and development, treatment will lead to a significant reduction in offending behaviour and criminality, with significant cost benefits for society, the legal system and the Irish State.

(Angela Morgan, Jean Long and Johnny Connolly)

1. Hayes JM and O'Reilly G (2007) *Emotional intelligence, mental health and juvenile delinquency*. Cork: Juvenile Mental Health Matters.

Public attitudes to mental health

In January 2007, the National Office for Suicide Prevention of the Health Service Executive commissioned research on public attitudes to mental health.[1] One thousand adults were interviewed in their own homes in January and February 2007. The overall objective of this research was to obtain a comprehensive view of attitudes to mental health, which will be used to inform a mental health awareness and attitudes campaign as set out in Action 10.1 of *Reach Out*, the National Strategy for Action on Suicide Prevention.

The survey found that more than eight in ten Irish adults (86%) considered their overall quality of life to be 'good' or 'very good'. However, this fell to 64% among those who had experienced mental health problems themselves. There was also some discontent with certain aspects of our society today, with 62% believing that 'these days people don't really know who they can count on', and 44% agreeing that 'people were better off in the old days when everyone knew how they were expected to act'. These feelings were more acutely felt by the over-35s.

Only 11% reported having experienced mental health problems themselves; the authors felt that this figure could be an understatement, in view of the sensitivity of the issue. Most experts agree that, in reality, one in four people experience a mental health problem at some stage in their lives. Twenty-three per cent reported having cared for or being related to someone who had mental health problems. Those working in the home and those who were separated, divorced or widowed tended to have more direct experience of mental health problems. Fifty-nine per cent claimed to have no direct or indirect experience of mental health problems.

While a substantial proportion of people (85%) agreed that 'anyone can experience mental health problems', this report reveals that stigma still exists in relation to mental health. Sixty-two per cent of respondents would not want people knowing about it if they themselves were experiencing mental health problems; 52% agreed that people with mental health problems should not be allowed to do important jobs, as doctors or nurses, for instance; and just 48% believed that the majority of people with mental health problems do recover.

Opinion was quite polarised on some issues related to mental health and there appeared to be fear among the general public surrounding mental

Public attitudes *(continued)*

health problems. Thirty-nine per cent felt that the public should be better protected from people with mental health problems; 36% felt that people with mental health problems were often dangerous; and 33% admitted that they would find it hard to talk to someone with mental health problems. However, 65% agreed that people with mental health problems were not to blame for their problems and 43% feared that they themselves might experience mental health problems in the future. Overall, there appeared to be an inherent acceptance that we are all potentially vulnerable to mental health problems.

There was an under-estimation of the prevalence of mental health problems in Ireland. Two-thirds estimated a prevalence of one in ten or less, while only 5% estimated a prevalence of one in four. Suicide (25%), alcoholism (19%) and depression (19%) were identified as the top three most important mental health problems that needed to be tackled in Ireland. Drug dependence was cited by 13% as the single most important health problem in Ireland. Men were more likely than women to identify alcoholism (22% vs. 19%) or drug dependence (17% vs. 13%) as the most important mental health problem.

The majority of Irish adults (74%) would consult their GP if they thought they had a mental health problem, and one in five would also turn to close friends or family for support. Specialist medical services, including those of counsellors, therapists, psychiatrists and psychologists, were considered less obvious sources of support. Those who had experienced mental health problems were most likely to seek support from their GP, counsellor/therapist and close friends.

This report identified a number of key areas where targeted education and awareness are required. These include education of the public on the true prevalence of mental health problems, focusing on eroding the stigma in relation to mental health, and increasing personal awareness of mental health.

(Deirdre Mongan)

1. National Office for *Suicide Prevention (2007) Mental health awareness and attitudes survey*. Dublin: Health Service Executive.

BZP – information exchange, risk assessment and control measures

On 12 December 2006, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) requested each national focal point to complete a questionnaire recording the use of 1-benzylpiperazine (BZP) in their country. The questionnaire allows formal exchange of information between member countries and the EMCDDA.

In Ireland the questionnaire was completed by the Alcohol and Drug Research Unit (ADRU) of the Health Research Board, and the Forensic Science Laboratory. The ADRU collated what was known about BZP in Ireland through literature, website and newspaper searches. The Forensic Science Laboratory reported the number of BZP seizures and described their contents.

BZP is not classified as a controlled drug and does not come under Ireland's Misuse of Drugs Act 1977. According to media reports, BZP is sold on the street outside major dance and music venues as well as in 'head/smart shops', often marketed as a 'legal alternative to ecstasy' and other stimulants, and purportedly sold only to people aged 18 or over. Recent newspaper reports indicate that the price of a BZP tablet in these shops ranges from €6.00 to €8.50. The Forensic Science Laboratory analysed samples from four BZP seizures in 2006.

A Europol–EMCDDA joint report[1] cited a New Zealand 'National household survey of legal party pill use' (2006) involving 2,010 respondents aged 13–45. This survey found that the psychological problems most often experienced following legal party pill use were 'trouble sleeping' (50.4%), 'loss of energy' (18.4%), 'strange thoughts' (15.6%), 'mood swings' (14.8%), 'confusion' (12.1%) and 'irritability' (11.4%). The physical problems most often experienced were 'poor appetite' (41.1%), 'hot/cold flushes' (30.6%), 'heavy sweating' (23.4%), 'stomach pains/nausea' (22.2%), 'headaches' (21.9%) and 'tremors and shakes' (18.4%). A recent *New Zealand Medical Journal* article described 80 BZP-related emergency department admissions occurring at Christchurch Hospital over a six-month period in 2005. The authors concluded that BZP can cause unpredictable and serious poisoning in some cases, and advised that people who have illnesses associated with seizures or heart disease should avoid using it. BZP was found in the body fluids of a small number of people who died in Malta, Sweden, Switzerland and the UK. Other stimulants and drugs were also present in these body fluids, making it difficult to determine the exact role of BZP in each fatality.

The information collated by Europol and the EMCDDA indicated that the health and social risks caused by the use and manufacture of, and traffic in, BZP, as well as the involvement of organised crime and possible consequences of control measures, could be thoroughly assessed by means of the risk assessment procedure outlined in Article 6 of Council Decision 2005/387/JHA.

