drugnet IRELAND

Issue 26
Summer 2008

Newsletter of the Alcohol and Drug Research Unit

New information on drug use by region:

→ Treatment trends

→ Prevalence data

→ Crime statistics

Drugnet Ireland online
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→ Trends in treatment data
→ 3rd SLAN survey
→ Regional drug prevalence data
→ Alcohol-related harm
→ Drug-related research – review of infrastructure
→ New crime statistics
→ Poverty and drug and alcohol use: public perceptions
→ Drug testing in prisons
→ Task force conference
→ UN assesses progress towards UNGASS goals
→ Online forums; networking sites; customised search engines

New Minister of State for drugs strategy

On 13 May the Taoiseach appointed Deputy John Curran, Fianna Fáil TD for Dublin Mid West, as Minister of State at the Department of Community, Rural and Gaeltacht Affairs with special responsibility for drugs strategy and community affairs. Deputy Curran is a member of the Dáil Committee on Public Accounts and the Joint Committee on Child Protection. He has been a member of the National Economic and Social Forum (NESF) since 2004.

Drugnet Ireland available in electronic format

The first issue of *Drugnet Ireland* to appear in the new electronic format (Issue 25) was published in April. Anyone wishing to subscribe just needs to fill in and submit an online form. All future issues will then be delivered directly to your desktop. The electronic newsletter is in the form of a micro website. The front page is included in an email and from here you can read the contents by simply clicking on the title of the article.

This is an important development for our newsletter. Interest continues to grow and we are aware of the need to make the contents more widely available with each issue. However, costs are also increasing. Publishing in electronic format is cost effective and will help us to maintain the level and frequency of output.

Publishing this way also means that fewer resources are consumed than in traditional publishing. It is therefore a more sustainable approach and, in this spirit, we would ask you to consider opting for the electronic version of *Drugnet Ireland*, rather than the print copy. You can choose this option on the online form. We are well aware of the convenience of having a physical, transportable copy, but you will find that the electronic newsletter is attractive and simple to use, and the content is easy to disseminate should you want to pass it on to a colleague. It will also make archiving easier and will enable us to add value to the content by linking to other online resources such as the National Documentation Centre.

Thank you for your support and interest over the past 25 issues of *Drugnet Ireland*. If you have any comments on the electronic version or suggestions for improvement please send them to drugnet@hrb.ie.

The current issue is available at http://newsweaver.ie/drugnet. Please go to the Subscribe/Unsubscribe link in the left margin and fill in the subscription form.

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Trends in treated problem drug use in Ireland, 2001 to 2006

On 14 May 2008, the Health Research Board published trends in treated problem drug use based on data reported to the National Drug Treatment Reporting System (NDTRS) and to the Central Treatment List (CTL).[1] It is important to note that the reporting system collects data on episodes of treatment, rather than the number of individual people treated each year. This means that individuals may appear more than once if they attend more than one treatment service in a year, and may reappear in subsequent years.

The main findings and their implications are:

- There were 68,754 cases treated between 2001 and 2006, of which 31,620 entered treatment during the six-year period. Of these cases, 29,373 (93%) lived in Ireland at an identified address, 2,203 (7%) lived in Ireland at an unidentified address and 44 (0.1%) did not live in Ireland.
- In Ireland, treatment for problem drug use is provided in outpatient, inpatient, low-threshold and general practice settings. Of the 68,754 cases treated between 2001 and 2006, the majority (68%) attended outpatient services.
- The number of individuals in methadone treatment from the preceding calendar year and carried forward on 1 January each year increased by 46%, from 4,963 in 2001 to 7,269 in 2006.
- Just over 2,300 methadone treatment places have been created since the beginning of the current National Drugs Strategy (2001–2008) and the number of outpatient services has increased by 25%.
- Of the 5,191 cases entering treatment for problem drug use in 2006, 51% received counselling as an initial intervention, 39% received methadone substitution, 17% received a brief intervention and 14% attended medication-free therapy. Thirty-six per cent of cases received more than one initial treatment intervention.
- The prevalence (all cases) of treated problem drug use among 15–64-year-olds living in Ireland, expressed per 100,000 of the population, increased by 15%, from 372 in 2001 to 426 in 2006.
- The incidence (new cases) of treated problem drug use among 15–64-year-olds living in Ireland was marginally lower in 2006 (74.8 new cases per 100,000) than in 2001 (75.7 new cases).
- The relatively stable incidence observed during the period masks separate trends in the former health board areas. The number of new cases increased by 100% in the Western, by 57% in the Midland, by 37% in the North Eastern and by 33% in the Mid-Western health board areas between 2001 and 2006. The number of new cases increased by 89% in the South Eastern Health Board area between 2001 and 2005 and then stabilised.
- An opiate (mainly heroin) was the most common main problem drug reported by new cases who lived in Dublin. There was a 31% decrease in the number of new opiate cases who lived in Dublin, from 675 in 2001 to 468 in 2006, indicating that the heroin epidemic in this area has abated. In contrast, there was a 96% increase in the number of new opiate cases who lived outside Dublin, from 226 in 2001 to 442 in 2006.
- The main problem drugs reported by new cases were cannabis (41%), opiates (39%) and cocaine (9%). The number of new cases who reported cocaine as their main problem drug increased noticeably, from 43 in 2001 to 342 in 2006. The number of new cases reporting cannabis as their main problem drug increased marginally.
- The vast majority (72%) of new cases treated between 2001 and 2006 reported problem use of more than one substance (polysubstance use).
- In total, 2,473 new injector cases entered treatment between 2001 and 2006. Over half of these were still injecting on entry to treatment, and 47% reported sharing injecting equipment. The proportion of injector cases who reported sharing equipment decreased from 51% in 2001 to 44% in 2006, which indicates the positive effect of proactive outreach work.
- In general, problem drug users are young and male, have low levels of education and are unlikely to be employed, indicating the importance of personal development and educational and employment opportunities as part of the drug treatment and reintegration process.
- Though small, the proportion of cases who reported being homeless and the proportion not born in Ireland increased steadily during the reporting period. The increase in the proportion of other nationalities seeking treatment may have implications for service provision as drug treatment interventions rely heavily on verbal communication.

(Jean Long)

1. Reynolds S, Fanagan S, Bellerose D and Long J (2008) ***Trends in treated problem drug use in Ireland, 2001 to 2006.*** HRB Trends Series 2. Dublin: Health Research Board.

Alcohol and drug data from third SLAN survey

On 29 April 2008, the Department of Health and Children published the third SLAN survey of lifestyle, attitudes and nutrition in Ireland. The then Minister for Health Promotion and Food Safety Pat The Cope Gallagher TD launched the findings for Ireland.[1]

The survey involved 10,364 face-to-face interviews with adults resident in Ireland, which represented a 62% response rate. The sample was drawn from the GeoDirectory using a multi-stage probability procedure, and was stratified by townland, urban–rural location, age and social class.

Respondents were asked a number of questions about their alcohol and drug use. The responses were weighted for age, gender, marital status, country of birth and ethnicity.

Respondents who had not consumed alcohol in the 12 months prior to the survey included:

- almost one in five of those surveyed
- 23% of women and 15% of men surveyed
- two in five of those aged over 65 years
- almost one-quarter of respondents classified as social class 5 or 6.[2]

Respondents who had consumed alcohol four or more times per week in the 12 months prior to the survey included:

- 8% of those surveyed
- 11% of men and 5% of women surveyed
- one in ten of those aged between 45 and 64 years
- one in ten of those classified as social class 1 or 2.[2]

Respondents who had consumed six or more standard drinks on one or more occasions per week in the 12 months prior to the survey included:

- 28% of those surveyed
- 38% of men and 17% of women surveyed
- two in five of those aged between 18 and 29 years
- just over one-third of those classified as social class 5 or 6.

The proportion reporting that they drank six or more standard drinks on one or more occasion per week in the year prior to the survey fell from 45% in 2002 to 28% in 2007. This decrease was observed across gender, age and social class. Some reduction in the proportion of the population that engaged in binge drinking could be expected as a result of the increase in excise on spirits, but this decrease is larger than expected. In addition, the authors note that this finding must be interpreted with caution because of the change in sample selection and data-collection methods in 2007 compared to those in 2002 and 1998, as shown in Table 1.

Sixty-seven per cent of the respondents who drank alcohol were car drivers, of whom 12% reported that they had driven in the year prior to the survey after consuming two or more standard drinks. More men (17%) than women (5%) reported this practice. Respondents classified in social class 5 or 6 were more likely to report this practice than those in other social classes, 15% compared to 12%. The percentage of drivers who reported this practice decreased from 16% in 2002 to 12% in 2007. This decrease is to be expected since random breath testing for drivers was introduced in June 2006. In addition, the different data-collection method used may account for a proportion of the change (Table 1).

Respondents were asked about their use of illegal drugs in the last year (Table 2). Six per cent reported that they had used an illegal drug in the year prior to the survey; the reported use of such drugs was higher for men (9%) than for women (4%). As expected, cannabis was the most commonly used drug. The percentage of those who used cocaine in the last year was surprisingly low at 1%.

Table 1 Summary of SLAN methods, 1998, 2002 and 2007

	SLAN 1998	SLAN 2002	SLAN 2007
Population	Adults aged 18+	Adults aged 18+	Adults aged 18+
Sampling frame	Electoral register	Electoral register	GeoDirectory
Sample	Multi-stage sample, drawn by electoral division	Multi-stage sample, drawn by electoral division	Multi-stage probability sample
Stratification	Percentage distribution across each of 26 counties, locality and gender	Percentage distribution across each of 26 counties, locality and gender	Percentage distribution across townlands, age groups, social classes and urban–rural location
Methods	Self-completion questionnaire and self-completion of Food Frequency Questionnaire	Self-completion questionnaire and self-completion of Food Frequency Questionnaire	Face-to-face interview and self-completion of Food Frequency Questionnaire
Obtained sample	6,539	5,992	10,364
Response rate	62%	53%	62%
Source: SLAN (2008)			

Data from third SLAN survey *(continued)*

In general, these data are not comparable to the results of the 2006/7 general population survey by the NACD as the SLAN survey excluded those between 15 and 17 and included those over 65 years.

In general, the use of confidence intervals would allow commentators to rule out sampling variation when comparing the SLAN surveys, both over time, and with other surveys completed at the same time.

(Jean Long)

1. Morgan K, McGee H, Watson D, Perry I, Barry M, Shelley E, Harrington J, Molcho M, Layte R, Tully N, van Lente E, Ward M, Lutomski J , Conroy R and Brugha R (2008) *SLÁN 2007: Survey of lifestyle, attitudes & nutrition in Ireland.* Main report. Dublin: Department of Health and Children.
2. Central Statistics Office classification by social class: 1. Professional workers; 2. Managerial and technical; 3. Non-manual; 4. Skilled manual; 5. Semi-skilled; 6. Unskilled.

Table 2 Last-year prevalence of illegal drug use in Ireland

During last year	Adults 18 years or over %	Males 18 years or over %	Females 18 years or over %
Illegal drug use*	6.0	9.0	4.0
Cannabis	5.0	8.0	3.0
Ecstasy	1.0	1.0	<1.0
Cocaine	1.0	2.0	<1.0

* Illegal drugs in this context are amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

Source: SLAN (2008)

Drug use among the general population in regional drugs task force areas

On 25 June Minister John Curran released a new bulletin outlining drug prevalence data by regional drugs task force (RDTF) area based on findings from the 2006/2007 national drug prevalence survey.[1] Drug prevalence surveys of the general population are important in that they can shed light on the patterns of drug use, both demographically and geographically and, when repeated, can track changes over time. The Irish survey followed best practice guidelines recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

As expected, the use of illegal drugs was lowest in the north west and highest in the east of the country (Table 1).

Lifetime use

- Cannabis was the most commonly reported illegal drug in each of the RDTF areas, with proportions ranging between 13% in the North West and 36% in the East Coast areas (Table 2 and Figure 1).
- Ecstasy was among the four most commonly reported drugs in each of the RDTF areas, with proportions ranging between 2% in the North West and 11% in North Dublin (Table 3).
- Cocaine was among the top four drugs ever used by the survey respondents in all areas except the North West RDTF (Table 4). Lifetime cocaine use was highest in the North Dublin and East Coast RDTF areas.
- Poppers were among the four most commonly used drugs in the north west of the country while amphetamines were among the more commonly used drugs in the south east.

Though the proportions were small, there were significant increases in lifetime use of cocaine in five task force areas in 2006/7 when compared to 2002/3[2] (Table 4).

(Jean Long)

1. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2008) *Drug use in Ireland and Northern Ireland: results from the 2006/2007 drug prevalence survey by regional drugs taskforce area.* Bulletin 2. Dublin: National Advisory Committee on Drugs.
2. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005) *Drug use in Ireland and Northern Ireland: first results (revised) from the 2002/2003 drug prevalence survey.* Dublin: National Advisory Committee on Drugs.

Drug use in RDTF areas *(continued)*

Table 1 Proportion of respondents who reported lifetime, last-year and last-month use of illegal drugs, by regional drugs task force area of residence

	Percentage that used any illegal drugs*					
RDTF area of residence	Ever in lifetime		In year prior to survey		In month prior to survey	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
East Coast	25.9	38.4†	6.3	12.4†	4.1	5.3
North Dublin City & County	29.5	32.2	8.4	12.8	5.3	8.2
South West (Dublin)	24.0	25.6	7.5	7.4	4.3	2.0
South East	18.5	25.4	6.9	7.9	3.1	3.6
North Eastern	18.9	22.9	6.4	5.7	2.4	1.1
Midland	11.0	19.6†	2.8	4.4	1.0	1.7
Mid West	12.0	18.0	3.2	5.8	1.6	1.4
Southern	12.1	16.3	4.7	4.9	2.1	2.0
Western	12.5	23.3†	2.9	4.7	1.9	1.6
North West	10.6	14.5	2.6	2.9	0.2	0.3

* Illegal drugs in this context are amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

†Significant changes in proportion for the two survey periods.

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005, 2008)

Table 2 Proportion of respondents who reported lifetime, last-year and last-month use of cannabis, by regional drugs task force area of residence

	Percentage that used cannabis					
RDTF area of residence	Ever in lifetime		In year prior to survey		In month prior to survey	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
East Coast	24.5	35.9†	6.1	11.3†	3.8	4.2
North Dublin City & County	26.9	28.8	7.7	11.9	4.5	7.9
South West (Dublin)	23.2	24.0	7.3	6.7	3.9	1.8
South East	16.8	23.3	5.8	5.1	2.1	2.8
North Eastern	17.8	19.5	5.2	4.6	1.9	0.8
Midland	10.7	17.0	2.8	4.1	1.1	1.1
Mid West	10.9	17.0	3.0	4.7	1.6	1.4
Southern	11.6	15.0	4.4	4.6	2.1	2.0
Western	12.0	21.0†	2.0	4.3	1.3	1.6
North West	9.3	12.8	2.2	2.9	0.2	0.3

†Significant changes in proportion for the two survey periods.

