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Newsletter of the Alcohol and Drug Research Unit

Health Research Board appoints new Chief Executive
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Analysis of treatment outcomes in the south east

The HRB National Drug Treatment Reporting System team: (Standing) Vivion McGuire, Ita Condron, Delphine Bellerose, Jean Long, (Seated) Anne Marie Carew, Aileen Connor, Suzi Lyons (Photo: JJ Berkeley)

Service providers in the south east of Ireland agreed to pilot the National Drug Treatment Reporting System (NDTRS) exit form in 2007. The south east includes counties Carlow, Kilkenny, Waterford, Wexford and South Tipperary. The exit form records all treatment interventions received by a client during a treatment episode, along with details of their treatment outcome at the time of discharge or transfer to another service. Drug treatment options include psycho-social interventions (brief intervention, counselling, group therapy, family therapy, psychotherapy, complementary therapy, and/or life-skills training) and medical interventions (detoxification, methadone reduction, substitution programmes and psychiatric treatment). Service providers in the south east recorded exit details for all clients discharged from their service in 2007.

The NDTRS 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 attended and were discharged from more than one treatment service in a calendar year.

The main findings from the pilot project are:

- In 2007, 1,630 cases exited treatment in the south east. Complete data were provided for 1,586 cases. Table 1 shows the number of these cases by the year they entered treatment.

Table 1 Number of cases exiting treatment in 2007, by year entered treatment for this episode

Year entered treatment	n	%
2003	3	0.2
2004	6	0.4
2005	24	1.5
2006	146	9.2
2007	1,407	88.7
Total	**1,586**	**100.0**

- Of the 1,586 cases exiting treatment, 1,319 (83.2%) lived in the south east, 262 (16.5%) lived in another area of Ireland, and 5 (0.3%) lived outside of Ireland.
- Treatment for problem alcohol and drug use in Ireland is provided by statutory and non-statutory services, including residential centres, community-based addiction services, general practices and prison services. Of the 1,586 cases exiting treatment in 2007, 1,101 (69.4%)

contents

Treatment outcomes *(continued)*

received treatment in an outpatient setting, and 485 (30.6%) in an inpatient setting. Low-threshold services (outpatient setting) provided treatment to 77 (4.9%) cases. General practitioners and prisons were not invited to participate in the pilot study as their data are not collected through the HSE South Drug Co-ordination Unit.

- The majority (69.3%) of clients exiting treatment in 2007 were male.
- The main problem substances reported by clients on entry to treatment were alcohol (69.2%), cannabis (11.8%), opiates (8.3%), and cocaine (5.8%). Other cases reported ecstasy, other stimulants (such as amphetamines), volatile inhalants, or benzodiazepines as their main problem drug.
- Just over two-fifths (41.4%) reported problem use of more than one substance (polysubstance use) on entry into treatment.
- One-fifth (20%) of referrals to treatment were made by hospitals/medical agencies, and 12.7% by the courts, probation services or police.
- Of the 106 clients who reported that they had injected at some point in their life, over half (54.7%) reported that had shared injecting equipment.
- Treatment interventions can be classified as psycho-social or medical. Clients may receive a number of interventions during a treatment episode. Of these, service providers identified one as the main treatment intervention when completing the exit form. Psycho-social interventions accounted for 94.5% of the main treatment interventions provided, while the remaining 5.5% were medical interventions.
- The main psycho-social interventions provided were counselling (46.9%), medication-free therapy (26.4%) and brief intervention (17%). Sixty-one cases (3.8%) received an alcohol detoxification as a main treatment intervention, 57 (3.6%) cases completed an education/awareness programme, and 8 (0.5%) cases received methadone substitution as a main treatment intervention.
- The client's condition on discharge was classified by service providers as stable if they had responded to treatment, and unstable if they had not responded. Of the 1,586 cases analysed, 1,099 (69.3%) were stable, 433 (27.3%) were unstable, 46 (2.9%) were classified as 'other' and 8 (0.5%) had died.
- Less than half (44%) of cases completed treatment; 25% refused further sessions or did not return for subsequent appointments; 13.2% did not wish to attend further sessions as they considered themselves to be stable; 11.3% were transferred to another site for further treatment; 4.7% exited because of non-compliance, 1.2% exited for other reasons, and 0.5% died.
- Figure 1 presents the relationship between clients' condition on exit (stable or unstable) and treatment outcomes. Over half of the cases who did not complete treatment (clients who considered themselves stable and clients who did not return for subsequent appointments) were stable on exit.