On 30 May 2007, the Scientific Committee of the EMCDDA completed a risk assessment for BZP. 'The overall conclusion of the Committee was that due to its stimulant properties, risk to health and the lack of medical benefits, there is a need to control BZP. However, the Committee felt that the control measures should be appropriate to the relatively low risks of the substance.'[2]

On foot of a proposal presented by the Commission to the European Council on 17 July 2007, the Council issued its decision that 'Member States shall take the necessary measures, in accordance with their national law, to submit [BZP] to control measures, proportionate to the risks of the substance, and criminal penalties, as provided for under their legislation …' (COM(2007) 430 final).

(Jean Long)

1. *Europol–EMCDDA Joint report on a new psychoactive substance: 1-benzylpiperazine (BZP)* (2007) http://www.emcdda.europa.eu/?nnodeID=16775 Accessed 21 June 2007.
2. CORDROGUE 35 10458/07 - *Risk assessment report of a new psychoactive substance: 1-benzylpiperazine (BZP)*. In accordance with Article 6 of Council Decision 2005/387/JHA on information exchange, risk assessment and control of new psychoactive substances.

Identifying new drugs and new drug trends with the help of drug helplines

In July 2007 the European Foundation of Drug Helplines (FESAT) published the results from its thirteenth monitoring project.[1] Since the beginning of 2001 FESAT has been collecting information every six months on the types of person contacting helplines, the content of these calls and how this has changed compared to the previous six months. According to the author, the main objective of this monitoring is to identify the emergence of new drugs and new drug trends; the data cannot quantify the size of any such changes.

Of the 34 relevant FESAT helplines, 18 helplines in 13 European countries, including Ireland, participated in the project. This article will describe some of the main changes that were reported by the helplines in Europe during the second half of 2006 when compared to the first half of 2006. The article also presents some unpublished information from the Drugs/HIV Helpline in Ireland.

The smallest of the 18 participating helplines in Europe answered an average of one call every second day, and the largest, 108 calls per day. Seven helplines answered 10 calls or fewer per day; eight helplines answered 11 to 30 calls; two helplines answered 31 to 60 calls and one helpline answered 61 or more calls. Half of the helplines answer 16 or more calls per day. The Drugs/HIV Helpline in Ireland answered an average of 15 calls per working day, though this figure included calls about sexual health. There were 1,875 calls between July and December 2006, which represents a 12% decrease when compared to the preceding six-month period. This decrease is consistent with other years, as the helpline receives more calls in the first six months of the year than in the second six months; this might be explained by summer and Christmas holidays (Aileen Dooley, of the Drugs/HIV Helpline personal communication, 2007).

The FESAT report notes a decline in the numbers of helplines reporting calls about cocaine and cannabis across Europe and an increase in the number of calls about GHB (gamma-hydroxybutyrate) (six helplines), amphetamines (five helplines) and benzodiazepines (five helplines). The number of helplines answering calls about alcohol (six helplines) remained stable. There were decreases in the numbers of calls about injecting heroin, magic mushrooms and ecstasy.

In Ireland, there was a large decrease in the number of calls to the Drugs/HIV Helpline about cocaine, from 226 in the first half of 2006 to 166 in the second half of 2006. There was some decrease in the number of calls about alcohol, from 238 in the first half of 2006 to 201 in the second half of 2006. There was a large decrease in the number of calls about cannabis, amphetamines and injecting heroin in the second half of 2006 when compared to the first half of 2006. There was some increase in the number of calls about poppers (Aileen Dooley, personal communication, 2007).

During the second half of 2006, two helplines in Europe received calls about drugs that had not been reported to them before. The Drugs/HIV Helpline in Ireland answered calls about five substances for the first time. Chief among these was LSA (d-lysergic acid amide), which occurs in the seeds of the morning glory plant and has hallucinogenic effects. Bearing out reports from the Forensic Science Laboratory in Ireland, the Irish helpline answered calls about benzylpiperazine (also known as BZP and marketed as 'Jacks'), which is taken orally and has effects similar to those of ecstasy. Also new to the Irish helpline in 2006 were calls about GHB, which is normally available as a liquid. Other substances mentioned for the first time were *Salvia* and Subutex. *Salvia divinorum* has hallucinogenic effects and can be smoked or chewed. Subutex (buprenorphine) is an opiate used in the management of opiate addiction. The Norwegian helpline reported first-time calls about the opioid analgesic tramadol (trade name Tramal), which is normally taken orally as a capsule, but which can be injected.

(Jean Long)

1. Hibell B (2007) *FESAT Monitoring Project – Changes during the second half of 2006*. Brussels: FESAT (The European Foundation of Drug Helplines).

More information about FESAT can be found at www.fesat.org.

The Drugs/HIV Helpline in Ireland is a confidential, freephone, active listening service offering non-directive support, information, guidance and referral to anyone with a question related to substance use or HIV and sexual health. Set up in July 1997, the service is funded and managed by the Health Service Executive.

The freephone number is 1800 459 459. The Helpline manager is Aileen Dooley.

Happy 10th birthday to the Drugs/ HIV Helpline

On 21 July 2007 it was exactly 10 years since the Irish Drugs/HIV Helpline first opened its lines to callers from across the country. On its 10th birthday, we reflect on what has developed into a skilled, professional service that has a respected place among the substance use and sexual health services in Ireland.

From the start, the ethos of the helpline was one of non-directive, non-judgmental support. Staff use active listening skills to help callers to explore their needs and, where appropriate, callers are given information and contact details of the services available to them. The focus is very much on the caller, whether a substance user, a parent, a son or daughter, a teacher, a student or a service provider.

The helpline was established primarily as a source of drug-related information and support, with the additional aim of reducing HIV transmission and supporting those with a positive diagnosis, particularly if linked to drug use. Perhaps the greatest surprise of the helpline's 10 years is how the HIV-related calls have developed. The service dealt with just 19 such calls in 1997 and 79 such calls in 1998, and now deals with over a 1,000 HIV calls each year. Also, 73% of callers who referred to a HIV concern in 2006 were concerned about sexual encounters as opposed to drug use.

The drug-related calls have shown interesting trends over the years. Cannabis has consistently been the drug most often referred to. In second place in terms of frequency were: heroin-related calls in 2004, cocaine-related calls in 2005, and alcohol-related calls in 2006. Helpline records can indicate trends in substance use and are a valuable source of information about drug use among individuals who are not engaged with treatment services.

The helpline has developed a database of over 300 relevant services nationwide. This is updated regularly and is used in conjunction with a computerised call-logging system to ensure that the best quality information is given to callers and that detailed anonymous data on calls can be collated and statistically analysed. This database is a useful resource not only for people seeking support but also for professionals working in the field who wish to ensure that the referral options that they give to clients are up to date.