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005, 2008)

Drug use in RDTF areas *(continued)*

Table 3 Proportion of respondents who reported lifetime, last-year and last-month use of ecstasy, by regional drugs task force area of residence

	Percentage that used ecstasy					
RDTF area of residence	Ever in lifetime		In year prior to survey		In month prior to survey	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
East Coast	5.4	7.6	2.5	2.3	0.9	0.5
North Dublin City & County	6.5	11.2	1.6	2.9	0.3	1.0
South West (Dublin)	5.9	4.1	1.3	0.5	0.0	0.0
South East	4.3	6.5	1.3	1.9	1.3	0.3
North Eastern	2.6	5.4	0.5	0.9	0.0	0.0
Midland	2.0	5.8†	0.9	0.9	0.0	0.3
Mid West	1.7	2.9	0.6	0.8	0.0	0.3
Southern	2.8	3.5	0.9	0.6	0.2	0.2
Western	1.8	4.4	0.3	0.9	0.3	0.3
North West	0.3	2.2†	0.0	0.3	0.0	0.3

†Significant changes in proportion for the two survey periods.

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005, 2008)

Table 4 Proportion of respondents who reported lifetime, last-year and last-month use of cocaine, by regional drugs task force area of residence

	Percentage that used cocaine*					
RDTF area of residence	Ever in lifetime		In year prior to survey		In month prior to survey	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
East Coast	6.3	9.1	2.3	3.1	0.5	0.8
North Dublin City & County	5.2	11.0†	1.7	3.3	0.8	1.4
South West (Dublin)	5.0	3.8	1.5	0.8	0.6	0.3
South East	2.5	6.7†	1.7	2.4	0.0	0.9†
North Eastern	1.2	5.6†	0.0	1.5	0.0	0.0
Midland	1.3	4.4†	0.3	1.7	0.3	0.9
Mid West	1.1	2.9	0.6	1.0	0.0	0.0
Southern	1.9	3.1	0.7	1.1	0.4	0.2
Western	1.6	3.5	0.7	1.5	0.4	0.4
North West	0.0	1.6†	0.0	0.3	0.0	0.3

*Cocaine in this context is cocaine powder and crack.

†Significant changes in proportion for the two survey periods.

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005, 2008)

Drug use in RDTF areas *(continued)*

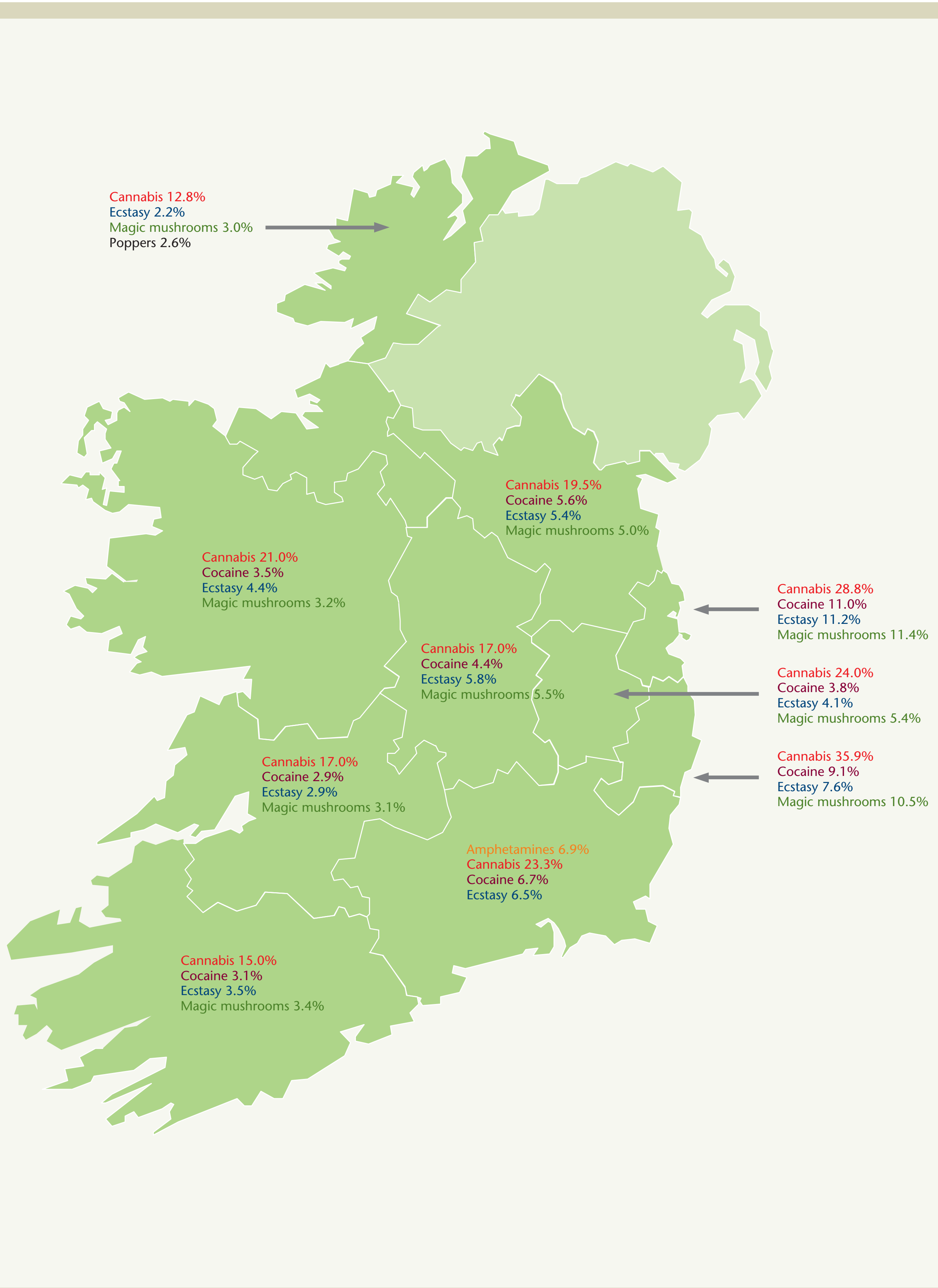


Figure 1 Lifetime prevalence among the general population of the four most commonly used illegal drugs in Ireland, by regional drugs task force area, 2006/7

Healing through creativity: RADE's cultural showcase

The fifth annual RADE (Recovery through art, drama and education) showcase of creative work produced by recovering drug users took place in May of this year. Established in August 2004, RADE's purpose is 'to train participants in arts activities designed to facilitate and encourage them in progression routes such as employment, further education and training'.[1] These participative programmes involve some of Ireland's leading contemporary artists from all artistic mediums. The event was opened by the then Minister of State Pat Carey TD in the Project Arts Centre in Temple Bar.

Ken Farrell and Christine Dempsey commenced by reciting their creative writing works entitled *Two Different Worlds*, which will feature in RADE's forthcoming book. This was followed by the world premier of *Raiders of the Lost Art*. This play, written and directed by RADE manager Michael Egan, blended myth with modern reality in a comic and vibrant fashion. An adaptation of the Táin Bó Cúailnge, it also served as the inspiration for the samples of art work and clips from a forthcoming documentary which were also on display. The art work is in preparation for an exhibition that will take place in Dublin Civic Offices from 30 June to 4 July.

The healing power of expression through creativity has recently gained increased attention.[2] Minister Carey spoke of this form of recovery as a useful 'agent for change' which harnesses both the strengths and weaknesses of a person's character. Referring to the current revision of the National Drugs Strategy, he stressed the need for innovation in order to help former drug users realise their 'highest levels of functional ability.' He reiterated this focus on original thinking required: 'Let's not be looking back, let's always look forward.' Michael Egan praised his cast, stressing the application of discipline, focus and attention that the play demanded. He closed by defining the programme as an 'alternative to other activities that drag you down'.

(Caroline Forde)

1. Further information is available on the RADE website at www.rade.ie. See also Connolly J (2007) President opens RADE's cultural showcase. *Drugnet Ireland*, Issue 22: 5.
2. Friend F (2008) Complementary therapy: creative writing. *Drink and Drugs News,* 21 April 2008: 12–13.

Upcoming RADE events:
RADE Art Exhibition on 30 June, 1.00 pm,
Dublin City Council Civic Offices, Wood Quay, Dublin 8.
Admission free. The exhibition is running for a week.

Raiders of the Lost Art on 14, 15, 17 and 18 July at 2.30 pm,
Ballyfermot Civic Centre, Ballyfermot.
Tickets €8. Call 01 454 8733.

Michael Egan, RADE Manager, with Minister Carey (Photo: JJ Berkeley)

Members of the cast of RADE's *Raiders of the Lost Art* (Photo: Evin McCarthy)

Alcohol Advisory Group reports

The Government Alcohol Advisory Group presented its report to the (then) Minister for Justice Brian Lenihan on 23 April 2008.[1] This Group was set up to examine key aspects of the law governing the sale and consumption of alcohol. The issues examined by the Group were:

- the increase in the number of supermarkets, convenience stores and petrol stations with off-licences, and the manner and conditions of sale of alcohol products in such outlets, including below-cost selling and special promotions;
- the increasing number of special exemption orders which permit longer opening hours being granted to licensed premises around the country; and
- the use, adequacy and effectiveness of existing sanctions and penalties, particularly those directed towards combating excessive and underage consumption.

The report highlights recent trends in alcohol consumption, public health and public order. It states that Ireland has one of the highest levels of alcohol consumption in the European Union, with levels in 2006 about 30% higher than the EU average. The number of people admitted to hospitals intoxicated or drunk rose to a peak in 2002, in line with a peak in alcohol consumption. Such admissions increased by 76% between 1997 and 2002. In 2006, approximately 60,000 proceedings were taken under the Criminal Justice (Public Order) Act 1994.

Alcohol Advisory Group reports *(continued)*

Recommendations of the Group

The report makes thirty-one recommendations, under four headings, including:

General

- The specific properties of alcohol are recognised in public policy-making and the consequences which flow from that recognition be taken into account in decision-making across the public policy spectrum.
- An overall national strategy on alcohol is developed and implemented with a coherent approach across government departments and other public bodies.

Sale of alcohol

- Applicants for a wine-retailer's off-licence are required to produce a District Court Certificate to the Revenue Commissioners.
- The grounds on which objection may be made to the granting of District Court Certificates for spirit, beer and wine off-licences are extended to include the suitability of licensed premises for the needs of local residents and the adequacy of the existing number of licensed premises in the neighbourhood.
- Off-sales of alcohol are restricted to the hours of 10.30am to 10.00pm, including Sundays, in the case of off-licences and mixed trading premises.
- Structural separation of alcohol products from non-alcohol products in mixed trading premises is introduced.
- The minimum age for selling alcohol in off-licences and mixed trading premises is increased to 21 years.
- A statutory provision to permit test purchasing of alcohol by persons under the age of 18 years is enacted.
- The District Court is authorised to insist upon an adequate CCTV system as a condition for the grant of a certificate, or renewal of a licence, in respect of an off-licence or mixed trading premises.
- Alcohol products are priced and sold on the basis of a unit price; this is intended to prohibit alcohol promotions and sales involving price discounts and '2 for 1' offers.

Extended trading hours

- Special exemption orders granted to nightclubs and late bars are to comply with fire safety standards and determination by the Court of maximum occupancy levels.
- The current statutory extended time limit of 2.30 am is changed to 2.00 am.
- The District Court does not grant a special exemption order for any premises unless satisfied that the special occasion will be conducted in a manner that will not cause undue inconvenience or nuisance to people living in the locality, or create an undue threat to public order or safety.
- Premises with theatre licences are subject to the general time limits applicable to public houses.
- The granting of general exemption orders which permit early opening for premises located in the vicinity of fairs and markets is repealed.

Sanctions, penalties and enforcement

- Fines for offences involving drunkenness, disorderly conduct and the provision of alcohol to under-age people is increased towards maximum District Court levels.
- A minimum closure period of two days is applied in the case of temporary closure orders for a first offence.

While these recommendations have been put forward to the Minister, they may not all be drafted into legislation. When announcing the establishment of the Group, the Minister also signalled that work would continue on the drafting of a comprehensive Sale of Alcohol Bill, which is included in the government's legislation programme for 2008. This Bill will modernise and streamline the laws relating to the sale and consumption of alcohol by repealing the Licensing Acts 1833 to 2004, as well as the Registration of Clubs Acts 1904 to 2004, and replacing them with updated provisions.

(Deirdre Mongan)

1. Government Alcohol Advisory Group (2008) *Report of the Government Alcohol Advisory Group*. Dublin: Department of Justice, Equality and Law Reform.

Alcohol-related harm in Ireland

The Health Service Executive (HSE) recently published *Alcohol-related harm in Ireland*, by Dr Ann Hope.[1] The report provides an overview of more than 30 recent studies and outlines the rising trends in alcohol consumption rates, and the harmful effects on the user and on other people. It looks at 60 factors relating to problem alcohol use, including health, workplace absences, pregnancy, domestic abuse, public order offences and road crashes.

The report makes it clear that alcohol-related harm is not confined to the drinker, but extends to the family, community and wider society. It describes the burden of harm to others, including public violence in the form of physical assaults, homicide, domestic violence and road injuries. Key findings presented in the report are shown below.

Alcohol-related harm to the drinker

- 28% of all injury attendances in Accident and Emergency departments in acute hospitals were related to alcohol.
- Alcohol-related hospital discharges increased by 92% between 1995 and 2002.
- Incidence rates for cancer of the liver had the highest increase of all cancer rates between 1994 and 2003.
- The number of new alcohol-related cancers will more than double for females and increase by 81% for males in the period 2005 to 2020.
- Alcohol affects an adolescent brain differently from an adult brain and damage from alcohol use during adolescence can be long term and irreversible.

Alcohol-related harm *(continued)*

- Almost half of men and over a quarter of women agreed that drinking alcohol had contributed to their having had sex without contraception.
- Between 1995 and 2004, sexually transmitted infections (STIs) increased by 217%.
- Alcohol was a contributory factor in 36.5% of all fatal crashes in 2003.
- Between 1996 and 2002, public order offences by adults increased by 247% (from 16,284 to 56,822); they decreased in 2003 and 2004 but increased again in 2005.

Alcohol-related harm to others

- Almost half (46%) of those who committed homicide were intoxicated at the time.
- Between 1990 and 2006, 2,462 people were killed on the roads between 9 pm and 4 am, the time most associated with alcohol-related accidents.
- In a general population survey, 44% of all respondents had experienced harm caused by their own or someone else's alcohol use.
- A study of college students found that almost two-thirds of male and over half of female students reported that they had experienced at least one incident of harm as a consequence of someone else's alcohol use.
- In a quarter of severe domestic abuse cases, alcohol was involved.
- The Coombe Women's Hospital found that 63% of women reported alcohol use during pregnancy, with 7% drinking six or more drinks per week.
- A survey of employers found that alcohol-related illness was cited by 12% of companies as a cause of short-term absence from work by males, and by 4% of companies as a cause of absence by females.

The report acknowledges that the findings paint a grim picture of the increasingly negative role played by alcohol in Irish society, which has major implications for policy makers, especially in the areas of health, justice and social policy. It calls for a set of integrated policies to reduce alcohol-related harm. It points out that the Strategic Task Force on Alcohol (STFA) provided the template for reducing alcohol-related harm in Ireland based on scientific evidence, but that there is no national structure with measurable targets and time-lines in place to implement the STFA recommendations. A number of areas are identified where immediate action is required:

- Effective policy – a set of integrated policies, based on effectiveness and cost effectiveness in reducing alcohol-related harm
- National structure – an agency or body taking responsibility for alcohol policy implementation, such as happens with drugs and tobacco
- Quality data systems – effective monitoring of alcohol-related harm needs quality data gathering across a range of alcohol-harm indicators, and many gaps still exist.