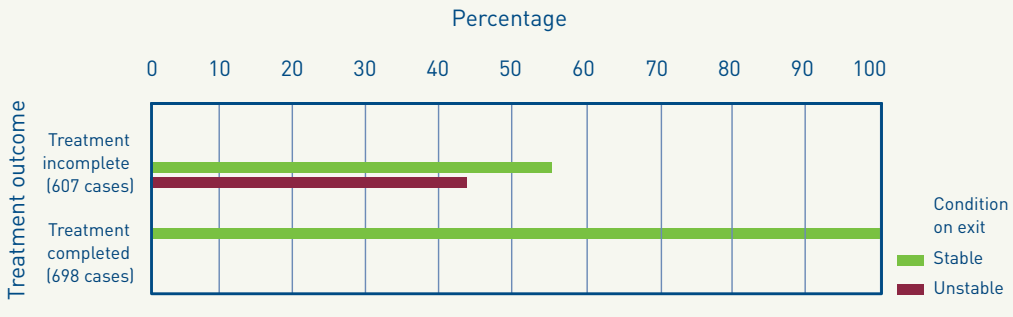


Figure 1 Clients' condition on exit, by treatment outcomes, 2007

- In relation to the 75 (4.7%) cases who exited treatment because of non-compliance, the reasons recorded were: failure to observe rules (60%), drug taking (33.3%), and violent behaviour (6.6%).
- The majority of cases (60%) did not have family members involved in their treatment.
- Figure 2 presents the relationship between the median[1] number of days in treatment and the main problem substance for the 698 cases who completed treatment. Half of the cases reporting alcohol as their main problem substance were in treatment for more than 31 days, while half of the cases reporting opiates and other stimulants were in treatment for more than 67 and 89 days respectively.

Treatment outcomes *(continued)*

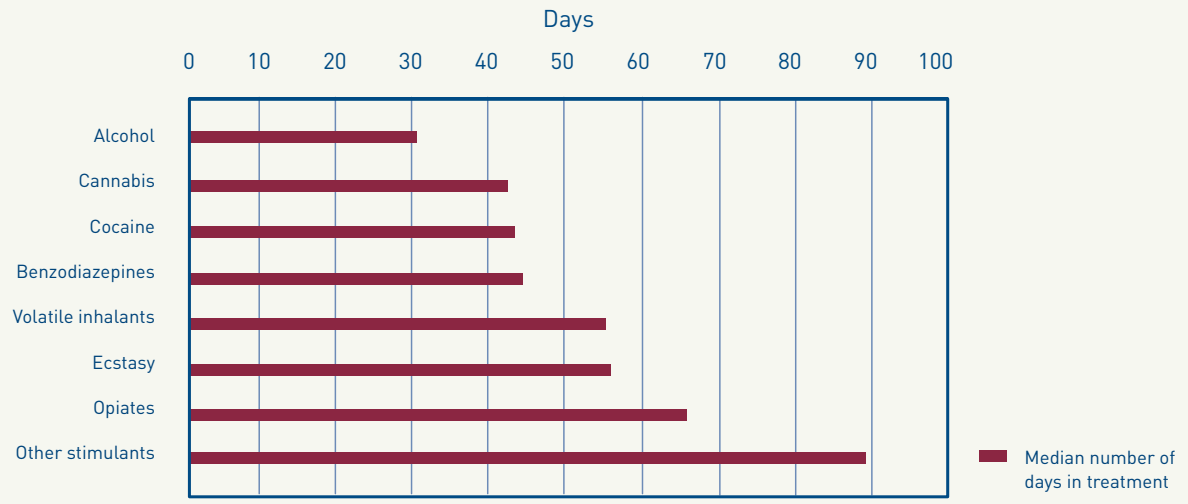


Figure 2 Median number of days spent in treatment, by main problem drug, 2007

- Figure 3 presents the relationship between the median number of days in treatment and polydrug use for the 698 cases who completed treatment. Of the cases reporting a drug as their main problem substance, those who used more than one drug spent approximately twice as many days in treatment as those reporting single substance use. The median number of days spent in treatment was the same for all cases who reported alcohol as their main problem substance, regardless of whether they used other drugs or not.