In 10 years the helpline has dealt with over 45,000 calls. We hope to build on its strengths and focus on improving the quality of the service provided to the public. We hope that in the coming years the helpline will officially become a national service, and that staff vacancies will be filled and opening hours extended. We hope to publish some research related to call data and to make our services database an online resource. The helpline is currently open from Monday to Friday from 10 am. If you have any questions about this service, please give us a call.

(Aileen Dooley)

SLAN survey data on illicit drug use

The Survey of Lifestyle, Attitudes and Nutrition (SLAN) is a national, cross-sectional, postal survey of adults in Ireland. It was first conducted in 1998[1] by the National University of Ireland, Galway, with a second survey carried out in 2002.[2] The surveys obtained 6,539 valid responses in 1998 and 5,991 in 2002. A section of each survey collected information on drug use. Participants were asked about their experiences of using the following illicit drugs:

- marijuana or cannabis
- non-prescription tranquillisers or sedatives
- amphetamine
- LSD
- cocaine
- heroin
- ecstasy
- drugs by injection with a needle, e.g. heroin, cocaine or amphetamines
- solvents
- magic mushrooms

For all the drugs listed except cannabis, the study collected data on use within the 12 months prior to the survey. Data on the frequency of cannabis use were collected for three time periods: within the last 30 days, within the last 12 months and within the respondent's lifetime. For the most part, the figures in this article refer to drug use within the past 12 months, referred to as 'current' drug use.

In 1998 1,143 people (17.5%) reported taking illegal drugs at some point in their lives; this figure increased to 1,173 (19.6%) in 2002. In both years the rate of current drug use was 7.6% of the population surveyed, which equated to 494 respondents in 1998 and 453 in 2002. In 1998, 27.3% of the drug-taking population had taken one of the drugs listed above in the previous 12 months; this decreased to 25.4% in 2002.

Cannabis was the most commonly used illegal drug, with lifetime use rates of 16.3% in 1998 and 18.6% in 2002, and current use rates of 6.2% in 1998 and 6.3% in 2002. The vast majority of those who reported taking only one drug used cannabis. In 1998, 89.6% of illicit drug users had taken cannabis within the past year, decreasing to 88.1% in 2002. Non-prescription tranquillisers or sedatives

SLAN survey data on illicit drug use *(continued)*

were the second most commonly taken drugs. Nineteen per cent reported using these drugs in 1998, decreasing to 13% in 2002.

The study also examined concurrent polydrug use. This is the use of different drugs on separate occasions within a 12-month period. Concurrent polydrug use was lower in 2002 than in 1998. Over 6% of current drug users reported using two of the above drugs in 1998 and 5.4% reported such use in 2002. In 1998, 9.4% used three or more drugs, while in 2002 the corresponding percentage was 7.8%. Cannabis was the drug most widely availed of by polydrug users; 96.7% had taken cannabis at some point in their lives and 82.4% were taking it concurrently with other drugs. Over one in six current polydrug users had taken cannabis before progressing on to other drugs, and over three-quarters of those engaging in polydrug use had taken cannabis within the last 12 months.

After cannabis, ecstasy was the illicit drug used most frequently in conjunction with other drugs. Eighty per cent of those who took drugs by injection also reported ecstasy use. Similarly, 71% of LSD users, 67.1% of cocaine users, 64.2% of amphetamine users and 21.4% of cannabis users also took ecstasy. There was a close link between heroin and cocaine use, with four out of five heroin users reporting that they also took cocaine.

Heavy drinkers and binge drinkers were more likely than social drinkers and non-drinkers to report illicit drug use. The average alcohol intake of those who reported using drugs was 6.5 units per drinking occasion, compared to 4.5 units in the non-drug-taking populace. Similarly, regular and occasional cigarette smokers reported a higher level of illicit drug use than non-smokers. Over one-third of drug users smoked regularly and 8.2% smoked occasionally, while among non drug-users only 20.1% smoked regularly and 2.9% smoked occasionally.

Gender was an important determinant of level of drug use, with 9.2% of men surveyed disclosing that they had taken drugs in the last 12 months, as opposed to 6.4% of women. Also, 4% of men surveyed were current polydrug users, in comparison to 2% of women. Of the 940 respondents who were currently using drugs, 21.1% of men and 14.5% of women were polydrug users. Men aged between 20 and 24 years were the most frequent users of illicit drugs, comprising over one-fifth of all current drug users and just under one-third of current polydrug users. One in five women aged between 20 and 24 years reported that they were current drug users, of whom almost one-fifth were polydrug users.

It must be noted that there are limits to the extent to which the SLAN data typify the level of illicit drug use in Ireland. The SLAN survey is not designed to collect information specifically about drug use and the amount of space it can devote to such questions is limited. Nevertheless, the SLAN data do offer useful insights about illicit drug trends in Ireland. A third SLAN survey is due for publication in late 2007.

(Aileen Connor)

1. Friel S, Nic Gabhainn S and Kelleher C (1999) *The national health & lifestyle surveys: survey of lifestyle, attitudes and nutrition (SLAN) & the Irish health behaviour in school-aged children survey (HBSC)*. Galway: National University of Ireland.
2. Kelleher C, Nic Gabhainn S, Friel S, Corrigan H, Nolan G, Sixsmith J et al. (2003) *The national health & lifestyle surveys: survey of lifestyle, attitudes and nutrition (SLAN) & the Irish health behaviour in school-aged children survey (HBSC)*. Galway: National University of Ireland.

New NDC information resource: Thesis page

The National Documentation Centre (NDC) continues to develop its library of electronic and print resources in the area of drug use and problem alcohol use. We have recently compiled a list of postgraduate theses relating to drugs and alcohol completed in third-level institutions in Ireland (including Northern Ireland). We have added this list to a new ' Thesis' page on our website (www.hrb.ie/ndc).

The Thesis page is searchable by keyword, and results can be sorted by author or by institution. To date, we have a record of 208 theses from 10 third-level institutions; 165 of these contain abstracts. All aspects of problem drug and alcohol use, including education, prevention, social policy and treatment, are represented. The record also includes work in related areas of research with a significant drug- or alcohol-related component, such as homelessness, prostitution, crime, infectious diseases and social exclusion. Information for the thesis listed was sourced from a wide range of disciplines, including addiction studies, geography and, even, architecture.