The report concludes that alcohol-related harm is complex and multifaceted and will not be reduced unless action is taken. The dramatic increase in alcohol-related harm does not bode well for the future health and well-being of the population in Ireland. Ireland is moving in the wrong direction, alcohol harm must be significantly reduced. Delaying the necessary action increases the growing burden of harm for everyone in society.

(Deirdre Mongan)

1. Hope A (2008) *Alcohol-related harm in Ireland.* Dublin: Health Service Executive – Alcohol Implementation Group.

New alcohol advertising codes

The Government has announced its decision to strengthen the measures in place to control alcohol advertising.[1] New advertising codes have been negotiated between the Department of Health and Children and representatives from the Irish alcohol and advertising industries. The purpose of these codes is to reduce the exposure of young people to alcohol advertising and marketing, and to limit the overall level of alcohol advertising and sponsorship across all Irish media.

Under the new measures:

- Alcohol advertising will not be permitted unless the relevant medium has an adult audience profile of greater than 75%, rather than 67% as currently applies.
- Where alcohol advertising is permitted, it will be limited to no more than 25% of available space or time on any occasion.
- No alcohol advertising slots or messages from sponsors before the normal ad breaks in sports programming (known as 'stings') will be allowed.
- Breakfast-time television (6–10 am) will be treated as children's viewing time and will not carry any alcohol advertising.
- All alcohol advertisements must be vetted and carry the Central Copy Clearance Ireland (CCCI) stamp of approval before acceptance by any media.
- A new consultative group will be established to advise and consult with the chairman of the Alcohol Marketing Communications Monitoring Body (AMCMB), which will allow a wider stakeholder involvement in the monitoring process.

The revised codes will be published shortly and will be operational by the summer. They will be reviewed by the AMCMB, which will have responsibility for monitoring compliance with the new codes.

(Deirdre Mongan)

1. Department of Health and Children (2008) *Minister Gallagher announces strengthened measures to control alcohol advertising.* Press release, 24 April. Retrieved 28/04/2008 from www.dohc.ie/press/releases/2008/20080424.html

Teenagers discuss solutions to alcohol misuse

A national consultation was undertaken by the Office of the Minister for Children and the Department for Health and Children in 2007 in order to investigate the views of teenagers in relation to problem alcohol use.[1] This consultation was on foot of the commitment by the Department of Health and Children to involve children and young people in researching their own lives, as highlighted in the National Children's Strategy 2000–2010.[2]

The consultation involved 257 Irish teenagers (aged 12–18) from secondary schools, youth organisations, Youth Reach centres and special interest groups. Five consultations were held, one each in Athlone, Sligo and Cork and two in Dublin. Workshops were facilitated by adults and some co-facilitated by young people from the Children and Young Peoples Forum (CYPF).

The consultation process involved the preliminary identification of solutions to problem alcohol use, which informed the themes for each workshop, and were then discussed by all participants at a Plenary session. There was considerable consistency in the themes identified at each consultation. The four main solutions identified were: a reduction in the legal age for drinking alcohol, alternative alcohol-free facilities, education, and law enforcement. The first two themes were noted as the most important by the teenage participants.

A small number of participants favoured raising the legal age limit to 21 years, while the majority favoured allowing 16–18-year-olds to drink in moderation under the monitoring of a 'safe-limit' card. A 'safe-limit' card would allow young people over the age of 16 a 'safe number' of alcoholic drinks of any type per night. They also recommended allowing those under the age of 16 to drink alcoholic beverages with less than 5% alcohol content. Participants reported that it would be more sociable and safer for young people to drink in public houses rather than covertly in public places. This would facilitate surveillance and reduce the 'buzz' surrounding teenage drinking which is enhanced by the illicit nature of the activity. Participants spoke of the necessity for an enforced system of identification for 12–25-year-olds. It was felt that only one form of identification should be accepted, such as the Garda Age Card, and that there was a clear need for tougher penalties for under age drinking.

The provision of affordable, alcohol-free facilities was an important solution highlighted by participants. While youth cafés were noted as a potential means of reducing the demand for alcohol-based recreation, it was noted that this would not fully eradicate the demand for alcohol among teenagers. It was argued that such facilities must have considerable teenage input in both their development and review.

Sport was noted as a vital area for developing alternative activities through both the strategic timing of activities (e.g. Saturday and Sunday mornings, thus hindering drinking behaviour on weekend nights) and increasing their inclusive focus, whereby participation is not restricted to a talented minority.

Participants identified a deficit in information relating to the consequences of problem alcohol use and felt that the delivery of age-appropriate material by objective professionals, rather than by teachers, could help greatly in addressing this deficit. It was noted that responsible drinking, rather than abstinence, was a more realistic approach for participants and that peer-mentoring and the use of role-models who drink responsibly could improve current alcohol education programmes. The role of parents was identified as important in underpinning education-based solutions, whereby a relationship of mutual respect, guidance and role modelling was paramount in fostering an attitude of responsibility towards alcohol use among teenagers.

While this report offers insights into teenagers' opinions, their recommendations for reducing problem alcohol use are in conflict with those advocated by the World Health Organization – regulating availability and increasing prices – which have been proven as the most effective policy interventions. It also appears that the teenagers were not informed of the effectiveness of potential solutions prior to the consultation; if this information had been provided, the strategies recommended might have been different.

(Sarah Gibney)

1. Department of Health and Children (2008) *Teenagers' views on solutions to alcohol misuse.* Dublin: Stationery Office.
2. Department of Health and Children (2000) *National Children's Strategy: our children – their lives.* Dublin: Stationery Office.

Drug-related research in Ireland 2001–2008

As Ireland's National Drugs Strategy (NDS) 2001–2008 is being reviewed, it is useful to consider how the research infrastructure has developed during this period and what contribution research has made to achieving the Strategy's aim to have 'valid, timely and comparable data on the extent and nature of drug misuse in Ireland'.

Information providers

For several years prior to the NDS the National Drug Treatment Reporting System (NDTRS), maintained by the Drug Misuse Research Division (DMRD, now called the Alcohol and Drug Research Unit, ADRU) of the Health Research Board (HRB), was the main source of information on drug misuse in Ireland and the DMRD supplied the EU with the data required for comparative analysis of the drug situation in the member states. In the year prior to the launch of the NDS, the National Advisory Committee on Drugs (NACD) was established to address remaining research and information gaps. Together with the DMRD, the NACD was given responsibility for providing the quality information and the comprehensive and comparable data essential to the delivery of a successful drugs strategy and to fulfilling Ireland's commitment to the EU in this area.[1]

Developments in research during the lifetime of the NDS are considered below.

1. **Prevalence data** – The NDS Review Group recognised the limitations of methods which extrapolated from treatment figures, and from statistics on drug-related arrests and deaths, to produce estimates of the prevalence of opiate use. A major task facing the NACD at the time was to determine how best the size and nature of the drug problem in Ireland could be measured. In 2005 the NACD published the findings of a major survey of households in Ireland and Northern Ireland carried out in 2002/2003. This survey was repeated in 2006/2007 and the results published in 2008. The NACD has also commissioned studies on drug prevalence among vulnerable groups, including the homeless, new communities in Ireland and Travellers.
2. **Treatment data** – The NDS Review Group recommended changes to ensure that treatment facilities reported problem drug use to the DMRD (now ADRU) in order to improve the efficiency and quality of flow of this information. The ADRU manages the National Drug Treatment Reporting System (NDTRS), an anonymised epidemiological database that records demand for treatment for problem alcohol and drug use. The NDTRS is one of two national registers that record drug treatment in Ireland; the other is the Central Treatment List (CTL), an administrative database used to regulate the dispensing of methadone treatment. The CTL is a complete register of all patients receiving methadone (as treatment for problem opiate use) in Ireland.
   Following a review of the NDTRS a concerted effort was made to improve the completeness and accuracy of recorded data from 2001.[2] In early 2008 the HRB was able to publish trends in treated drug use across Ireland between 2001 and 2006. In 2006 the NACD published the results of a longitudinal study evaluating the effectiveness of drug treatment (ROSIE). This study found that there was a significant reduction in heroin and other drug use one year after treatment uptake.
3. **Drug-related deaths** – The NDS recommended that Ireland should develop a dedicated system for recording drug-related deaths, a capacity essential for comparative analysis with other countries. The NDS envisaged that this task would be undertaken by the Central Statistics Office (CSO), who had responsibility for maintaining the General Mortality Register. However, in 2005 the ADRU, on behalf of the departments of Justice and Health, established the National Drug-Related Deaths Index (NDRDI), a census of drug-related deaths (such as those due to accidental or intentional overdose) and deaths among drug users (such as those due to hepatitis C and HIV). The NDRDI is a multi-source index, extracting and matching data from coroners' files, the CTL, the Hospital In-Patient Enquiry Scheme (HIPE), and the General Mortality Register.
4. **Drug-related infectious diseases (HIV, hepatitis)** – The NDS Review Group used statistics compiled by the Department of Health and Children as the main source of information on HIV and hepatitis infection among drug users in the general population. Two major reports provided a detailed picture of the prevalence of drug-related infectious diseases in prisons. There have been some developments in this area during the lifetime of the NDS. The Health Protection Surveillance Centre (HPSC) introduced an extended surveillance system for hepatitis B in 2004 and for hepatitis C in 2007. In 2006 the HRB published an overview on blood-borne viral infections among injecting drug users in Ireland between 1995 and 2005. However, there has been no concerted effort to monitor the incidence and prevalence of hepatitis B, hepatitis C or HIV among drug users since the NDS was launched.
5. **Drug-related arrests and offences and drug seizures** – The annual reports of the Garda Síochána were the source of information on drug-related arrests and offences and on seizures referred to by the Review Group. Since then, improved data management by Garda authorities has led to improvements in the quality of these data. The Garda Síochána Act 2005 transferred responsibility for the

Drug-related research *(continued)*

compilation and publication of recorded crime statistics from An Garda Síochána to the CSO. In 2008 the CSO adopted a new classification system for criminal offences in its new publication Garda recorded crime statistics 2003–2006. The new system includes a distinct category of 'controlled drug offences', broken down into three sections covering supply, possession and other drug offences.

Developments under the last of these indicators are a good example of how the increase in research and information-gathering capacity since 2001 in certain areas can affect capacity in apparently unrelated areas. For instance, the NACD's selection of drugs and crime as a priority area and its decision to support specific research projects in this field, including a major study on drug markets, were based on evidence derived from the ROSIE study, research on vulnerable groups mentioned above, community studies and drug trend monitoring, as well as on specific studies on drugs and crime undertaken by the HRB.

The first years of the new drugs strategy will see more of this cross-fertilisation as information from dedicated prevalence studies, more comprehensive and accurate treatment demand data and drug-related deaths data are published and assimilated and we come closer to closing the information gaps identified by the NACD.[3] The bodies charged with implementing the actions under the various pillars of the new strategy will thus be able to work in a much richer information environment than prevailed in 2001.

(Brian Galvin and Louise Farragher)

1. The HRB and NACD publications referred to are available on the organisations' websites at www.hrb.ie and www.nacd.ie.
2. Kavanagh P, Long J and Barry J (2006) Completeness and accuracy of the drug treatment reporting system in Dublin, Ireland. *Irish Journal of Medical Science,* 175 (3): 52–56.
3. In its 2005–2008 business plan the NACD matched its work programme to most of the gaps identified by the Interim Advisory Committee on Drugs in 2000. Most of the remaining gaps relate to criminal justice issues and cost effectiveness in delivery of treatment, prevention and other interventions.

CSO report: 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).

On 28 January this year the CSO issued *Headline crime statistics: quarter 4 2007*.[1] This quarterly report compared the headline crime statistics for quarter four of 2006 and 2007, using the old Garda headline crime classification system. On 17 April the CSO introduced a new Irish Crime Classification System (ICCS), together with an overview summarising the history of the former headline classification system and the rationale behind the new system. On 23 April the CSO published *Garda recorded crime statistics, 2003–2006*, based on the new ICCS.[2] This was accompanied by a briefing document, *Interpreting crime statistics*, issued on 25 April, which explained the sources used and the difficulties encountered in relation to crime classification. The findings of the 28 January and 23 April reports are described in this article.

Garda recorded crime statistics provides an overview of the background to its publication and framework. It also outlines the revisions made to the recording of crime data on the PULSE system (Police Using Leading Systems Effectively), the counting rules used in relation to crimes committed, issues around the detection of crime and the interpretation of court proceedings. There are also a number of selected features, including the breakdown of recorded controlled drug offences by city. Appendix II of the report presents details of the Garda Síochána Diversion Programme.

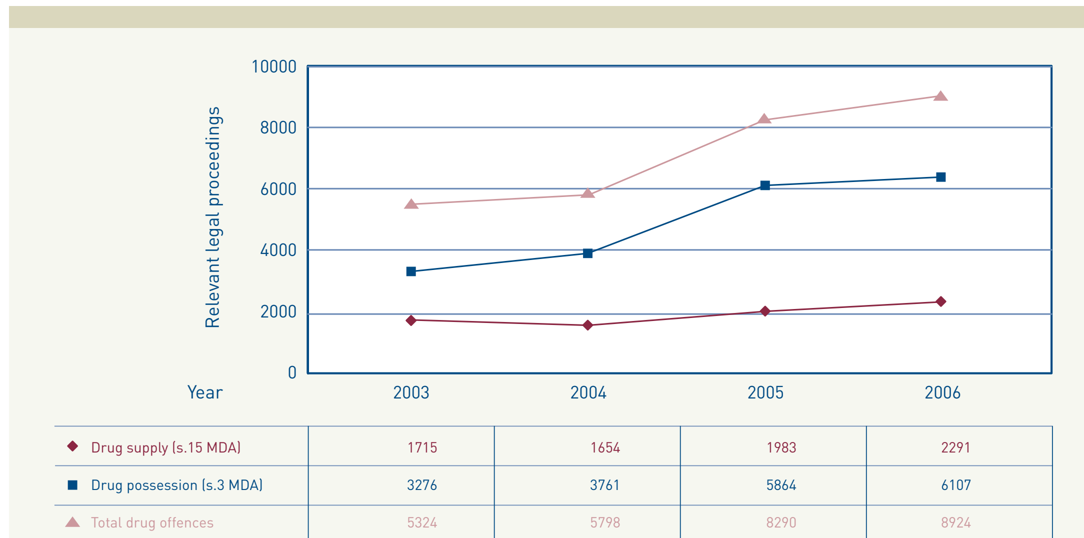
The vast majority of drug offences reported come under one of three sections of the Misuse of Drugs Act (MDA) 1977: section 3 – possession of any controlled drug without due authorisation

All four Central Statistics Office publications mentioned in this article are available on the CSO website at www.cso.ie.