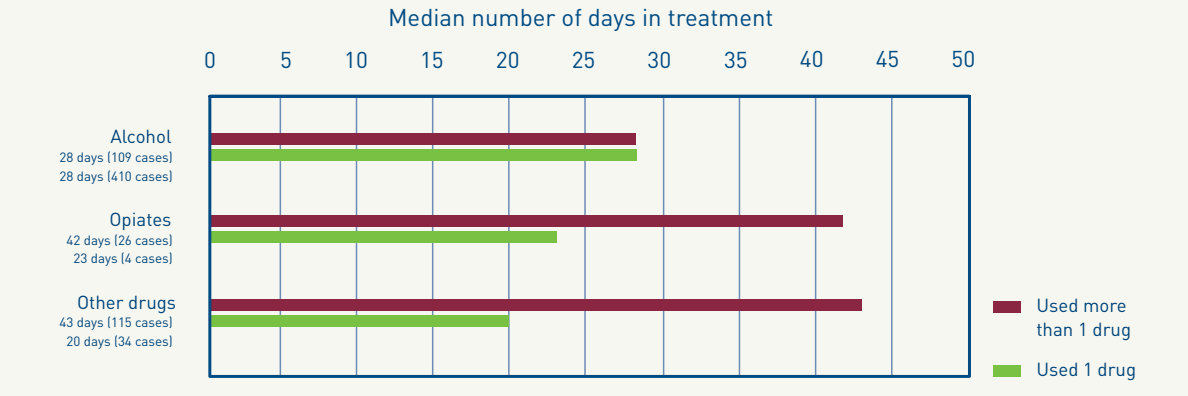


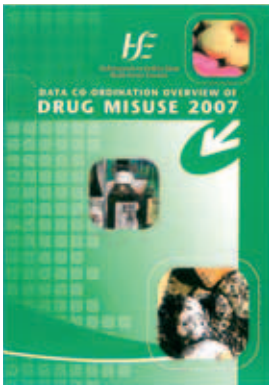
Figure 3 Median number of days spent in treatment, by main problem drug and by use of more than one drug, 2007

Exit data for psycho-social treatment interventions have become available for the first time in Ireland through the completion of the exit form. Analysis shows that treatment outcomes in the south east are largely positive. Service providers in Donegal, Sligo and Leitrim have agreed to pilot the exit form in 2008, and in 2009 the exit form will become available to all service providers throughout Ireland.

(Anne Marie Carew, Martina Kidd, Delphine Bellerose and Jean Long)

The NDTRS team would like to express sincere thanks to all the service providers who completed the exit form in 2007. Their co-operation is very much appreciated.

1. The median is the value at the mid-point in a sequence of numerical values ranged in ascending or descending order. It is defined as the value above or below which half of the values lie. Unlike the mean (average), the median is not influenced by extreme values (or outliers). For example, in the case of five drug users aged 22, 23, 24, 24 and 46 years respectively, the median (middle value) is 24 years, whereas the mean is 27.8 years. While both the median and the mean describe the central value of the data. In this case, the median is more useful since the mean is influenced by the one older person.



Substance misuse in the HSE south eastern area

The Health Service Executive (HSE) South published its annual report, *Data co-ordination overview of drug misuse 2007,* in July 2008.[1] The report comprises three sections: treatment services, education and prevention, and supply control.

The section on treatment services analyses data collected from statutory and voluntary drug and alcohol treatment agencies, acute general hospitals and psychiatric hospitals in the HSE South Eastern Area. Data from the drug and alcohol treatment services are returned to the National Drug Treatment Reporting System in the Health Research Board.

The total number of individuals seeking treatment in 2007 was 2,951, an increase of 310 on the 2006 figure. The report notes that there was not full year reporting from some services because of retirement and illness. Some 223 concerned persons (family members or close friends of substance users) contacted treatment services in the south east in 2007, an increase of 108 on the 2006 figure.

The combined total of continuous care clients and new referrals who were treated was 2,265.

Of these:

- 69% were male and 31% female.
- 7.1% were under the age of 18, and 43% were aged between 20 and 34.
- Alcohol (64%) was the most common main problem substance for which treatment was sought, followed by cannabis (12%) and heroin (10%).
- The numbers seeking treatment for alcohol and cannabis decreased since 2006, while the numbers seeking treatment for cocaine, heroin, MDMA, amphetamines and volatile inhalants increased.
- 9% of treated clients reported that they had injected a substance at some point in their lives, of whom over half (53%) reported that they had shared injecting equipment.

Data presented in this report are useful for planning future services.