The Thesis page was originally targeted at students. However, in view of the broad range of topics represented, we believe that this new resource will be of value to a wider audience. This is a great opportunity to disseminate information on postgraduate research as masters and doctoral theses are primary literature and are valuable contributions to the world of research.

The NDC does not hold copies of theses in its library. Most of those listed can be accessed through the library of the relevant institution shown in the record; the location and shelf number are given where possible.

To include a record of your thesis on our database:

If your thesis or dissertation is NOT currently listed on our Thesis page, we invite you to send the following information to ndc@hrb.ie:

- your name
- the title of your thesis
- the year of completion
- the associated third-level institution
- the degree awarded (e.g. MA, MSc, PhD)
- an abstract of your work (250 words).

If you find an error in your listing, or would like to add information (such as an abstract), please send an e-mail to ndc@hrb.ie. Please indicate that you are correcting a listing already in the database.

(Mairea Nelson)

In brief

On 18 April 2007 the **European Commission** (Anti-Drugs Policy Coordination Unit in the DG for Justice, Freedom and Security) published its report on the results of the open consultation on the Green Paper on the role of civil society in drugs policy in the EU.[1] The Commission has invited civil society organisations (CSOs) to apply for membership of a Forum that will serve as a platform for informal exchanges of views and information between the Commission and CSOs on drugs policy. The first meeting of the Forum will be held before the end of 2007. The future of this initiative is conditional on the adoption by the EU of the 'Drugs Prevention and Information Programme 2007–2013'. www.ec.europa.eu

In April 2007 a report **Addressing issues of social exclusion in Moyross and other disadvantaged areas of Limerick City** was delivered to the Cabinet Committee on Social Inclusion. In respect of drugs and other problems, author John Fitzgerald stated that co-ordination of services was not enough and there needed to be 'special dedicated teams' to provide 'full service integration'. He also recommended that 'a local focus' for drug-related interventions should be immediately established for Limerick City and it should work closely with the development agencies to identify appropriate interventions. www.limerickcity.ie

On 9 May 2007 a **BA in Applied Addiction Studies**, the first Irish undergraduate degree in addiction studies, was launched. It was developed by the Addiction Training Institute in partnership with Athlone Institute of Technology. www.addiction.ie

Between 13 and 17 May 2007 the **International Harm Reduction Association (IHRA)** held its 18th annual conference in Poland. The theme of the conference was 'Harm Reduction: Coming of Age'. It included around 90 sessions covering illicit drugs, alcohol, tobacco, sex work, HIV/AIDS, young people, and prisons. www.ihra.net

In May 2007 a **Hepatitis Group** was established by the Health Service Executive (HSE) to make recommendations on an action plan for hepatitis C in Ireland. Comprising 20 people, the Group will report on priority actions in relation to hepatitis C. It is looking at hepatitis C from the perspective of surveillance, treatment and prevention. The Group may be contacted via joebarry@tcd.ie

On 12–13 June 2007 the first **Annual progress review on the implementation of the EU Drugs Action Plan 2005–2008** (doc. 17101/06 CORDROGUE 118) was adopted at a meeting of the Justice and Home Affairs Council of Europe. www.europa.eu

On 18 June 2007 the **Organised Crime Task Force (OCTF)** in Northern Ireland published its annual report for 2006. It reported that over £22 million worth of drugs had been seized. It anticipated that illicit drugs will continue to pose a serious threat in 2007/8. www.octf.gov.uk

On 26 June 2007, **International Day against Drug Abuse and Illicit Trafficking**, the UN Office for Drugs and Crime (UNODC) launched an anti-drugs campaign with the slogan 'Do drugs control your life? Your life. Your community. No place for drugs.' The slogan will be used for three years, focusing on drug abuse in 2007, drug cultivation and production in 2008, and illicit drug trafficking in 2009. The aim is to inspire and mobilise people to support drug control. www.unodc.org

In June 2007 **Removing the boundaries: a profile of drug prevalence in North County Dublin** was published by North Dublin City and County Regional Drugs Task Force. The study finds that problem drug use in North County Dublin is more hidden than in Dublin Inner City. It suggests this may be because of the rural nature of much of North County Dublin, with small close-knit communities, where individuals might feel more stigmatised than in the city if they were to declare their problem. In addition, opportunities for local treatment are lacking, other than in Swords/Donabate; service users from other areas must travel daily to the city to obtain treatment and/or to fill prescriptions. www.ndublinrdtf.ie

On 29 June 2007 the **European Centre for Disease Prevention and Control (ECDC)** and the **EMCDDA** signed a co-operation agreement to tackle drug-related infectious diseases and to contribute to the broader EU effort to prevent and control communicable diseases. Areas of mutual interest will be identified by the agencies and implemented through projects relating specifically to epidemiology and disease prevention and control. www.emcdda.eu

On 1–3 July 2007 the first world conference on **medication-assisted treatment of opiate addiction**, together with the inaugural meeting of the World Federation for the Associations for the Treatment of Opioid Dependence (WFATOD), was held in Ljubljana, Slovenia. www.seea.net

On 12 July 2007 Barnardos' **Annual review 2006: no child gets left behind** was launched. It contains the following observation, 'Oftentimes children are referred to Barnardos because they are missing school. When we meet with the family it becomes clear that school attendance is an outward symptom of what's happening at home. There may be issues such as alcoholism, drug abuse, depression, separation and loss. … When you work with the whole family, you can make changes in the home and have a major impact on a child's life.' www.barnardos.ie

In July 2007 a consultation paper *Drugs: Our Community, Your Say* was launched in the UK. It marks the preliminary stage in developing the next national drugs strategy for the UK. The current strategy expires in 2008. www.homeoffice.gov.uk

(Compiled by Brigid Pike)

1. For an overview of the Green Paper and of the broader debate on the role of civil society in policy development at EU and UN level, see Pike B (2006) Civil society to have a role in EU drugs policy. *Drugnet Ireland*, Issue 19: 19–20.

From *Drugnet Europe*

Raising awareness of HPV

Cited from article by Alessandro Pirona and Dagmar Hedrich, Drugnet Europe *No. 59, July–September 2007, p.3*

The recent authorisation by the European Commission of a prophylactic vaccine against the Human Papilloma Virus (HPV) could greatly improve the prevention of HPV infections in Europe and help reduce the incidence of cervical cancer.