Table 1 Annual total headline drug offences, 2006 and 2007

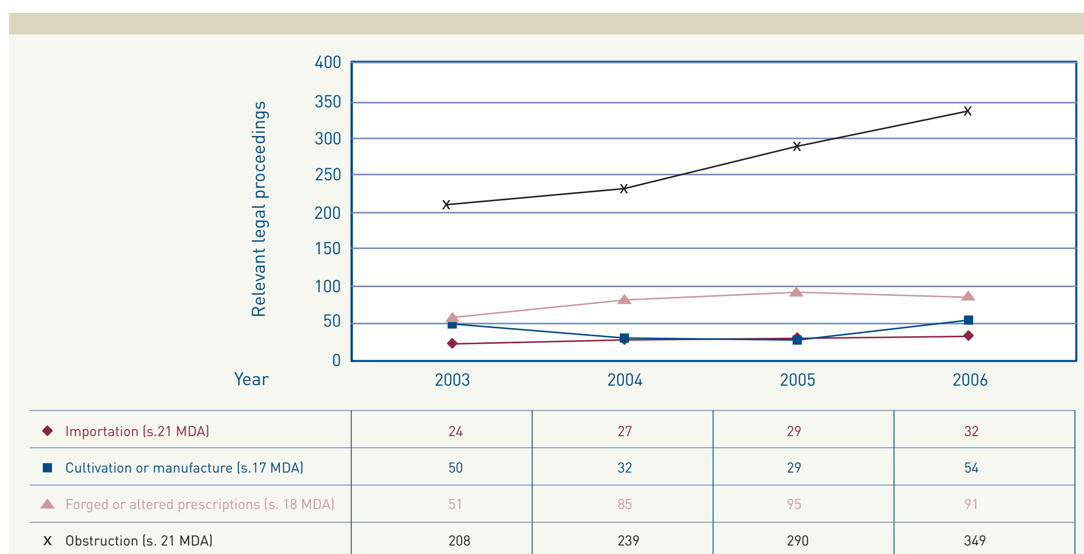
	Offence type		
	Possession for sale or supply	Cultivation, manufacture or importation	Obstruction
2006	3,025	135	472
2007	3,620	214	589
% Increase	19.7	58.5	24.8
Source: CSO (2008a)			

Drug crime statistics *(continued)*



	2003	2004	2005	2006
◆ Drug supply (s.15 MDA)	1715	1654	1983	2291
■ Drug possession (s.3 MDA)	3276	3761	5864	6107
▲ Total drug offences	5324	5798	8290	8924

Figure 1 Trends in relevant legal proceedings for possession (s.3 MDA), supply (s.15 MDA) and total drug offences, 2003–2006
Source: CSO (2008b)



	2003	2004	2005	2006
◆ Importation (s.21 MDA)	24	27	29	32
■ Cultivation or manufacture (s.17 MDA)	50	32	29	54
▲ Forged or altered prescriptions (s. 18 MDA)	51	85	95	91
X Obstruction (s. 21 MDA)	208	239	290	349

Figure 2 Trends in relevant legal proceedings for selected MDA offences, 2003–2006
Source: CSO (2008b)

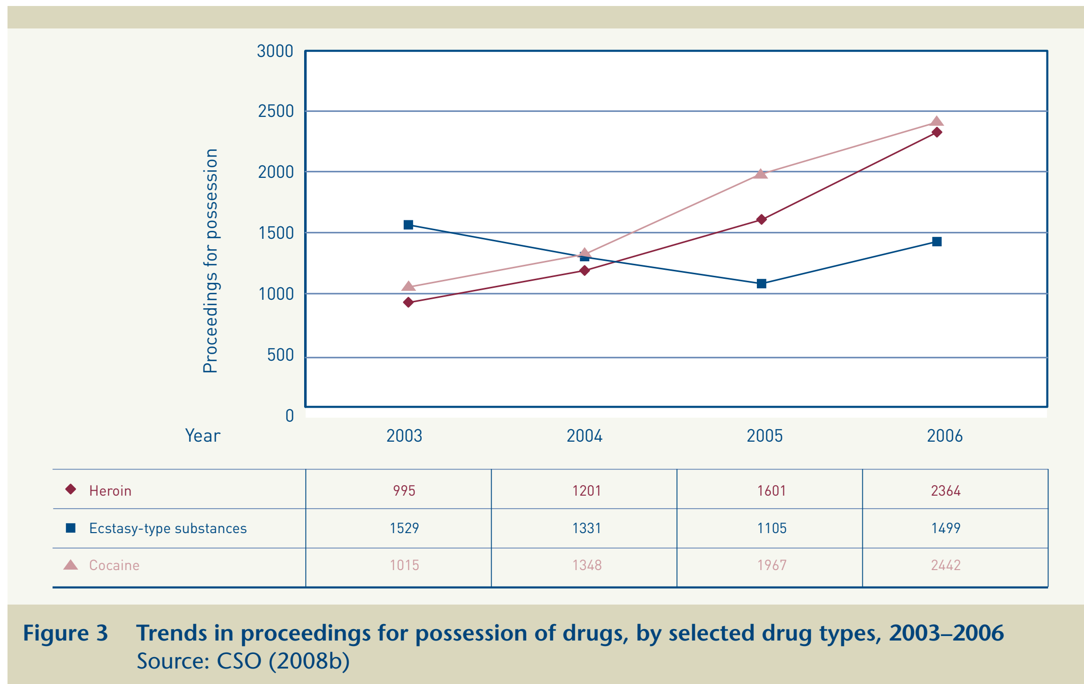
(simple possession); section 15 – possession of a controlled drug for the purpose of unlawful sale or supply (possession for sale or supply); and section 21 – obstructing the lawful exercise of a power conferred by the Act (obstruction). Other MDA offences regularly recorded relate to the unlawful importation into the State of controlled drugs (section 21); permitting one's premises to be used for drug supply or use (section 19); the use of forged prescriptions (section 18); and the cultivation of cannabis plants (section 17).[3]

Table 1 displays total headline offences in the drugs category for the years 2006 and 2007. Increases were recorded in all such offences in 2007, with an overall increase of 791 (21.8%). The offence of cultivation, manufacture or importation of drugs, while the lowest in the category, showed the largest percentage increase (58.5%) in 2007. Possession of drugs for sale or supply, representing the largest offence type in the drugs category, increased by 595 (19.7%).

Figure 1 shows trends in relevant legal proceedings for possession and supply between 2003 and 2006.[4] The majority of these proceedings are for drug possession, which have risen since 2003 and accounted for 68.4% of drug offence proceedings in 2006. The number of relevant legal proceedings for supply offences in 2006 was 2,291, representing 25.7% of total drug offence proceedings.

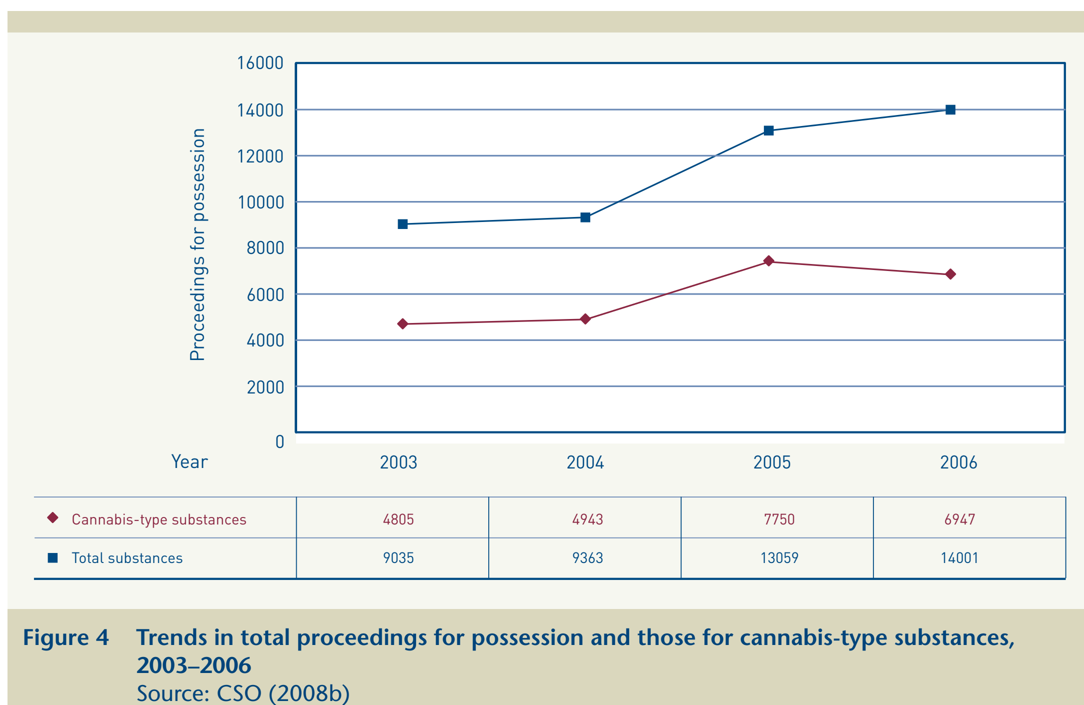
Figure 2 shows trends in relevant legal proceedings for a selection of other drug offences between 2003

Drug crime statistics *(continued)*



	2003	2004	2005	2006
◆ Heroin	995	1201	1601	2364
■ Ecstasy-type substances	1529	1331	1105	1499
▲ Cocaine	1015	1348	1967	2442

Figure 3 Trends in proceedings for possession of drugs, by selected drug types, 2003–2006
Source: CSO (2008b)



	2003	2004	2005	2006
◆ Cannabis-type substances	4805	4943	7750	6947
■ Total substances	9035	9363	13059	14001

Figure 4 Trends in total proceedings for possession and those for cannabis-type substances, 2003–2006
Source: CSO (2008b)

and 2006. Obstruction offences increased steadily from 208 in 2003 to 349 in 2006. Following a two-year decline, relevant legal proceedings for cultivation or manufacture of drugs increased during 2006 to slightly above the 2003 figure.

Figure 3 shows trends in proceedings for possession of drugs, by drug type, for a selection of substances between 2003 and 2006.[5] Both heroin and cocaine show steady increases since 2003, with heroin increasing by 47.7% between 2005 and 2006. Following a 38% decline over two years, proceedings for possession of ecstasy-type substances increased by 35% between 2005 and 2006, almost reaching their 2003 level.

Figure 4 shows trends in total proceedings for possession and those for cannabis-type substances between 2003 and 2006. Cannabis-type substances consistently accounted for the majority of these proceedings, representing 6,947 (49.6%) of the total in 2006.

Table 2 provides a breakdown of events that take place once an incident of a controlled drug offence is recorded in the PULSE system. The table is based on the 2006 data and includes the new ICCS references. The data provided in Table 2 enhance our understanding of the operation of the criminal justice system. Of the 67 cases of importation/manufacture of drugs in which court

Drug crime statistics *(continued)*

Table 2 Incidents recorded, resultant proceedings and outcomes for offences, 2006

Offence type	Recorded	With relevant proceedings	Court proceedings commenced	Conviction	Proved & order made without conviction/ Probation of Offenders Act	Non-conviction	Pending (incl. appeals allowed)
Controlled drug offences (10)	14,233	8,924	5,762	2,676	428	757	1,901
Importation or manufacture of drugs (101)	135	86	67	29	5	3	30
Possession of drugs (102)	13,488	8,398	5,353	2,507	413	704	1,729
Other drug offences (103)	610	440	342	140	10	50	142
Source: CSO (2008b)							

proceedings commenced, 29 resulted in a conviction and 30 were pending. Of the 5,353 possession cases in which proceedings commenced, 2,507 resulted in conviction and 1,729 were pending.

(Johnny Connolly and Caroline Forde)

1. Central Statistics Office (2008a) *Headline crime statistics: quarter 4 2007*. Dublin: CSO.
2. Central Statistics Office (2008b) *Garda recorded crime statistics 2003–2006*. Dublin: Stationery Office.
3. See also Connolly J (2007) Drug-crime statistics. *Drugnet Ireland,* Issue 23: 16-18.
4. 'Relevant proceedings' refers to the legal proceedings, such as prosecution, taken in relation to the offence as it was originally recorded in the PULSE system.
5. 'Proceedings' is a list of charges and proceedings which do not necessarily relate to the offence as it was originally recorded in the PULSE system.

CSO report: illicit drug market statistics

The report, *Garda recorded crime statistics 2003–2006*, published by the Central Statistics Office (CSO) in April provides data which can assist us in understanding aspects of the operation of the illicit drug market in Ireland.[1] With regard to the so-called middle market level, which involves the importation and internal distribution of drugs, data on drug supply offence prosecutions by Garda division are a possible indicator of national drug distribution patterns.[2] 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. This data can be compared with drug treatment data, to show us whether the heroin trade is growing outside the Dublin region for example (see p.2 of this issue). Such data can also provide an indicator of trafficking patterns by showing, for example, whether there is a concentration of prosecutions along specific routes. Figure 1 shows the number of relevant legal proceedings for drug supply offences by Garda region outside the Dublin Metropolitan Region (DMR).[3]

The upward trend since 2004 in relevant legal proceedings for drug supply continued in 2006 (Figures 1 and 2). Although the majority of such proceedings still take place in the DMR, the proportion of the total number which take place outside the DMR has increased since 2004 (Figure 2).

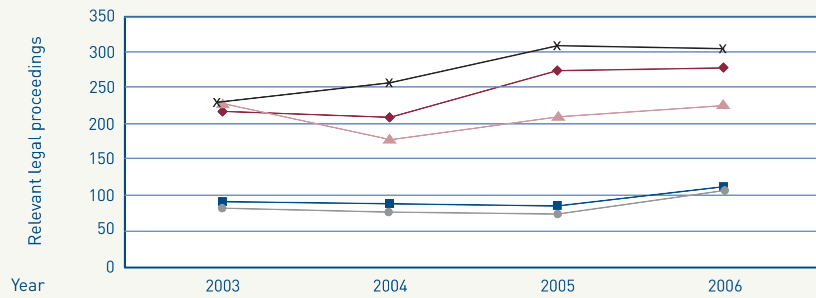
The number of drug seizures in any given period can be affected by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of traffickers to law enforcement activities. However, drug seizures are considered as indirect indicators of the supply and availability of drugs.

Cannabis seizures account for the majority of all drugs seized. Of the 8,417 reported drug seizures in 2006, 4,243 (50.4%) were cannabis-related. Figure 3 shows trends in seizures for a selection of drugs, excluding cannabis, between 2003 and 2006. We can see a continuous steady rise in cocaine seizures since 2003. Heroin seizures rose sharply during 2006, increasing from 763 in 2005 to 1,254 in 2006. The number of seizures of ecstasy-type substances also rose in 2006, following a steady decline since 2003.

(Johnny Connolly and Caroline Forde)

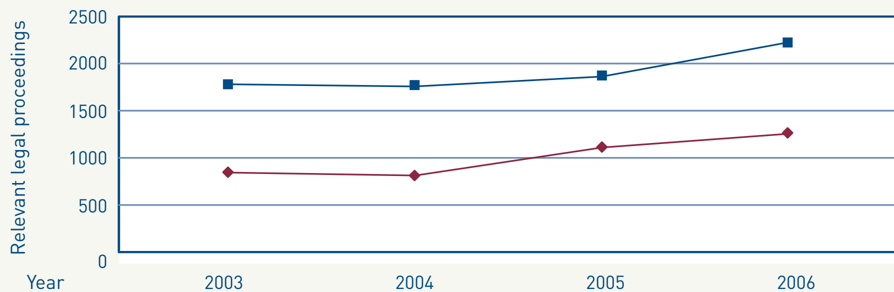
1. Central Statistics Office (2008) *Garda recorded crime statistics 2003–2006*. Dublin: Stationery Office.
2. Connolly J (2005) *The illicit drug market in Ireland.* Overview 2. Dublin: Health Research Board. See also Connolly J (2007) Drug-crime statistics. *Drugnet Ireland,* Issue 23: 16–18.
3. The report uses the term 'relevant proceedings' which refers to the legal proceedings, such as prosecution, taken in relation to the offence as it was originally recorded in the PULSE system.