(Anne Marie Carew)

1. Kidd M (2008) *Data co-ordination overview of drug misuse 2007.* Waterford: HSE South.

The Intoxicating Liquor Act 2008

The Commencement Order on the Intoxicating Liquor Act 2008 was signed on 23 July 2008. The purpose of this Act is to amend the Licensing Acts 1933 to 2004 and the Criminal Justice (Public Order) Act 1994 in order to give effect to reforms recommended by the Government Alcohol Advisory Group.[1]

The main provisions in the new Act are as follows:

Sale of alcohol

- Off-sales of alcohol will be restricted to the hours from 10.30 am to 10.00 pm (12.30 pm to 10.00 pm on Sundays and on Saint Patrick's Day).
- Any future applicants for a wine retailer's off-licence will also require a District Court certificate. The grounds on which the District Court may refuse to grant a certificate for a spirit, beer or wine retailer's off-licence will be extended. When granting a certificate, the District Court may also impose a condition that a CCTV system be installed.
- In premises that are engaged in mixed trading, such as supermarkets, convenience stores and petrol stations, alcohol products must be displayed and sold in a specified area that is structurally separated from the rest of the premises. As compliance with this provision may require structural alterations to premises, it is intended to give licensees an adequate period of time to make the necessary arrangements before bringing it into force.
- The grounds on which an objection may be made to the grant of a District Court certificate for any off-licence will be extended to include consideration of the needs of the neighbourhood and the adequacy of the existing number of off-licences in the area.
- Test purchasing of alcohol products will be permitted in both on- and off-licences; appropriate safeguards for the protection of the young people concerned will be put in place.

Extended opening hours

- The conditions under which 'special exemption orders' can be made will be amended to require the operation of a CCTV system and compliance with fire safety standards. The public order ground on which objection may be made by the gardaí to the grant of such orders is also being strengthened.
- The sale of alcohol in premises with theatre licences will be permitted only during

Intoxicating Liquor Act *(continued)*

normal licensing hours, or during extended opening hours under a special exemption order granted by the District Court.

Public order

- The gardaí will have the power to seize bottles and containers of alcohol in the possession of a person who is aged under 18 years. It will be an offence for a person, when requested by a garda, to refuse to give his or her name, address and age, or to hand over the bottle or container, with a fine of up to €500 on conviction.

Alcohol promotions and discount sales

- Advertising, promoting, selling or supplying alcohol at reduced prices will be prohibited.

Penalties and sanctions

- There will be a minimum two-day closure period for temporary closure orders made by the District Court on the conviction of licensees for certain licensing offences, for example, sale of alcohol to a person under 18, or permitting drunkenness or disorderly conduct on the premises. Certain fines in the Licensing Acts 1833 to 2004 and fines under the Criminal Justice (Public Order) Act 1994 will be increased.

The majority of provisions in the Act came into operation on 30 July 2008. The provisions relating to test purchasing of alcohol products and to structural separation of alcohol in supermarkets and convenience stores have not yet been commenced.

(Deirdre Mongan)

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

Tackling alcohol misuse in the UK

The British Medical Association recently published a report, *Alcohol misuse: tackling the UK epidemic,*[1] which describes drinking patterns and indicators of alcohol-related harm in the UK, and considers a range of evidence-based policies to tackle problematic levels of alcohol misuse.

The UK is among the heaviest alcohol consuming countries in Europe, with consumption rising from 3.9 litres per capita in 1950 to 8.9 litres in 2006. The prevalence of alcohol consumption varies considerably by ethnic group. Only 9% of the White British population are non-drinkers, whereas 48% of people of Black African origin and 90% of those of Pakistani and Bangladeshi origin abstain from alcohol. While the majority of individuals who consume alcohol do so in moderation, 23% of men and 12% of women drink above the UK recommended limits. The report estimates that 7% of the adult population are alcohol dependent.

Alcohol is causally related to over 60 different medical conditions and, in the majority of cases, the risk of disease increases with a higher volume of consumption. It has been estimated that alcohol misuse accounts for more than 22,000 premature deaths per year in England, of which 1,000 are suicides. The alcohol-related death rate in the UK almost doubled between 1991 and 2005, from 6.9 to 12.9 per 100,000 population. The burden of alcohol-related mortality is shifting to younger age groups in both men and women, and toward the most socially deprived groups. In England, the rate of mortality from liver cirrhosis trebled between 1970 and 1995, while the rate in the EU decreased by 30%. In addition, alcohol was implicated in 17% of road deaths in 2006.

Alcohol misuse is a major cause of admission to hospital in both emergency and non-emergency settings. It has been estimated that 70% of all admissions to emergency departments at peak times are alcohol related. In England, the number of hospital admissions of adults aged 16 and over with a primary or secondary diagnosis related to alcohol use more than doubled, from 89,280 in 1995/96 to 187,640 in 2005/06.