HPV is highly transmissible and is linked to virtually all cervical cancer cases. According to the World Health Organisation (WHO), it is the second biggest cause of female cancer mortality worldwide, claiming around 250,000 lives annually. Every year, some 15,000 women die from this preventable disease in Europe, with the newer EU Member States reporting twice as many cervical cancer cases as the old EU-15. …

Young female drug users, especially those involved in sex work, are at a high risk of contracting sexually transmitted infections (STIs), including HPV, due to high levels of risky sexual behaviour. Studies conducted in Spain and Denmark showed that, in all age groups, HPV prevalence was highest among female sex workers (over 65% in the 'under-20' year group), followed by women attending STI clinics and in prison. …

Outreach health services and STI or HIV clinics linked to drug treatment services can contribute to raising awareness on HPV and to increasing vaccine coverage by disseminating information to young female drug users. However, targeted cervical screening and safe-sex practices remain crucial components in preventing cervical cancer.

Local authorities, a 'logical partner' in tackling drugs

Cited from paper released by Wolfgang Götz, EMCDDA Director on 26 June 2007, Drugnet Europe *No. 59, July–September 2007, p.4.*

Local authorities are a logical partner in dealing with drug-related problems. They are best placed to fine-tune and adapt drug policies to the needs and resources of their community. They are also at the frontline in the fight against drug-related crime and in dealing with the social repercussions of drug use.

One of the main tests for local decision-makers is finding the right balance between protecting the wider community against drug-related crime, on the one hand, and, on the other hand, helping drug users through social and healthcare interventions to reduce their risk-taking and guide them into treatment.

Treating drug users is very often the domain of local authorities, as services are frequently managed and financed at local level. I believe that one of the main challenges for local authorities in the coming years in tackling drugs will be precisely in this area. One reason is that, although treatment centres are generally more numerous and better equipped today than they were a decade ago, they are still very much geared towards problems relating to heroin use (e.g. there are now over half a million people in Europe in drug substitution treatment). But, as more and more individuals seek treatment for problems linked to synthetic drugs, cannabis, cocaine or polydrug use, services will need to adapt to more, and very varied, problems.

Among the new developments we have witnessed in the last five years in the prevention of drug use in Europe is 'selective prevention', aimed at high-risk groups, families and communities who are often by-passed by prevention work in more traditional settings.

Our 2006 Annual Report noted a greater involvement here of municipalities, as selective prevention calls for cooperation between youth, education, health, social and law enforcement services which is typically local.

Drug-related public expenditure

Cited from an article by Xavier Poos, Drugnet Europe *No. 59, July–September 2007, p.6.*

'Producing estimates of public expenditure on drugs' is a key objective of the current EU drugs action plan (2005–2008). In this context, the EMCDDA will support the European Commission and EU Member States in developing a common methodology to estimate direct and indirect drug-related expenditure in the EU, candidate countries and Norway.

Current research at the EMCDDA is aimed at identifying, developing and testing methods at EU level for quantifying public expenditure in this field. In close collaboration with the Reitox network and international experts, the agency is also working on a 'Selected issue' on public expenditure to be released alongside its 2008 Annual Report.

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

If you would like a hard copy of the current or future issues of either publication, please contact: Alcohol and Drug Research Unit, Health Research Board, Knockmaun House, 42–47 Lower Mount Street, Dublin 2. Tel: 01 2345 127; Email: adru@hrb.ie.

Drugs in focus – policy briefing

No. 16: Drugs and crime – a complex relationship

To advance the overall EU drugs strategy's aim of ensuring a high level of security for the general public, the EU drugs action plan 2005–2008 includes an explicit action to develop a common definition of drug-related crime. This policy briefing, No 16, explores the different types of offences that might be encompassed under a general heading of drug-related crime, and proposes a definition encompassing four categories:

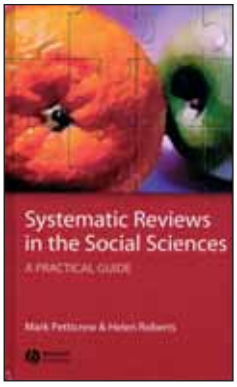
1. Psychopharmacological crimes: crimes committed under the influence of a psychoactive substance, as a result of its acute or chronic use;
2. Economic-compulsive crimes: crimes committed in order to obtain money (or drugs) to support drug use;
3. Systemic crimes: crimes committed within the functioning of illicit drug markets, as part of the business of drug supply, distribution and use; and
4. Drug law offences: crimes committed in violation of drug (and other related) legislation.

The briefing concludes with a series of considerations for policy-makers:

- A range of factors and conditions lead offending and drug-using populations to follow a variety of pathways, each of which may make a specific and distinct connection between drugs and crime. Responses to drug-related crime therefore need to be complex, differentiated and targeted.
- Understanding the links between drugs and crime is not merely of theoretical interest but also has profound implications for public policy, as knowledge of these links determines how society responds to drug-related crime. Thus, it is necessary to promote research in Europe on the drug–crime link and its various connections in order to determine how to reduce drug-related crime.
- Although defining drug-related crime is a reductive exercise that cannot account for the whole complexity of the drug–crime nexus, a clear definition of the term 'drug-related crime' is required as a prerequisite for evaluation.
- There is a need in Europe to develop sound methodologies, based on multi-source models, for assessing the extent and patterns of, and trends in, drug-related crime.
- National estimates of the extent and patterns of drug-related crime are essential if studies of the social costs of drugs are to become meaningful, as such studies often face difficulties in taking into account crimes other than drug law offences.
- Methodologies to estimate drug-related crime will help to improve evaluation of the effect of interventions and measures aimed at reducing drug-related crime, both in the field of drug demand reduction (treatment, harm reduction) and crime prevention/reduction (situational crime prevention, alternatives to imprisonment, social crime prevention).

Recent publications

Books



Systematic reviews in the social sciences: a practical guide
Petticrew M and Roberts H
Blackwell Publishing 2006, 336 pp.
ISBN 978 1 4051 2110 1

Aimed at social science researchers, this book is a step-by-step guide to planning and conducting a systematic literature review. The authors do not deal exclusively with reviews of the effectiveness of interventions – the focus of most of the recent interest in systematic reviews (viz. the Campbell and Cochrane collaborations). They also look at the systematic review as a way of synthesising the evidence about a wide range of questions, moving beyond 'What works?' to 'What's important?' Systematic reviews can provide evidence to address such questions as the prevalence of a problem, the correlation of two variables, the implementation, or costs, of a programme, or the meaning stakeholders ascribe to a programme or its context. They are also valuable as a method of mapping out areas of uncertainty and directing new research efforts.