Drug market statistics *(continued)*



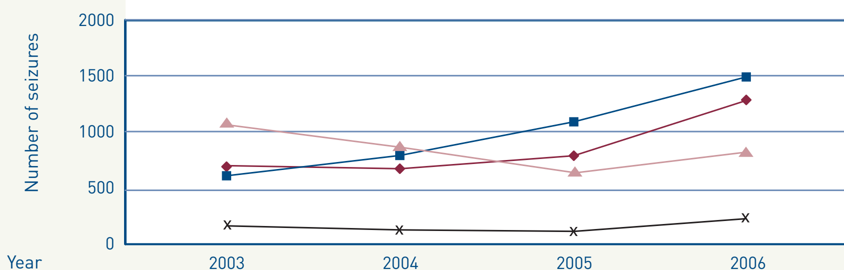
	2003	2004	2005	2006
◆ Eastern region	214	211	269	276
■ Northern region	91	89	85	111
▲ South eastern region	232	179	218	235
x Southern region	234	258	314	310
● Western region	88	71	70	105

Figure 1 Drug supply (s.15 MDA) offences outside the Dublin Metropolitan Region where relevant legal proceedings commenced, 2003–2006
Source: CSO (2008)



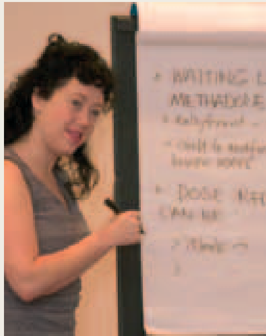
	2003	2004	2005	2006
◆ Dublin Met. Region	856	846	1027	1254
■ Total	1715	1654	1983	2291

Figure 2 Trends in total number of relevant legal proceedings for supply offences and those in the Dublin Metropolitan Region, 2003–2006
Source: CSO (2008)



	2003	2004	2005	2006
◆ Heroin	660	612	763	1254
■ Cocaine	566	753	1045	1500
▲ Ecstasy-type substances	1083	806	689	858
x Amphetamines	211	145	125	277

Figure 3 Trends in the number of seizures of selected drugs, excluding cannabis, 2003–2006
Source: CSO (2008)



Caroline Gardner (Progression Routes Initiative Co-ordinator, SAOL Project) speaking at the seminar (Photo: JJ Berkeley)

Community detoxification pilot scheme

A series of seminars was held on 8 April with health care professionals and community and voluntary groups to introduce intra-agency community methadone detoxification protocols. It aimed to give opportunities for discussion around offering community detoxification as a viable alternative option for people. The then Minister of State Pat Carey TD also addressed the participants.

These protocols will be piloted in the North Inner City Drugs Task Force (NICDTF) area over the next 18 months. They aim to provide an option for people who find it difficult to take up a residential detoxification bed due to family or work commitments. They may also benefit individuals who want to reduce their methadone dosage in order to access a residential programme. They were developed in response to concerns voiced by the community and by drug users that people were being 'parked' on long-term methadone maintenance.

These protocols are based on best practice guidelines from the UK and input from Irish experts. They emphasise empowerment – drug users are empowered to choose what treatment option best suits them, but also to take responsibility for their treatment. The protocols are designed to address the concerns of GPs about the risk factors associated with the process, including integrating the necessary social support for their patient for a successful and safe detoxification.

Overview of process

Assessment – When the client expresses an interest in undertaking the programme, the process starts with an assessment (including history of drug misuse which may also require testing). The client needs to provide one month's clean urine (free from opiates and illicit use of prescription drugs) and sign a consent form.

Meetings are held with the client, their case manager and GP to explain the process, clarify roles and responsibilities, and provide education on the dangers of relapse and overdose in detoxification. If the urinalysis shows non-compliance, in special circumstances and on agreement between all parties, the detoxification may go ahead.

The case manager – The case manager's role is important as it provides the social support essential for a successful and safe detoxification outside a residential facility, which the GP alone cannot provide. The case manager is responsible for assessing the client's suitability for the programme and for ensuring that correct protocols are followed. He/she has primary responsibility for the client's care plan. In consultation with the client, the case manager will develop a relapse-prevention and aftercare plan, and will work with the client during and after the detoxification (for a minimum of six months).

The client – Clients wishing to undergo a community detoxification also have responsibilities under the protocol. As well as providing clean urine samples, they must show willingness to engage regularly and reliably with their case manager and treatment agency. They must also commit to inform the case manager if they relapse or wish to stop the detoxification.

Contra-indications

- Previous history of epileptic seizures while undergoing detoxification
- Dual addiction, where both addictions are unstable or where a second addiction other than opiates is uncontrolled
- Severe mental health problems that are currently untreated
- Major medical illness
- Active treatment for hepatitis C
- Pregnancy

Example of methadone detoxification schedule

- Reduce methadone intake by 5ml per week until client reaches 50ml
- Continue at 50ml for one month, then
- Reduce by 3–5ml per week until client reaches 20ml
- Continue at 20ml for one month (attempt to transfer to community pharmacist where possible), then
- Reduce by 3ml per week until client reaches 10ml
- Continue at 10ml for one month, then
- Reduction from 10ml to zero may require:
  - Buprenorphine or lofexidine detox
  - Continued community detox as above
  - In-patient detox.

Benzodiazepine detoxification – The aim of benzodiazepine detoxification is to become drug free, not to be maintained on lower doses. In this case, the client shows their commitment by attending four care planning meetings over a period of two to six weeks. They are also required to fill out weekly drug diaries[1].

The future – This pilot project will be monitored for at least the next 18 months by the steering committee. Caroline Gardner is the Progression Routes Co-ordinator. progressionroutes@saol.project.ie

(Suzi Lyons)

1. See Department of Health and Children (2002) *Benzodiazepines: good practice guidelines for clinicians,* pp 21–25. Available on the DOHC website at www.dohc.ie/publications.

EMCDDA update on GHB/GBL

On 17 March 2008, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published a thematic paper, *GHB and its precursor GBL: an emerging trend case study.*[1] GHB (gamma-hydroxybutyric acid) is commonly known as liquid ecstasy. It was used in the eighties for its body-building effects, and in the nineties as a recreational drug at music venues. In 2000, the EMCDDA and its partners carried out a risk assessment on GHB and the drug was placed under international control by the United Nations in March 2001. Since 2001 the new controls have curtailed the open sale of the drug but there are now concerns over its chemical precursors, GBL (gamma-butyrolactone) and 1,4-butanediol, which are now being sold as substitutes for GHB, and are not controlled by international law.

The chemical precursors of GHB are widely used for legitimate purposes (for example, in cleaning solvents) and can be purchased over the internet from 15 suppliers in Germany, The Netherlands, Poland and the UK. Health warnings are displayed on 12 of the 15 sites. Italy, Latvia and Sweden have introduced controls on one or both precursors. GBL and 1,4-butanediol can be used easily to manufacture GHB. Indeed, when ingested by humans the precursors are naturally converted to GHB.

The use of GHB/GBL in recreational settings is relatively uncommon when compared to that of ecstasy or cocaine. Little is known about the use of these chemicals in private settings. According to the authors, the effects of GHB/GBL on humans, when taken in small quantities, are similar to those of alcohol, but increase greatly with each small increase in quantity consumed. The toxic effects of the drug include impaired consciousness and coma. Hospital emergency departments in Ibiza, Amsterdam and London reported a rising number of non-fatal overdoses due to GHB or GBL. These substances have rarely been shown to be implicated in the death of a drug user because forensic analysis is difficult due to the short period of time it can be detected in blood or urine and due to the fact that low quantities of GHB are normally present in the body. There is little or no evidence to implicate GHB in date rape.

(Jean Long)

1. Hillebrand J, Olszewski D and Sedefov R (2008) *GHB and its precursor GBL: an emerging trend case study.* Lisbon: European Monitoring Centre for Drugs and Drug Addiction.

Eurobarometer survey on poverty and exclusion

In September 2007, the European Commission published a Special Eurobarometer survey of public opinion about poverty and exclusion.[1] This survey canvassed the views of 26,466 respondents in the 27 EU member states and 1,000 residents of Croatia. TNS MRBI carried out 1,000 interviews in Ireland.

Perceptions about the existence and the causes of poverty

In general, poverty is seen as a widespread problem that affects the majority of people to some extent. Europeans feel that, in their own area, about three people out of ten (29%) live in poverty and one person in ten lives in extreme poverty.

Poverty is seen to affect more people living in new member states than in the former EU15 countries (63% vs. 32%). However, in the former EU15 countries there was a significant increase since 2002 in the proportion of people who perceive poverty to exist (+12%).[2]

Those surveyed were asked which of four statements as to why people live in need was closest to their own opinion (Table 1).

The top three perceived reasons why people are poor or excluded from society are work related (Figure 1). The fourth reason given is addiction (29%). An examination of answers according to the respondents' socio-economic background reveals

Table 1 Respondents' opinions as to why people live in need

	Europe %	Ireland %
Because they have been unlucky	19	26
Because of laziness and lack of willpower	20	16
Because there is much injustice in society	37	30
It's an inevitable part of progress	13	11
None of these	6	4
Don't know	5	13

Eurobarometer *(continued)*

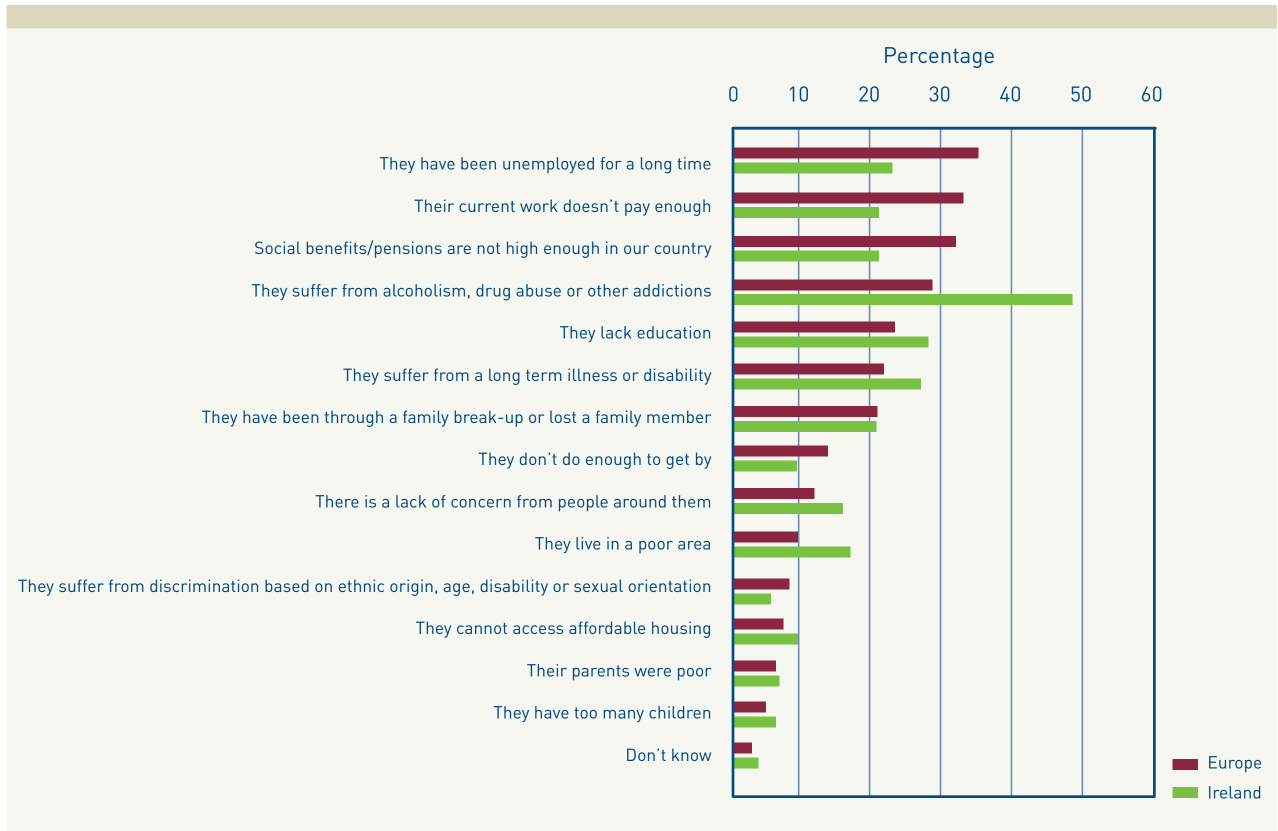


Figure 1 Perceived reasons* why people are poor or excluded from society
*Respondents could choose a maximum of three options from those provided.
Source: Poverty and exclusion Eurobarometer 2007

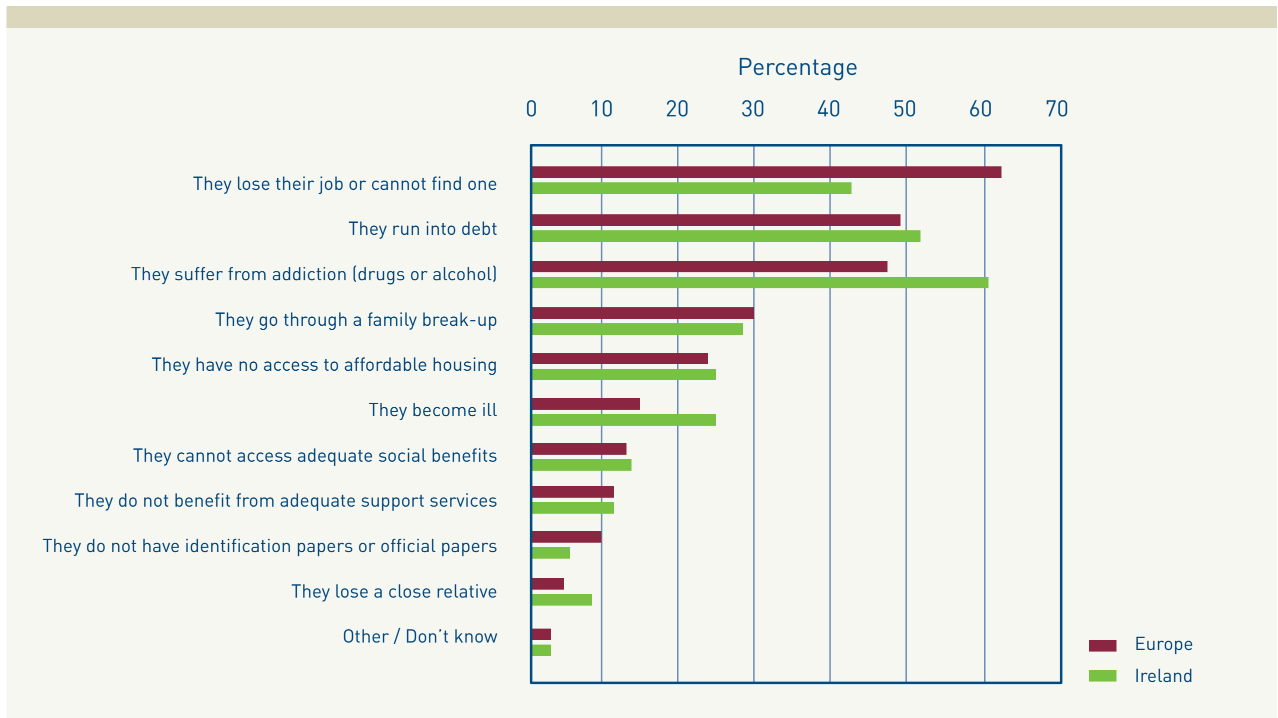


Figure 2 Perceived reasons* why people become homeless
*Respondents could choose a maximum of three options from those provided.
Source: Poverty and exclusion Eurobarometer 2007

Eurobarometer *(continued)*

a fairly similar ranking. For most groups, the same three items top the list, although addiction appears in the top three among people living in rural villages (33%), students and the youngest respondents (both 32%), managers (31%), employees (30%) and those who stayed in full-time education until the age of 20 or older (29%). Respondents classed by the survey as 'not poor' mention addiction more frequently (at 36%) than they do some of the work-related reasons. Those who believe poverty is a person's own fault are most inclined to see alcoholism and other addictions as a reason for poverty (44%).