Alcohol misuse can lead to many harmful social consequences. Approximately half of homeless people are alcohol dependent. Parental alcohol misuse is correlated with child abuse and significantly impacts on a child's environment. In 2004, it was estimated that between 780,000 and 1.3 million children were affected by parental alcohol problems in England. It has been estimated that alcohol misuse results in 17 million working days lost annually in England. The total annual societal cost of alcohol misuse in England has been estimated at £55.1 billion.

There has been considerable deregulation and liberalisation of alcohol control policies in the UK, which has been accompanied by an increase in consumption levels and alcohol-related problems. This report criticises the focus of the UK government on interventions that are popular but ineffective, such as educational programmes and media campaigns, and the rejection of policies such as increased taxation and reduced availability that have been found to reduce alcohol consumption and related problems. It also criticises the UK government's emphasis on partnership with the alcohol industry and self-regulation, which has at its heart a fundamental conflict of interest that does not adequately address individual and public health. In the Licensing Act 2003, which permits 24-hour opening in England and Wales, public health was not considered as one of the licensing objectives.

The report calls on the government to show leadership and implement a full range of effective evidence-based policies that will reduce the burden of alcohol misuse, including:

1. **Higher taxes on alcoholic drinks, proportionate to the amount of alcohol in the product.** The affordability of alcohol in the UK increased by 65% between 1980 and 2006. Levels of alcohol consumption (particularly among heavy drinkers and young drinkers) and related problems are responsive to price; it is estimated that a 10% increase in alcohol price would lead to a 10% fall in consumption.

Alcohol misuse in the UK *(continued)*

2. **Reducing availability.** Availability of alcohol should be regulated through a reduction in licensing hours for on- and off-licensed premises. The density of alcohol outlets should be taken into account when considering planning or licence applications.
3. **Responsible retailing and industry practices,** including strict enforcement of legislation prohibiting the sale of alcohol to intoxicated customers and people under the age of 18, and the abolition of irresponsible promotional activities such as happy hours and two-for-one offers.
4. **Measures to reduce drink-driving.** The legal limit for the level of alcohol permitted while driving should be reduced from 80mg/100ml to 50mg/100ml, and random breath testing should be introduced.
5. **Early intervention and treatment of alcohol misuse.** The detection and management of alcohol misuse should be an adequately funded and resourced component of primary and secondary care and include formal screening for alcohol misuse, referral for brief intervention and specialist alcohol treatment services, and follow-up care and assessment at regular intervals.

This report describes the situation regarding alcohol in the UK; similar trends can be observed in Ireland, where the levels of per capita consumption are even higher. It is clear that alcohol misuse is a serious problem in both countries and that action must be taken to significantly reduce alcohol-related harm. This report provides a range of recommendations that must be collectively implemented in order to effectively tackle alcohol misuse and its associated harms; however, this requires strong political commitment and leadership.

(Deirdre Mongan)

1. BMA Board of Science (2008) *Alcohol misuse: tackling the UK epidemic.* London: British Medical Association.

Young people, alcohol and drugs

Young people, alcohol and drugs,[1] the report of a study by Palmer and O'Reilly, was presented at an international conference at University College Dublin in May 2008. This study compared a group of 462 second-level or post-Leaving Cert students aged 14–19 (the 'community group') to a similarly aged 'clinical group' of 30 adolescents in residential treatment for substance misuse in the south and south east of Ireland. The study examined substance use behaviour, coping style, motivations for alcohol and drug use and family functioning. In addition, qualitative interviews were conducted with 10 young people from the clinical group.

In the community group, 86% stated that they consumed alcohol; the average age of first alcohol use was 13.4 years. The average number of drinks consumed on a typical drinking occasion was 5.7, ranging from four drinks among 15-year-olds to seven among 19-year-olds. One-third stated that they drank alcohol at least once a week; there was a pattern of more frequent drinking with increasing age. Spirits were the most common alcoholic drink, consumed by 54%, followed by alcopops (47%), cider (42%) and beer (39%). However, beer was the most popular drink among males (63%) and alcopops was the beverage of choice among females (72%). Binge drinking on a weekly basis, defined as consuming five or more drinks on a single drinking occasion, was reported by 23% of respondents.