This book outlines the rationale and methods of systematic review, drawing on examples from such diverse fields as psychology, criminology, education, transport, social welfare, public health, and housing and urban policy. It includes detailed sections on assessing the quality of both qualitative and quantitative research; searching for evidence in the social sciences; meta-analytic and other methods of evidence synthesis; publication bias; heterogeneity; and approaches to dissemination. The authors discuss some emerging issues – in particular the part played by different research designs in systematic reviews, including qualitative research; approaches to reviewing complex interventions; the means of dealing with variations between studies in terms of design and study quality; and ways of involving stakeholders in the process of planning and carrying out systematic reviews. Important information and useful tips are highlighted in text boxes throughout the book, and each chapter ends with summarised 'Key learning points'.

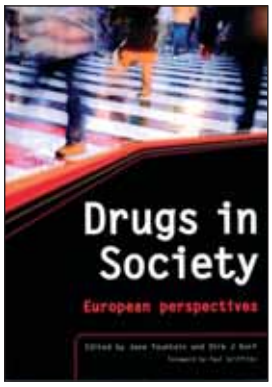
Drugs, clubs and young people: sociological and public health perspectives
Sanders B (ed.)
Ashgate 2006, 200 pp.
ISBN 0 7546 4699 8

This edited collection of ten studies offers critical insights on drug use among young people by exploring and analysing behaviours common at raves and nightclubs from sociological and public health perspectives.

Recent publications *(continued)*

Material based on solid, empirical research is drawn from the US, the UK and Hong Kong to provide cross-cultural comparisons, allowing for the demystification of stereotypical presentations and the illumination of concerns surrounding young people who attend clubs and/or use club drugs. The contributions provide many theoretical insights related to illicit club drug use and supply, which aim, in part, to challenge current orthodoxies on the role of drug use within young people's lives.

The book is arranged in four sections. The opening two chapters are introductory, the first an overview of raving, clubbing, club drugs and the responses they have generated, and the second an exploration of the origins of rave research in the UK and a discussion of the ramifications of personal experience in the course of researching the issues as a professional. The next three chapters comprise the second section and are concerned mainly with club drug use among young people in New York City. The next two chapters discuss the use of club drugs outside of club settings, focusing on ketamine and on ecstasy use among young, low-income women. The final three chapters explore aspects and experiences of club drugs and 'night-time economies' in Hong Kong and London, and examine alcohol, club drugs (primarily ecstasy) and violence in clubs in the UK. The book has a 32-page bibliography and both a subject and an author index.



Drugs in society: European perspectives
Fountain J and Korf D (eds)
Radcliffe Publishing 2007, xvii, 136 pp.
ISBN 978 184619 093 3

This book's editors and contributors are all members of the European Society for Social Drug Research (ESSD). ESSD was established in 1990 with the principal aim of promoting social science approaches to drug research. This aim is reflected in the focus of the ten papers included in the book, and in the Foreword by Paul Griffiths of the European Monitoring Centre for Drugs and Drug Addiction, which warns: 'It may be useful for many reasons to be able to describe general patterns of drug use in Europe but we forget at our peril the underlying reality of our subject matter.'

The diverse and wide-ranging papers presented here are unified by a common perspective, where drug use is not simply reduced to questions of dependence or compulsion, and where the principal concern is not solely to audit consequences. Rather, the book is about drug use as a dynamic social behaviour where understanding meaning and motivations, and culture and context, are as important as understanding the actions of chemicals on the brain or body. This unique overview of the variation in the ways recreational and other drugs are used across Europe includes critical reflections on current drug policy.

The papers describe studies by the various authors in the following areas: the perceptions of drugs and drug users in Portugal; Danish cannabis policy and practice; characteristics of the cannabis market in Belgium; ephedra for fun, performance and weight loss; khat and the Somali diaspora; life in exile and vulnerability factors for substance use; the stigma of drug use and the experience of prisoners in England and Wales; a system allowing the prescription of different substances for the maintenance of opioid addicts in Austria; methadone programmes, control strategies and responses; and description and analysis of some common logical fallacies in addiction research.

Journal articles

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

Alcoholics Anonymous in Ireland: AA's first European experience
Butler S and Jordan T
Addiction 2007; 102(6): 879–886

The aim of this study was to trace the evolution of Alcoholics Anonymous in Ireland from its establishment there in 1946, focusing on the efforts of early members to publicize the fellowship and negotiate a role for themselves in relation to existing religious and healthcare institutions. The authors conducted archival research, drawing mainly on primary sources in AA archives in New York and Dublin. The authors found that anticipated tensions between this fellowship, which had its roots in Evangelical Protestantism, and the politically powerful Roman Catholic Church in Ireland were skilfully avoided; initial hostility from the medical profession quickly dissipated; and AA distanced itself from policy debate on the wider topic of alcoholism as disease. The authors conclude that the relatively smooth introduction of AA to Ireland, the first European country in which it was established, may be attributable to the essentially pragmatic nature of the fellowship and the strategic abilities of its early members.

Characteristics of opiate users presenting for a new treatment episode: baseline data from the national drug treatment outcome study in Ireland (ROSIE)
Comiskey C and Cox G
Drugs: education, prevention and policy 2007; 14 (3): 217–230

The Research Outcome Study in Ireland (ROSIE) is the first large-scale, prospective, multi-site, drug treatment outcome study in Ireland, documenting progress at six-month, one-year and three-year intervals. Using a structured questionnaire, the substance use, health, crime and social problems of 404 opiate users were assessed at treatment intake. While the majority of study participants were opiate users, polydrug use was the norm (76%, n = 308). Most participants had a history of injecting drug use (77%, n = 308); however, only 42% (n = 170) reported injecting in the preceding 90 days. Participants reported a range of mental and physical health complaints and extensive contact with social care services. High crime rates were observed. Analysis revealed differences in the characteristics and substance use of participants across treatment modalities. The authors conclude that the range and severity of problems affecting individuals commencing treatment for their problem drug use highlights the complex needs of the cohort. These problems create substantial costs for providers of social care services in Ireland and can affect treatment outcomes.