Unlike their European counterparts, Irish respondents see 'alcoholism, drug abuse or other addictions' as the most likely reason for poverty or social exclusion (49%).

Causes of homelessness

The Irish also differ from other Europeans regarding homelessness. Again, they place higher significance on addiction, seeing it as the number one reason for people becoming homeless (60% vs. 46% for Europeans) (Figure 2).

All answers were examined in relation to the respondents' own feelings of subjective poverty and degree of financial difficulty. The less economic strain people suffer, the more likely they are to see addiction as a cause of homelessness, with 56% of people with no economic strain holding this view, compared to 33% of people who suffer the most economic strain.

Standard of living

The survey finished with an examination of what Europeans consider acceptable in order to have a decent standard of living. Seventy-four items relating to financial means, housing conditions, durable goods, basic necessities and social integration were included in the survey. Most are deemed to be absolutely necessary (31 items) or necessary (26 items). There is also a great degree of consensus among Europeans regarding the requirements for children to live and develop well.

People's views about what is required for a decent standard of living are most strongly influenced by the social norms, expectations and values of their country. The actual standard of living in a country seems to be less relevant.

(Mary Dunne)

1. TNS Opinion & Social (2007) *Poverty and Exclusion.* Special Eurobarometer 279. Luxembourg: Office for Official Publications of the European Communities. http://ec.europa.eu/public_opinion/archives/ebs/ebs_279.pdf
2. The 2002 report, *Social precarity and social integration: Report for the European Commission* based on Eurobarometer 56.1, was conducted under the framework of the Eurobarometer (special Eurobarometer 162 / Wave EB56.1). It is available at www.ec.europa.eu/public_opinion/archives/eb_special_en.htm.

Irish Prison Service annual report 2006

The Irish Prison Service (IPS) annual report for 2006 was published in December 2007.[1] In 2006 there were 12,157 committals to prison: 5,642 under sentence; 5,311 on remand; 1,196 under immigration law; and eight for contempt of court. These committals related to 9,700 individuals. Of the 5,642 sentenced committals, 113 were for intoxication (by alcohol) in a public place and 395 for drug offences (up 29% on the 2005 figure).

The IPS aims 'to provide a range of care services to prisoners to a standard commensurate with that obtaining in the wider community'. Included are medical, dental, psychiatric, psychological, education, vocational training, work, welfare, spiritual, counselling and recreational services. Healthcare is provided to prisoners by psychiatrists, general practitioners, nurses, counsellors and medical orderlies.

Drugs and prison

In May 2006 the Minister for Justice launched the IPS drugs policy and strategy document, *Keeping drugs out of prisons.* This sets out the steps required to tackle the supply of drugs into prisons, to provide adequate treatment services to those who are addicted to drugs, and to ensure that developments in the prisons are linked to those in the community. The IPS has reported significant progress in implementing this strategy.

Treatment and rehabilitation services

New services and programmes for addicted prisoners were developed in 2006. These were delivered by the IPS in partnership with the Health Service Executive (HSE) and contracted private services.

- Seven nurse officers and five prison officers were allocated to dedicated drug treatment teams in Cloverhill and Wheatfield prisons.
- An additional consultant in addiction was provided to improve the quality and co-ordination of drug treatment in prisons.
- A contract was awarded to Merchants Quay Ireland to provide access for prisoners to addiction counselling (1,000 hours per week).
- The Dormant Accounts Fund financed four community groups to provide addiction counselling and other supports to prisoners while in prison and on release in the community.
- A consultant-led infectious diseases service was contracted from St James's Hospital to provide treatment to prisoners who suffer from infectious diseases. It is hoped to expand this service to other sites.
- A HSE consultant in forensic psychiatry in the Western Region was contracted to provide dedicated sessions to Limerick Prison.
- The second contracted pharmacy service was introduced to Loughan House (an open prison) in April 2006.
- A tender for dedicated pharmacy services to provide drug treatment was developed and awarded. This will provide pharmacy services in a number of closed prisons.

IPS annual report *(continued)*

Table 1 Numbers of individuals receiving methadone treatment* in Irish prisons in 2006

Prisons	Total patients during 2006	New patients in 2006	Number on 31 December 2006
Cloverhill Prison	678	107	175
Dochas Centre	216	20	32
Limerick Prison	8	0	6
Midlands Prison	19	2	12
Mountjoy Main Prison	416	13	145
Mountjoy Prison Medical Unit	48	2	12
Portlaoise Prison	2	1	2
St Patrick's Institution	8	1	6
Wheatfield Prison	184	16	82
Total	**1579**	**162**	**472**

*Methadone treatment in this context is either substitution or detoxification.

- The psychology service in Irish prisons increased its team to seven clinical psychologists, eight counselling psychologists and one forensic psychologist.
- Further work was undertaken to promote and facilitate the use of the prison medical record system through training and support, and the development of changes based on user feedback.

Nine prisons provided methadone treatment to 1,579 prisoners in 2006, of whom 162 were receiving methadone for the first time (Table 1). It is noteworthy that methadone treatment was not provided in two large prisons, Cork and Castlerea.

Eliminating the supply of drugs

During 2006 the IPS intensified its focus on preventing illicit drugs being brought into prisons. The traditional means of effecting supply reduction – staff vigilance, physical searches and supervision of people entering prisons – continue to be reinforced by means of improved facilities and procedures. Specific measures put in place in 2006 include:

- More secure prisoner visiting arrangements, which involve greater control over the number and identity of visitors, and enhanced supervision of such visits
- Enhanced perimeter security through improved netting and closer co-operation with the Garda Síochána
- Enhanced technology for searching of cells and prison property, resulting in improved detection and seizure of contraband
- The introduction of dogs to detect drugs on people entering prisons and to aid searches within prisons.

(Vivion McGuire and Jean Long)

1. Irish Prison Service (2008) *Annual report 2006.* Dublin: Irish Prison Service.

Drug tests in Irish prisons

Information on drug testing in prisons from 2005 to 2007 was obtained from the Irish Prison Service by *The Irish Times* under the Freedom of Information Act.[1,2,3] According to this data, more than 20,000 voluntary tests were carried out each year to monitor drug use and responses to treatment. These tests included those carried out on committals (new entries) as well as on existing inmates. It may be assumed therefore that some of the positive test results relate to drugs or alcohol consumed outside the prison. Between one-third and one-half of those screened tested positive for at least one drug. The common metabolites detected indicated use of cannabis, benzodiazepines and opiates (Table 1). It is not clear whether the numbers of positive cases excluded prisoners who were prescribed benzodiazepines; if they do not, these figures overstate the extent of unregulated use of benzodiazepine in prisons. Cocaine and alcohol were detected in a small number of tests. The profile of positive drug tests was similar among prisoners tested in Mountjoy, Wheatfield, Limerick, Midland and Cloverhill prisons. The proportion of positive tests was low in St Patrick's Institution and in Castlerea and Cork prisons.

(Jean Long)

1. Conor Lally (18 February 2008) 40,000 positive drug tests in prisons. *Irish Times*: 1.
2. Conor Lally (18 February 2008) Prison drugs figures show extent of challenge ahead. *Irish Times*: 4.
3. Data confirmed in personal communication with W Burke of the Irish Prison Service (13 June 2008).

Drug tests in Irish prisons *(continued)*

Table 1 Numbers of tests, by prison, and number (%) of positive tests, by prison and by drug type, 2007

Prison	No. of tests	Cannabis	Benzodiazepines	Opiates	Cocaine	Alcohol	Amphetamines
Mountjoy Main	3,680	1,860 (51%)	1,871 (51%)	2,112 (57%)	78 (2%)	23 (0.6%)	29 (0.8%)
Dochas Centre	2,464	844 (34%)	1,294 (50%)	751 (46%)	85 (11%)	55 (3%)	14 (1%)
Wheatfield	4,369	2,122 (49%)	1,572 (36%)	1,842 (44%)	51 (1%)	31 (0.7%)	35 (0.8%)
Cloverhill	3,301	833 (25%)	1,206 (37%)	1,141 (35%)	267 (8%)	79 (2%)	31 (0.9%)
St Patrick's Instit.	3,489	245 (7%)	179 (5%)	86 (3%)	12 (0.3%)	14 (0.4%)	20 (0.6%)
Castlerea	92	14 (15%)	17 (19%)	9 (10%)	0 (0%)	0 (0%)	2 (2%)
Loughan House	407	128 (32%)	55 (14%)	16 (4%)	7 (2%)	9 (2%)	8 (2%)
Shelton Abbey	382	97 (25%)	45 (12%)	22 (6%)	19 (5%)	12 (3%)	10 (3%)
Limerick	518	189 (37%)	233 (43%)	228 (44%)	3 (0.6%)	18 (4%)	5 (1%)
Cork	97	3 (3%)	8 (8%)	1 (1%)	0 (0%)	1 (1%)	0 (0%)
Midland	1,694	263 (16%)	422 (25%)	871 (51%)	18 (1%)	9 (0.5%)	9 (0.5%)
Portlaoise	20	3 (15%)	4 (20%)	4 (20%)	0 (0%)	1 (5%)	0 (0%)

Source: Data received from the Irish Prison Service

Task force community representatives conference

The Local/Regional Task Force Community Representatives Conference, facilitated by CityWide and hosted by the National Drugs Strategy Team (NDST) and the Inter-Departmental Group on the National Drugs Strategy (IDG), took place at the Killeshin Hotel in Portlaoise from 4 to 6 April. In light of the development of the new National Drugs Strategy 2009–2016, the main objective of this conference was to consult with community representatives so as to identify priority actions needed to address drug misuse in communities. A further objective included establishing how communities can play a lead role in developing, planning and delivering the new National Drugs Strategy.

The conference commenced with opening addresses from Garda Detective Superintendent Barry O'Brien, Chairperson of the National Drugs Strategy Team; Anna Quigley, Co-ordinator of CityWide Drugs Crisis Campaign and Pat Carey TD, the then Minister of State with responsibility for drugs strategy. The Minister acknowledged the progress made since 1996, but underlined the need for advances in the area of rehabilitation. He was particularly eager to establish the National Drug Rehabilitation Implementation Committee. In relation to the new strategy, he urged communities to voice their concerns and ideas: 'The development of this new strategy gives all of you an opportunity to voice your views and I believe that "everything is up for grabs" in relation to developing a new strategy.'

While the three key areas focused upon were drug treatment, supply control and prevention, a recurring theme throughout the conference was the perceived need for a revised set of political structures to deal with drug misuse. Fergus McCabe, community representative for the IDG, argued that drug misuse requires a special ministry and a cabinet committee located in either the Department of Health or the Department of the Taoiseach.

Drug treatment and prevention

Liam O'Brien of CARP, Tallaght, outlined the development of drug treatment in Ireland since the early 1990s. He noted that some of the biggest challenges in the current climate include the emergence of cocaine as a destabilising influence on recovering opiate users, the reluctance to acknowledge the damaging effects of alcohol abuse and the unwillingness of communities outside Dublin to acknowledge growing opiate misuse in their areas.

The drug treatment workshop produced a set of priority actions which included:

- Implement the NACD recommendations on drug use and mental health.
- Identify gaps in service provision.
- Review the effectiveness of existing treatment options.
- Meet women's needs, especially in relation to childcare.

With regard to prevention, Martin Hayes, community representative on the NDST, highlighted the need for fresh thinking in prevention strategies. He suggested that harm reduction can be seen as a preventative strategy as it prevents an escalation in serious drug-related harms. Priority actions from the prevention workshop included:

- Audit the Social, Personal and Health Education (SPHE) and Walk Tall programmes to ascertain if and how schools are delivering them.

Task force conference *(continued)*

- Include a community representative on the SPHE programme.
- Develop culturally sensitive programmes and collaborate with leaders of new communities in Ireland.
- Implement best practice to support parents and families.

Supply control
Criminologist Johnny Connolly of the Health Research Board highlighted the significant gaps in our understanding of how illicit drug markets operate. He pointed out that, despite the major anxiety within society about drug-related crime and the huge resources invested in drug law enforcement, we have very limited information on how these resources are used or what sort of impact they have. He suggested that there is growing evidence internationally that partnership between stakeholders including local communities, law enforcement, local authorities and health workers offers the most sustainable method of responding to many drug problems in this area. He suggested that the joint policing committees and, in particular, the local policing fora being rolled out in line with the National Drugs Strategy and the Garda Síochána Act, 2005, have the potential to provide the necessary infrastructure through which such partnership approaches can be delivered at local level.

Priority actions from the supply control workshop included:

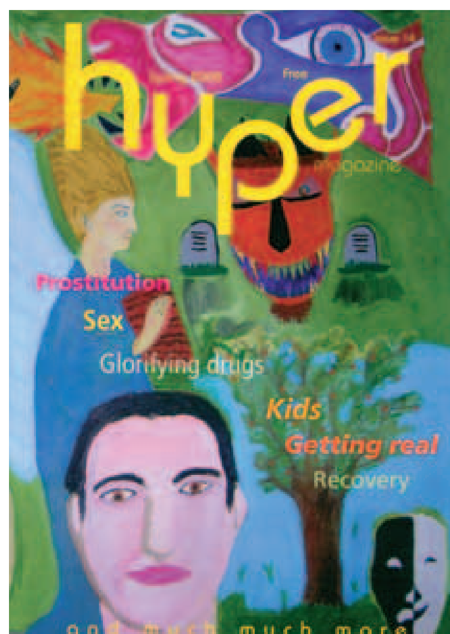
- Put community policing fora in place in all LDTF areas as a matter of urgency and facilitate discussion as to how the model can be adapted to RDTF areas.
- Develop a more intensive and targeted response to drug 'hotspots' identified at local level.
- Implement a national programme of arrest referral schemes.
- Encourage liaison between the Courts Service, the NDST and drugs task forces to progress Action 72 of the strategy relating to the training of members of the judiciary.
- Expand the means by which people can safely and anonymously contact the gardaí in relation to drug dealing.
- Ring-fence money obtained through the Criminal Assets Bureau for re-investment in local communities most affected by drugs.
- Address drug supply within the Traveller community in local and regional policing plans.

Sinead Smyth of Pavee Point emphasised the importance of accommodating the needs of communities of interest[1] in the next drugs strategy. She reported that groups such as Travellers and immigrants are often under-represented in service delivery and emphasised that 'there needs to be a big push within the NDS to support equality issues as it is very ad hoc and piecemeal'.

Dr Gemma Cox of the National Advisory Committee on Drugs (NACD) emphasised the importance of developing an integrated set of measures or community indicators to aid targeted action and help relevant bodies monitor the benefits to the community of actions around drugs.[2] Dr Mary Ellen McCann of University College Dublin (UCD) presented results from a collaborative study by CityWide, UCD and the NDST which assessed the role and experience of community representatives. There are 140 representatives nationally who are generally nominated, invited or elected to their position. The study reported that the role of community representatives mainly involved taking issues form the grassroots level and feeding them into task forces, assisting in emergencies and planning. The study also found that, while community representatives appreciate the opportunity to contribute to the development of their communities, many were dissatisfied with the minor impact they felt they were currently making. A report on the conference will be provided by CityWide Drugs Crisis Campaign in the coming weeks and can be accessed on their website www.citywide.ie.

(Anne Marie Donovan and Johnny Connolly)

1. Communities of interest have been described as groups or communities who have shared identity, experiences and purposes. They are often referred to as 'hard to reach groups'.
2. More details on community indicators are reported in Loughran and McCann (2006) A community drugs study: developing community indicators for problem drug use. Dublin: NACD.



Copies of Spring issue of *Hyper* available from NDC: 01 2345175 or ndc@hrb.ie

MQI safer injecting guide

On 3 April 2008, Merchants Quay Ireland (MQI) launched the booklet *Safer injecting* at a seminar focused on reducing the harm associated with injecting drug use.[1]

In launching the guide, Minister of State Pat Carey TD stated that the reality of substance misuse meant that, in the short term, abstinence was rarely achievable, making harm reduction interventions necessary. He said that there was a need to develop more needle and syringe-exchange services in Ireland, while acknowledging that such action might invite criticism.

This safer injecting guide is produced for people who inject drugs. The booklet includes advice about safer injecting practices and different types of injecting – into a vein or muscle, or under the skin (skin popping). The importance of washing one's hands prior to injecting to reduce the risk of infection is a simple and important point highlighted in the guide. Advice is provided about how to look after veins and decrease vein damage. Readers are encouraged to seek medical attention if they experience any health-related issues associated with injecting. A full description of the necessary injecting equipment is provided, along with the important statement that 'single-use syringes are the safest as water and/or bleach will not destroy all viruses'. Overdose prevention techniques and responses are described, along with information on the increased risk of overdose due to polydrug use. The necessity for protection against the acquisition and transmission of blood-borne viruses is also discussed.

For further information, contact Merchants Quay Ireland on (01) 645 6524/00 or www.mqi.ie, or drop in to the service at 4 Merchants Quay, Dublin 8.

(Janet Robinson)

1. Merchants Quay Ireland (2008) *Safer Injecting: reducing the harm associated with injecting drug use.* Dublin: MQI.

UN assesses progress in tackling world drug problem

Between 10 and 14 March 2008 the Commission on Narcotic Drugs (CND), the central policy-making body of the United Nations (UN) in drug-related matters, met in Vienna for its 51st Session.[1] A key event at the Session was a thematic debate on progress achieved by governments in meeting the goals and targets for the years 2003 and 2008 as set out in the Political Declaration adopted by the UN General Assembly Special Session (UNGASS) on Illicit Drugs in 1998.[2] Broadly speaking, the goals and targets included achieving significant and measurable results in the field of demand reduction; eliminating or significantly reducing the illicit manufacture, marketing and trafficking of psychotropic substances; and eliminating or significantly reducing the illicit cultivation of the coca bush, the cannabis plant and the opium poppy.

The following is a summary of the 'salient points' made in this debate, as identified by the Chair of the Commission:

General comments

- In the 10 years since the adoption of the Political Declaration, progress had been made; for example, today there is a more structured legal scheme and better tools for the international fight against drugs. However, the objectives established in 1998 have not been accomplished.
- The quality of the information on which the performance of the international drugs control scheme is assessed needs to be improved.
- The importance of the principle of common and shared responsibility, as enshrined in Article 2 of the Political Declaration, was a recurrent theme in the debate. Speakers reminded participants that at the centre of the international fight against drugs are human beings.

Demand reduction

- An evidence-based and long-term sustained comprehensive approach to demand reduction is necessary. This approach should take into consideration the imbalance of resources for demand reduction; the stigma on drug dependent persons; and the need to focus on the reduction of human suffering, including measures to reduce the harm caused by drugs, as one of the main aims of the international drug control conventions.
- Civil society and the capacity of non-governmental organisations (NGOs) need to be engaged in efforts to reduce the demand for drugs.

Supply reduction

- As regards the fight against illicit drug supply, the thematic debate recognised the progress made on many fronts including the development of national drug strategies, improved enforcement capacities and regional and international co-operation.
- At the same time, the debate confirmed that there have been significant changes over the past 10 years in illicit drug supply, including:
  - new trafficking trends
  - diversified sources of production of drugs, including the illicit manufacture and trade of ATS
  - the increasing use of alternative or substitute chemicals that are not subject to international or national control
  - the impact of globalisation in reducing the difference between producer and consumer countries in the production, trafficking and consumption of drugs
  - the ever-growing links between drug trafficking and international organised crime.

UN and the world drug problem *(continued)*

As well as the thematic debate, and deliberations on the reports tabled by UNODC and the INCB, the Session also passed 18 resolutions. Among these were the following:

Cannabis

- Refocusing prevention, education and treatment efforts for young people
- Reducing the demand for and abuse of cannabis
- Combating the illicit cultivation of and trafficking in cannabis

Drug users

- Promoting early detection of drug use cases by health and social care providers by applying the principles of interview screening and brief intervention approaches to interrupt drug use progression and, when appropriate, linking people to treatment for substances abuse
- Strengthening co-operation between the UN Office on Drugs and Crime and other UN bodies for the promotion of human rights in the implementation of the international drug control treaties
- Promoting co-ordination and alignment of decisions between the Commission on Narcotic Drugs and the Programme Coordinating Board of the Joint UN Programme on HIV/AIDS

Drug control

- Strengthening cross-border co-operation in the area of drug control
- Achieving a balance between demand for and supply of opiates used to meet medical and scientific needs
- Strengthening international co-operation for the control of precursor chemicals used for the manufacture of synthetic drugs
- Responding to the threat posed by the distribution of internationally controlled drugs on the unregulated market
- Controlling international movement of poppy seeds obtained from illicitly grown opium poppy plants
- Sharing information on the use of non-scheduled substances as substitutes for scheduled substances frequently used in the illicit manufacture of narcotic drugs and psychotropic substances, and on new methods of manufacture of illicit drugs.

(Brigid Pike)

1. *The CND Report on the Fifty-first Session* (Advanced unedited version, E/2008/28; E/CN.7/2008/15) is available at www.unodc.org/unodc/en/commissions/CND/session/51.html. The report sets out in full the 18 resolutions passed by the CND; summarises the deliberations on the thematic debate together with the Chair's summary; and provides an account of the deliberations on drug demand reduction, illicit drug traffic and supply, and the implementation of the international drug control treaties. The reports that informed this last series of deliberations are also available on the UNODC website.
2. The Political Declaration is available at www.un.org/ga/20special/poldecla.html.

Online innovation and use of new technologies

In April the Drug and Alcohol Programme (DAP) launched a new section of the www.drugs.ie website. This new section provides a discussion forum for professionals working in the area of drug and alcohol addiction.

So far 125 professionals in the fields of drug prevention and education, research and treatment have registered to use the forum. A core group of regular contributors has begun discussions on a wide variety of topics including concepts of best practice, the National Drugs Awareness Campaign and early-warning systems. These online discussions provide an opportunity for professionals in the drugs field to share knowledge in an informal and constructive environment. The forum also harnesses the benefits of an online environment, the ability to work and communicate across geographic boundaries and the power to link directly to relevant resources.

The forum is structured under the following headings:

- General Drugs Discussion

drugs.ie website

drugs.ie website

Online innovation *(continued)*

- Research & Development Discussion
  (A forum for discussion on topics relating to research and development in the drugs field in Ireland)
- National Drugs Strategy Discussion
  (A forum specifically for discussion on the Irish National Drugs Strategy)
- Resources
- Upcoming Events
- Training
- Jobs

This forum is the first of its kind in the drugs field in Ireland. If you would like to register to use the forum, send an email to helpline@dap.ie. Please include your full name, organisation, email address and telephone number. Staff from the drugs.ie site will then contact you to complete your registration.

Social networking sites

Other drug-related organisations are developing an internet presence. Prevention and youth groups have been developing a presence on the popular social networking sites. The Southern Regional Drugs Task Force has maintained a presence on the popular Bebo site since 2007 and it can be accessed at www.bebo.com/drugstaskforce. The site provides links to the recent national drug awareness campaign 'The Party's Over' and to the current HSE underage drinking campaign video.

drugs.ie website

The Fermoy Community Drugs Initiative Bebo site (www.bebo.com/MartinaM58) was created in February 2008 and is maintained by Martina Munnelly, a community drugs outreach worker. The Fermoy site includes links to Cork-based youth cafés, news cuttings on the dangers of binge drinking and embedded videos of innovative drug prevention campaigns from Australia on the dangers of cannabis use.

The power of such social networking sites lies in their ability to create and foster online networks or groups of people with similar interests. Young people are encouraged to 'become friends' and join a network with groups such as the Fermoy Community Drugs Initiative or the Bantry Youth Café, which has 362 friends. Visitors can upload photographs, leave comments, add drug awareness campaigns to their site and create a journal or blog of activity.

At the international level, America's Truth campaign, designed to prevent young people from smoking, has established a strong presence on multiple social networking sites including Bebo (16,077 friends), Xanga and My Space.

Customised search engines

A recent innovative development is the Addiction Search Engine (www.addictionsearch.net). Tony Duffin, director of the Ana Liffey Drug Project, has used the Google search engine to create a customised search engine which searches over 600 dedicated drugs and drug-related websites. The selected sites include the National Documentation Centre on Drug Use, EMCDDA, NACD, Drug Policy Action Group, Merchants Quay Ireland and a large number of quality international drug-related sites. By using the Addiction Search Engine as a first port of call when performing an internet search, you will find many more significant and useful results than you would by doing a general Google search. It is certainly a page to be added to 'my favourites.'

The use of online forums, social networking websites and customised search engines by drug awareness campaigns, task forces and prevention groups is a relatively new phenomenon in Ireland. Many of these sites are built on openly accessible software or ready-made platforms such as My Space or Google Custom Search. As such, the cost involved in developing such an online presence is often low, but it takes commitment and time to investigate, develop and maintain the sites. Often this work is undertaken voluntarily. The use of these innovative technologies demonstrates a desire among Irish drugs workers to share knowledge and to provide accurate and timely drug-related information in a variety of accessible formats.

(Louise Farragher)

Departing ADRU Staff

Siobhán Reynolds

At the end of January 2008, Siobhán Reynolds left the Alcohol and Drug Research Unit (ADRU) where she had worked as an analyst with the National Drug Treatment Reporting System since January 2005. During this time Siobhán made a significant contribution to the NDTRS. Siobhán will be missed by her colleagues in the ADRU and by those outside the HRB with whom she worked in data co-ordination. We wish her every happiness and success in her new position.

Lorraine Coleman

At the end of February 2008, Lorraine Coleman left the Alcohol and Drug Research Unit (ADRU) where she had worked as a researcher with the National Drug-Related Deaths Index since August 2005. During this time Lorraine, alongside her colleagues, collected seven years' data on drug-related deaths from the coroners' services. Lorraine will be missed by her colleagues in the ADRU and Coroner Services. We wish her every happiness and success in her new position.

In brief

In 2008 the **Democracy, Cities and Drugs (DC&D) II project 2008-2010** was launched. Based on the lessons learned from the first DC&D project, DC&D II aims to help EU cities develop local, partnership-based drug policies and practices involving all relevant stakeholders. www.democitydrug.org

During 2008 the **Children Acts Advisory Board (CAAB)**, whose mission is to seek significantly better outcomes for vulnerable children through the co-ordinated delivery of services, has been upgrading its website. www.caab.ie

On 24–29 January 2008 as part of **Beyond 2008 – A global forum on the 1998–2008 review of the United Nations General Assembly Special Session on Illicit Drugs**, the regional consultation for the European Union and EFTA countries was held in Budapest. The report from this consultation is available on the website of the Vienna NGO Committee on Narcotic Drugs. www.vngoc.org

On 5 February 2008 **COSC**, the **National Office for the Prevention of Domestic, Sexual and Gender-based Violence**, launched its website. Set up in June 2007, Cosc (which means to stop or prevent) works with other organisations in the sector to ensure the delivery of co-ordinated services for victims, raises awareness about the level and impact of these crimes and about local services for victims, and develops strategies for preventing and dealing with these crimes in line with best international practice and standards for service delivery and for training programmes. www.cosc.ie

On 5–7 March 2008 the **World Red Cross/Red Crescent (RC/RC) Congress on Humanitarian Drug Policy** was held in Barcelona. After the conference, the attending youth staff and volunteers held an additional youth meeting with representatives of 11 national societies, the International Federation and the Senlis Council, the think-tank that had sponsored the event. At this meeting, participants discussed current programmes and new ideas related to working with drug users. www.ifrc.org / www.senliscouncil.org

On 12 March 2008 **Stereotyping of young people**, a resource pack developed by the **Equality Authority** and the **National Youth Council of Ireland**, was launched. It is intended to support young people and youth organisations to recognise and challenge stereotyping of young people. www.equality.ie / www.nyci.ie

On 12 March 2008 **What research tells us about the reasonableness of the current priorities of national drug control** was presented by Rosalie Pacula of the RAND Drug Policy Research Center before the US House Oversight and Government Reform Committee, Subcommittee on Domestic Policy. In her testimony Pacula argued:

1. although the US drugs strategy appears 'balanced', being based on three primary objectives – to stop use before it starts, to heal America's drug users, and to disrupt illicit drug markets – the budget reflects a strong emphasis on supply reduction efforts (65.2% of the requested budget for 2009);
2. the problem with this unbalanced approach becomes clear if you understand the epidemic nature of drug problems and the current stage of the expected epidemic for each major drug of abuse in the US today. The current mix of enforcement, prevention and treatment strategies is not the optimal for managing the drug situation the US faces; and
3. the problem is not just one of balance in the budget, but also one of waste. In several areas, the 2008 National Drug Control Strategy advocates continuing or new support for programmes that have either (a) never been scientifically proven to be effective and which on analytic grounds seem unlikely to be successful or (b) have already been shown to be completely ineffective. www.rand.org/multi/dprc/

On 27 March 2008 the **National Youth Justice Strategy 2008–2010** was launched. The Strategy focuses on children who have already had some contact with the criminal justice system. Under the objective 'To make the youth justice system more effective through providing clear, unified and strategic leadership', the Department of Community, Rural and Gaeltacht Affairs is called on to: 'Work with the Irish Youth Justice Service (IYJS) to ensure that appropriate synergies are achieved between the National Youth Justice Strategy and policies and the aims of the National Drugs Strategy 2001–2008 and its successor, RAPID and CLÁR programmes, and community and local development programmes, and that there is a coordinated approach to the delivery of services to disadvantaged areas'. www.iyjs.ie

In March 2008 the **Beckley Foundation Drug Policy Programme** published its 13th report ***Recalibrating the regime: the need for UN system-wide coherence in drug control and human rights.*** The report looks at the tensions between some aspects of the global drug control system, and UN human rights standards. www.beckleyfoundation.org/policy

On 21 April 2008 **Barnardos** launched a new family support initiative. Barnardos' project in Buckingham Street, in Dublin's north inner city, will work with children from birth to about the age of 12 who face severe or chronic threats to their well-being – for example, children who come from families where there is addiction, financial pressure, parents in prison, or a parent with mental illness. www.barnardos.ie

On 23 April 2008 the **Central Statistics Office (CSO)** released ***Garda recorded crime statistics 2003–2006***, the first set of crime statistics using the newly completed Irish Crime Classification System (ICCS), which replaces the headline/non-headline offence classification introduced in 2000. Drug-related offences form a distinct class of offences in the new system. www.cso.ie

(Compiled by Brigid Pike)

From *Drugnet Europe*

Estimating the total burden of drug-related mortality

Cited from article by Danica Klempová and Julián Vicente in Drugnet Europe *No. 62, April–June 2008*

The EMCDDA's key indicator on drug-related deaths collects information predominantly on drug-induced deaths (also described as poisonings or fatal overdoses). Several causes of death, besides fatal overdose, are found to be considerably higher in problem drug users than among their peers. These include diseases (e.g. HIV/AIDS, liver disease); trauma (e.g. accidents, homicide) and suicide. It was estimated that in the 1990s and early 2000s, 10–20 % of mortality among young adults in several European cities studied could be attributed, directly or indirectly, to opioid use.