Recent publications *(continued)*

The human bite injury: a clinical audit and discussion regarding the management of this alcohol fuelled phenomenon

Henry FP, Purcell EM and Eadie PA
Emergency Medicine Journal 2007; 24(7): 455–458

Human bite injuries are both deceptive and challenging in their presentation and management. They remain a frequent presentation to our unit, most often following late night alcohol-fuelled aggression. The aim of this study was to audit the management of these wounds, with particular focus on infective complications and outcomes. A three-year retrospective chart review was undertaken on all patients referred to the plastic surgery unit between 1 January 2003 and 31 December 2005. A total of 92 patients with 96 human bite wounds were identified. The majority were male (92%). Alcohol consumption was documented in 86% of cases. The majority (70%) occurred over the weekend or on a public holiday. Facial injuries made up 70% of injuries, with the remainder being to the upper limb. The ear was the most common target of all facial injuries (65%). Infection was documented in 18 cases (20%), with bite injuries to the upper limb and those presenting late (more than 12 hours after the event) having a higher incidence of infection. The authors conclude that human bite wounds present a challenge to any emergency department, given the many issues involved in their management. Underestimation of the complexity and potential sequelae of these wounds will result in a suboptimal outcome for the patient.

Effectiveness of daily outpatient alcohol detoxification by an Irish public psychiatric hospital – a pilot study

Agyapong V, Benbow J and Browne R
Irish Journal of Psychological Medicine 2007; 24(1): 23–26

The aim of this study was to assess the effectiveness of daily outpatient detoxification in an Irish public psychiatric hospital. The outpatient records of patients presenting to the Assessment Unit of St Brendan's Hospital in one year (August 2004–July 2005) with symptoms of alcohol dependence syndrome (ADS) and commencing daily outpatient detoxification were examined retrospectively. The results were compiled and analysed using descriptive statistics.

Forty patients underwent outpatient alcohol detoxification in one year and complete records were available for 32 patients (80%). Seven patients (22%) presented with co–morbid psychiatric conditions, including depression (four patients), anxiety disorder (two patients) and personality disorder (one patient). All seven patients were known to psychiatric sector services. Of the 32 patients commencing detoxification, 28 (87.5%) attended on the second day and 22 (69%) attended their third day's appointment. Only 17 patients (53%) completed the outpatient detoxification. Thirteen patients (40.6%) received at least two outpatient detoxifications during the year, of whom seven (58%) received the second within two months of the first. The records of 20 patients (62.5%) showed that they had received advice regarding self-referral to counselling services.

The authors conclude that a high proportion of patients (47%) presenting with symptoms of ADS did not complete daily outpatient detoxifications. A high proportion of all patients (40.6%) also underwent multiple outpatient detoxifications during the year. It is possible that the separation between alcohol detoxification and alcohol counselling services in Ireland contributed to these disappointing results.

The homeless mentally ill – an audit from an inner city hospital

O,Neill A, Casey P and Minton R
Irish Journal of Psychological Medicine 2007; 24(2): 62–66

The aim of this study was to determine the proportion of those that are homeless attending the Mater Hospital's psychiatric service, including those presenting to accident and emergency who were homeless, and to compare the homeless group with the non-homeless so as to obtain a profile of this group. All adults over 16, referred for psychiatric assessment, attending A&E were included, as were those attending outpatient clinics, liaison consultations and inpatients in the psychiatric unit, in the six-month period from January to June 2003. Excluded were those who were under 16, who refused to participate, who did not speak English, those with a diagnosis of personality disorder and organic brain damage. Questionnaires were completed by psychiatric registrars and a community psychiatric nurse, with an ICD-10 diagnosis recorded on each individual, in consultation with the treating consultant psychiatrist.

A total of 628 patients were seen in MUH during the study period, and 13.8% were homeless. Of the homeless, 56.3% were seen as emergency referrals in the A&E, 23% were inpatients (including the psychiatric unit and consultations in medical/surgical wards) and 20.7% were seen in the outpatient department. Of all the A&E referrals to psychiatry, 34.8% were homeless. The homeless presented most commonly in suicidal crisis (26.6%) compared with 12.5% in the non-homeless group. Substance-abuse disorders were the primary diagnosis in 42.3% of the homeless group, accounting for 14.2% in the housed sample. Outcome for both groups was similar, with slightly more homeless being referred for psychiatric admission (17.8%) compared to 12% in the non-homeless group. The authors conclude that mental illness and the need for psychiatric services remain a serious issue for a significant segment of the homeless population. The homeless are over-represented in our accident and emergency department, with their psychological and medical needs not being met in primary care. An integrated multi-disciplinary treatment approach, including outreach work, that addresses their many needs, appears to hold the greatest promise of success in this population.

(Compiled by Louise Farragher and Joan Moore)

Upcoming events

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

September

10–12 September 2007

European Association of Addiction Therapy, 3rd Annual Meeting
Venue: Palais Ferstel, Vienna, Austria

Organised by / Contact: EAAT, c/o RPA Communications Ltd, Unit 2B, Hampton Works, Sheen Lane, London, SW14 8AE

Tel: +44 (0)2084 871421
Email: info@eaat.org
www.eaat.org

Information: EAAT 2007 provides a focus for understanding the scientific medical and social bases of addiction and a discussion forum to further develop relevant therapies throughout Europe. The conference also provides a central platform through which information can be disseminated across country and cultural boundaries. The EAAT will approach the problem of addiction from many different angles, and foster the evaluation and development of research strategies and treatment programmes. Through the annual conference and international collaborative ventures, the EAAT aims to improve our understanding of prevention and treatment of addictive behaviours, with much emphasis on psycho-pharmacological treatment.

20–22 September 2007

Addictions information in the Google era: dealing with challenges
Venue: Brussels, Belgium

Organised by / Contact: Marc Wauters, Elisad (European Association of Libraries and Information Services on Alcohol and other Drugs)

Email: marc.wauters@vad.be
www.elisad.eu

Information: This will be the 19th Elisad annual meeting. Topics covered will include:

- Prevalence of alcohol and drug use in Belgium
- Drug research in Flemish nightlife
- The Partywise prevention campaign
- The Elisad portal for knowledge on substance abuse in Europe
- The EU drug strategy
- Situation of AOD libraries in the USA
- The EMCDDA documentation centre
- Supporting evidence based practice
- Internet search tools in 2007
- Adding value beyond Google: controlled vocabulary and targeted information

21 September 2007

SMMGP 2nd National Conference. Bringing it Together: Effective primary care based drug treatment services – 07 and beyond
Venue: Burlington Hotel, Birmingham

Organised by / Contact: Substance Misuse Management in General Practice (SMMGP). Contact Heather Malcolm, Sexual Health On Call (SHOC), 22 Lonsdale Road, Queen's Park, London NW6 6RD

Tel: +44 (0)207 604 4826
Fax: +44 (0)207 604 4826
E-mail: shoc@gp-e84025.nhs.uk
www.smmgp.org.uk/html/news/events.php

Information: Primary-care-based substance misuse treatment services are becoming well established, and improving. The conference is an ideal opportunity for those involved in developing services to come together to focus on where we are now and where we want to go in the future of primary care based services. It is also a forum for discussion about the development of services which focus on the person and not simply the drug, and an opportunity to develop and strengthen regional networks. This year's conference focuses on 'Bringing it Together', how we can all work to improve the care of our patients who use drugs and/or alcohol and who may be infected or affected by hepatitis or HIV. As always, we value the input of patients, carers, users and multidisciplinary colleagues from the field, GPs, shared care coordinators, service managers, DAAT officers, commissioners and shared care workers.