Two innovative approaches, applied to date in only a few studies, involve estimating the total burden of mortality related to drugs by:

- applying the information from cohort studies to national estimates of the prevalence of problem drug use; or
- estimating drug-attributable fractions and applying them to general mortality registries.

Using these methods, the EMCDDA launched a project with Czech experts in 2007 to analyse data availability and the methodological possibilities for estimating the overall mortality of problem drug users in the EU. The project, running until the end of the year, will culminate in a report that will provide the basis for possible work on this issue at EU level in the future.

EMCDDA launches best practice portal

Cited from article by Jennifer Hillebrand in Drugnet Europe *No. 62, April–June 2008*

The EMCDDA has launched the first version of its Internet portal on best practice in the fields of drug-related prevention, treatment, harm reduction and social reintegration. The portal project was conceived to meet the needs of professionals, policy-makers and researchers. It offers an array of tools and standards designed to improve the quality of interventions and highlight examples of evaluated practice across Europe. Also available are links to further information sources and a glossary to help guide the user through the portal.

The portal is divided into four sections: evidence of efficacy; tools for evaluating practices; standards and guidelines for the implementation of practices; and examples of evaluated practices (Exchange on Drug Demand Reduction Action – EDDRA).

Evidence of how interventions work in real-life conditions can be found in the new edition of the EDDRA databank, now available through the portal. EDDRA is primarily designed to help professionals and policy-makers plan and implement interventions in response to drugs. The databank features examples of evaluated interventions in different countries and settings, thus helping to generate evidence of efficacy of demand reduction projects.

Visit the EMCDDA best practice portal at www.emcdda.europa.eu/themes/best-practice

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. 18: Substance use among older adults: a neglected problem

According to this briefing in the EMCDDA *Drugs in focus* series, the number of older people with substance use problems or requiring treatment for a substance use disorder is estimated to more than double between 2001 and 2020, placing new and greater demands on treatment services. Programmes that are accustomed to dealing mainly with young populations will need to adapt to meet the needs of this older group.

The paper discusses key issues in relation to substance use in older people under six headings: prescribed and over-the-counter drugs; illicit drugs; alcohol; special risks for the elderly; identification and assessment; and treatment interventions and services.

The briefing concludes with a series of policy considerations:

- Relatively little is known about the treatment of substance use in older adults. However, older patients engage well with treatment programmes, and can achieve satisfactory treatment outcomes.
- Problematic use of prescribed and over-the-counter medications by older adults is common. Improved identification requires regular monitoring of medication use and treatment response, and careful assessment of other social and health problems that could be caused by substance use.
- The prevalence of illicit drug use by older adults is increasing. Addiction treatment and other healthcare services are insufficiently aware of the needs of older drug users and need to anticipate and prepare for predicted increases in demand from this age group.

Drugs in focus *(continued)*

- Alcohol problems are more prevalent among older adults and may co-exist with problem drug use. Drug services may need to review their care systems to ensure that alcohol-related problems are recognised.
- Many social, psychological and health problems may affect older adults and put them at increased risk of substance use. Such problems require specific attention if interventions for this group are to be fully effective.
- Improved assessment of substance use disorders among older adults may require age-specific measures of use and dependence. Although the identification of substance use disorders may be difficult, primary care and other healthcare services are well placed to screen for substance use problems.
- Appropriate and effective treatment should be tailored to the specific needs of older drug users. This may require modifying existing forms of treatment, or developing new ones. In particular, treatment should be more attentive to co-morbid health conditions faced by older adults.

Recent publications

Journal articles

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

Methadone induced torsade de pointes in a patient receiving antiretroviral therapy

Falconer M and Molloy D
Irish Medical Journal 2007; 100(10): 631–632

Adverse drug reactions account for approximately 5% of acute medical admissions. A 34-year-old male patient receiving antiretroviral therapy, methadone and flurazepam presented to the emergency room following collapse with associated loss of consciousness. Cardiac monitoring demonstrated marked Q-T prolongation followed by the cardiac arrhythmia, torsade de pointes. The patient made a full recovery following withdrawal of the antiretroviral therapy and a reduction in methadone dose. Methadone is a recognised cause of this potentially fatal cardiac arrhythmia which is more likely to occur when methadone metabolism is inhibited by drugs such as HIV tease inhibitors.

Rabbitte revisited: the first report of the ministerial task force on measures to reduce the demand for drugs - ten years on

Butler S
Administration 2007; 55(3): 124–144

In this article, Shane Butler revisits the *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* better known as the 'Rabbitte report' to examine how the report has influenced Irish drugs policy since its publication in 1996. He concludes that the Rabbitte report introduced a more 'normalised' and routine style of drug policy making in Ireland and that the statutory structures put in place as a result of the report, including the Local Drugs Task Forces, continue to operate as part of the national response to the drugs situation.

Treatment response of bipolar and unipolar alcoholics to an inpatient dual diagnosis programme

Farren CK and Mc Elroy S
Journal of Affective Disorders 2007; 106(3): 265–272

Depressed and bipolar alcoholics represent a significant affective subgroup that has a poorer prognosis than either diagnosis alone. To date few systematic treatment programs have been developed to treat dual diagnosis. An inpatient treatment program was developed at St Patrick's Hospital Dublin to treat dual diagnosis clients with alcohol dependence and either unipolar or bipolar affective disorder. Clients (N=232) were assessed for depression, anxiety, elation, cravings, drink and drug intake on admission, discharge, 3 and 6 months post-discharge from the programme.

In the overall group there was a reduction in number of drinking days and units per drinking day over the study ($p<.01$). There was a 71.8% complete abstinent rate at 3 months and 55.8% at 6 months in the depression group, non-significantly greater than for the bipolar group at 64.7% and 54.1% respectively. Gamma GT, MCV and craving scores were significantly reduced over time ($p<.01$). Mania, depression and anxiety inventory scores fell over time in both groups ($p<.01$). 15-21year-olds were more severely anxious, had higher illicit drug use, and were more likely to relapse to drug use than older clients. Bipolar 1 clients were significantly more likely than bipolar 2 clients to be on mood stabilisers at all follow-up stages ($p<.001$). The authors stated that the research was limited by the fact that no control group was used.

The authors concluded that there is evidence for efficacy of a specifically designed dual diagnosis inpatient treatment program as both depressed and bipolar alcoholics had significant reductions in all measurements of mood, craving, and alcohol/drug consumption by self report and biological markers, suggesting both diagnoses can be effectively treated together.

Recipient syringe sharing and its relationship to social proximity, perception of risk and preparedness to share

Smyth BP and Roche A
Addictive Behaviors 2007; 32(9): 1943–1948

The authors examined the association between the perceived risk attached to recipient syringe sharing and the past and future practice of this unsafe injecting activity. Injecting drug users (IDU) with a history of past sharing with sexual partner identified significantly less risk in this activity compared to those with no past history of borrowing from sexual partner. Significant differences in risk perception were also found when comparing IDU with and without a history of sharing with close friends and with acquaintances. Preparedness to share in the future was significantly associated with lower perceived risk in borrowing from sexual partners ($p=0.009$) and close friends ($p=0.01$).

The authors concluded that perceived risk is associated with both past sharing and preparedness to share in the future, particularly with groups of closer social proximity. Cognitive interventions which succeed in elevating perceived risk could reduce actual sharing with other IDU of close social proximity.

Recent publications *(continued)*

The prevalence of self-reported deliberate self harm in Irish adolescents

Morey C, Corcoran P, Arensman E and Perry IJ
BMC Public Health 2008; 8: 79

This article is available at www.biomedcentral.com/1471-2458/8/79

Deliberate self harm (DSH) is a major public health problem, in particular among young people. Although several studies have addressed the prevalence of DSH among young people in the community, little is known about the extent to which DSH comes to the attention of medical services, the self harm methods used and the underlying motives. The aim of this study was to determine the prevalence of DSH in adolescents and the methods, motives and help seeking behaviour associated with this behaviour.

A cross-sectional survey using an anonymous self-report questionnaire was administered in 39 schools in the Southern area of the Health Service Executive, Ireland. Of the 4,583 adolescents aged 15-17 years who were invited to participate in the survey, 3,881 adolescents took part (response: 85%). A lifetime history of DSH was reported by 9.1% (n = 333) of the adolescents. DSH was more common among females (13.9%) than males (4.3%). Self cutting (66.0%) and overdose (35.2%) were the most common DSH methods. A minority of participants accessed medical services after engaging in DSH (15.3%). The authors conclude that DSH is a significant problem in Irish adolescents and the vast majority do not come to the attention of health services. Innovative solutions for prevention and intervention are required to tackle DSH in adolescents.

Alcohol, cognitive impairment and the hard to discharge acute hospital inpatients

Popoola A, Keating A and Cassidy E
Irish Journal of Medical Science 2008; 177(2): 141–145

The aim of this research was to examine the role of alcohol and alcohol-related cognitive impairment in the clinical presentation of adult in-patients less than 65 years who are 'hard to discharge' in a general hospital. The authors conducted a retrospective medical file review of in-patients in CUH referred to the discharge coordinator between March and September 2006.

Of 46 patients identified, the case notes of 44 (25 male; age was 52.2 ± 7.7 years) were reviewed. The average length of stay in the hospital was 84.0 ± 72.3 days and mean lost bed days was 15.9 ± 36.6 days. The number of patients documented to have an overt alcohol problem was 15 (34.1%). Patients with alcohol problems were more likely to have cognitive impairment than those without an alcohol problem [12 (80%) and 9 (31%) P = 0.004]. Patients with alcohol problems had a shorter length of stay (81.5 vs. 85.3 days; t = 0.161, df = 42, P = 0.87), fewer lost bed days (8.2 vs. 19.2 days; Mann–Whitney U = 179, P = 0.34) and no mortality (0 vs. 6) compared with hard to discharge patients without alcohol problems.

The authors concluded that alcohol problems and alcohol-related cognitive impairment are hugely over-represented in acute hospital in-patients who are hard to discharge. Despite these problems, this group appears to have reduced morbidity, less lost bed days and a better outcome than other categories of hard to discharge patients. There is a need to resource acute hospitals to address alcohol-related morbidity in general and Wernicke–Korsakoff Syndrome in particular.

(Compiled by Louise Farragher)

Upcoming events

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

September

8–10 September 2008
World Forum Against Drugs
Venue: City Conference Centre, Folkets Hus, Stockholm
Organised by / Contact: World Forum Against Drugs
Tel: +46 8 644 21 74
Email: @ info@wfad08.org
www.wfad08.org

Information: The first World Forum Against Drugs will take place in Stockholm, Sweden. The main theme for the conference is 'One hundred years of drug prevention'. Speakers at the conference will be some of the most prominent people in the world in the field of anti-drug work, people working practically with local projects and people with personal experiences of great interest. World Forum welcomes individuals and organisations campaigning to achieve a society free from the abuse of illicit drugs.

15–16 September
1st Global Conference on Methamphetamine: Science, Strategy and Response
Venue: Prague City Hall, Czech Republic
Organised by / Contact: Weave Consulting
www.globalmethconference.com

Information: The primary objective of this conference is to provide an arena for the world's preeminent scientists, leaders, and professionals working on issues related to methamphetamine to gather to discuss the intersection between methamphetamine use, public health, law enforcement, and civil society.

The conference has been organized in response to an emerging consensus among experts that methamphetamine use is a complex problem that presents a significant challenge to existing philosophies and strategies. While local and national communities are under siege by a perceived methamphetamine epidemic rush to pursue solutions, many facets of the problem remain to be discovered, examined, debated, illuminated and verified.

Upcoming events *(continued)*

October

27–28 October 2008
2008 National Conference on Injecting Drug Use
Venue: London West Novotel, Hammersmith
Organised by / Contact: Exchangesupplies
www.exchangesupplies.org

Information: A packed and varied programme with over 30 parallel sessions, meetings, poster presentations and films to inform practice, disseminate research, explore policy and develop skills. Conference highlights will include:

- The launch of the 2008 'shooting up' report
- Draft NICE guidance – what it said, how you responded
- Promoting the transition from injecting to smoking
- Injecting-related bacterial infections
- TB and blood-borne viruses
- Speedball injecting
- Teaching people to access veins – practical issues
- The injecting of human growth hormone (HGH) explained

November

13–14 November 2008
The Society for the Study of Addiction 2008 Symposium. Addiction Across the Life Span: Tracking Processes of Recovery
Venue: Park Inn, York, UK
Organised by / Contact: Society for the Study of Addiction
Tel: +44 (0)113 295 2787
Email: graham.hunt@leedspft.nhs.uk
www.addiction-ssa.org

Information: This year's event focuses on 'Addiction Across the Life Span, Tracking Processes of Recovery'. Please send abstracts for consideration as delegates' oral/poster presentations to: Graham Hunt, Executive Office, SSA, 19 Springfield Mount, Leeds, LS2 9NG. Email: membership@addiction-ssa.org Any addiction-related subject will be considered, and all poster papers are eligible for the £500 poster prize, to be awarded by an independent panel. More details will follow shortly.

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 and alcohol situation, its consequences and responses in Ireland.

The ADRU maintains two national drug-related surveillance systems and is the national focal point for the European Monitoring Centre for Drugs and Drug Addiction. 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 and alcohol use.

***Drugnet Ireland* is published by:**
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