October

4–5 October 2007

Getting a Grip: Winning or Losing. Fourth National Conference on Substance and Alcohol Misuse for Local Authorities, the Public Service and Drug/Alcohol Misuse Service Providers.
Venue: Malton Hotel Killarney

Organised by / Contact: Kerry Life Education Ltd.

Tel: +44 (0)65 35135
Email: lifeed@eircom.net
http://www.kerrylifeeducation.com

11–12 October 2007

Conference on Quasi-Coerced Treatment and other alternatives to imprisonment
Venue: Palace of the Parliament, Bucharest, Romania

Organised by / Contact: Council of Europe Pompidou Group and the Romanian National Anti-Drug Agency

Information: This event is a continuation of efforts undertaken by the Pompidou Group Expert Forum on Criminal Justice to improve

Upcoming events *(continued)*

criminal justice responses to the drug situation, by seeking to promote changes in the policies and practices concerning the management of drug-using offenders in prison, as well as alternative approaches to imprisonment. Speakers' topics will include: an overview of existing mechanisms in EU member states; a review of evidence for the effectiveness of Quasi-Coerced Treatment (QCT); and evaluation methods and cost effectiveness of QCT programmes.

15–16 October 2007

2007 National Conference on injecting drug use
Venue: Glasgow Radisson Hotel

Organised by / Contact: Exchange Supplies

Tel: +44 (0)1305 262244
Fax: +44 (0)1305 262255
Email: info@exchangesupplies.org
www.exchangesupplies.org

Information: A packed and varied programme of plenary sessions covering key issues and over 30 parallel sessions, meetings, poster presentations and films all designed to inform practice, disseminate research, explore policy and develop skills. Plenary keynote topics will include:

- composition of illicit drugs: manufacture, adulterants, purity
- developing our understanding of sharing, and how to reduce it
- providing needle exchange to young people
- insulin use by body-builders
- pharmacy needle exchange
- crack cocaine preparation and injection

November

8–9 November 2007

Democracy, Cities & Drugs, 3rd Conference
Venue: Venice, Italy

Organised by / Contact: Democracy, Cities and Drugs. Contact Thierry Charlois

Tel: +33 (0)1 40 64 49 00
Email: conference-venice@democitydrug.org
www.democitydrug.org

Information: 3rd conference on local, integrated & participative responses to the issue of drugs use. Includes sessions covering the following topics:

- The political environment of local partnerships
- Epidemiology and new trends of drug using
- Judges and local partnerships
- Innovative practices
- Sharing practices with Central, Eastern European and Balkan countries
- Drugs and Cities: What images?
- Integration between care facilities and law enforcement

March 2008

13–14 March 2008

NDTC 08: National Drug Treatment Conference
Venue: Radisson Hotel, Glasgow

Organised by / Contact: Exchange Supplies

Tel: +44(0)1305 262244
Fax: +44 (0)1305 262255
Email: info@exchangesupplies.org
www.exchangesupplies.org

Information: 2008 sees the introduction of a new UK drugs strategy and review of the clinical guidelines influencing the way practitioners work with drug users. The NDTC is the biggest forum for the drug treatment field to discuss key issues and help shape the year ahead.

- Key plenary and workshop presentation titles will include:
- The new drug strategy: implications for policy and practice
- 'Natural recovery' from problematic drug use
- Families: how can we help? How can they help?
- More drug treatment with less money
- Understanding the heroin and cocaine supply chain
- Post-release initiatives for drug-using prisoners
- Alcohol, cannabis, cocaine, ecstasy (ACCE): the post heroin and crack generation
- Brief interventions with alcohol: why not with drugs?
- Are the NICE guidelines nice enough?
- Engaging black and minority ethnic communities in drug service development

May 2008

11–15 May 2008

International Harm Reduction Association, 19th International Conference: Towards a global approach
Venue: Palacio de Congresos, Fira de Barcelona, Spain

Organised by / Contact: International Harm Reduction Association (IHRA)

Tel: +44 (0) 207 462 6997
Fax: +44 (0) 207 462 6999
Email: info@ihraconferences.com
www.ihra.net/Barcelona/Home

Information: IHRA's harm reduction conferences have been held around the world each year since 1990, and the next event in this highly successful

series takes place in the city of Barcelona. Over five days, this conference will be the main meeting point for those interested in harm reduction, and an invaluable platform for debate, discussion, and the dissemination of new and evolving good practice in addressing drug use and associated harm.

29–31 May 2008

EUROPAD 8 Conference
Venue: Kempinski Hotel, Sofia, Bulgaria

Organised by / Contact: EUROPAD: European Opiate Addiction Treatment Association

www.europad.org

Information: Further details to be announced.

***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:

Alcohol and Drug Research Unit
Health Research Board
Knockmaun House
42–47 Lower Mount Street
Dublin 2
Tel: 01 2345 127
Email: adru@hrb.ie

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

The Alcohol and Drug Research 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.

Sarah Fanagan
At the end of July 2007, Sarah Fanagan left the Alcohol and Drug Research Unit (ADRU) where she had worked as an analyst with the National Drug Treatment Reporting System since August 2005. During this time Sarah made a significant contribution to the NDTRS. She worked on the collection of data for 2004 to 2006 from the HSE areas outside Dublin, Kildare and Wicklow, the development of a computerised data-entry programme, and the design of a pilot exit form. Sarah's intelligence and warmth and her calm and analytical approach to her work will be missed by her colleagues in the ADRU and by those outside the HRB with whom she worked in data co-ordination. Sarah got married in August and has now moved to Abu Dhabi. We wish her and her husband Fiachra every happiness and success in their new life together.