Thirty-eight per cent of the community group reported negative consequences of alcohol use. Most frequently reported were: getting into an argument (20%); trouble at home (18%); accident or injury (13%); and a physical fight (13%). Males were significantly more likely than females to report that alcohol use had led to a physical fight, had led to damage to property, or had resulted in trouble with the police.

Half of the community group reported having used an illicit drug, and the average age of first drug use was 14.5 years. Cannabis was the most commonly reported drug used (41%), followed by inhalants (30%), poppers (17%) and cocaine (11%). Regular use of cannabis, defined as once a month or more, was reported by 13%. Negative consequences of drug use were reported by 11% of the total group. In contrast to consequences of alcohol use, performance affected at school/work was the most common consequence of drug use (7%).

Of the 30 participants in the clinical group, four met the criteria for an alcohol abuse disorder and 26 had an alcohol dependent disorder. Polydrug use was common, with 27 also meeting the criteria for dependence on other substances. This group reported a high level of co-existing psychological problems. The qualitative interviews identified a range of personal and environmental factors as influential in their initial substance use, including poor family functioning, and using alcohol as a coping strategy.

This report identifies the need for epidemiological studies of substance use among young people. It recommends further research to evaluate the effectiveness of preventative interventions and to examine the efficacy of treatment interventions for adolescent substance misuse, including long-term follow up in an Irish context.

(Deirdre Mongan)

1. Palmer D and O'Reilly G (2008) *Young people, alcohol and drugs.* Cork: Juvenile Mental Health Matters.

New Chief Executive for HRB

The Health Research Board appointed Mr Enda Connolly as Chief Executive in June 2008. Mr Connolly brings to his new position more than 30 years' experience with IDA Ireland, where he had a pivotal role in leading change, developing strategy, building stakeholder confidence and securing significant foreign direct investment. The new CEO will focus on articulating and implementing a clear vision and strategic direction for the HRB and health research in Ireland in a changing healthcare landscape.

Dr Hamish Sinclair, formerly head of the Drug Misuse Research Division, had been Acting Chief Executive prior to Mr Connolly's appointment. He will continue in his position as Director of Health Information and In-house Research, to which he was appointed in 2007.

Flash Eurobarometer on young people and drugs

In May 2008 Eurobarometer published the results of a survey of young EU citizens' attitudes and perceptions about the drugs issue.[1] The fieldwork was carried out between 14 and 18 May 2008. Over 12,000 randomly selected 15–24-year-olds were interviewed across the 27 EU member states. The survey was carried out by telephone, with web-based computer assisted telephone interviewing (WebCATI).[2] The findings relating to Irish respondents are summarised below.

Potential and actual sources of information on drugs

Ireland had the highest proportion of respondents who would choose to talk to a friend when looking for more information about illicit drugs and drugs use. Irish young people were also among those most liable to talk to their parents or relatives about drugs and drug use. While Irish respondents favoured talking to a health professional such as a doctor or nurse, they clearly did not favour talking to a counsellor or someone else at a specialised drug centre. When asked about information channels used in the past year, Irish respondents reported a rather different pattern: they had drawn principally on media campaigns, followed by friends, and then Internet sources.

Perceived health risks of using drugs

Respondents were asked to rank the health risks associated with various substances as high, medium or low. Substances seen by most Irish respondents as posing a medium or high risk to health were heroin (98.7%), cocaine (98.5%) and ecstasy (95%). Smaller percentages of respondents regarded as medium or high the risk posed to health by tobacco (78.8%), cannabis (74.2%) and alcohol (73.5%). Only 12.7% perceived alcohol as posing a high risk, while 28.4% deemed tobacco and 30.1% deemed cannabis as doing so.

How should society's drug problems be tackled?

Respondents were asked to rank a series of actions that public authorities could take to deal with the drug problem as either the 'most effective' or the 'second most effective' way of combating the problem. Respondents in Ireland were among the least likely to see the clampdown on drug dealers and traffickers as effective. Conversely, Irish respondents were among the most likely to believe that the treatment and rehabilitation of drug users was an effective way to deal with society's drug problems. Irish respondents (22%), along with those in the UK and The Netherlands, were the ones who most favoured the legalisation of drugs.

To ban or regulate illicit drugs, alcohol and tobacco?

Substances that most Irish respondents felt should continue to be banned were heroin (97%), cocaine (95%) and ecstasy (95%). Just 61% of Irish respondents believed that cannabis should continue to be banned, and 39% believed that it should be regulated. With regard to alcohol, the largest proportions of respondents who supported continued regulation were found in the The Netherlands and Ireland (96%); just 4% of Irish respondents favoured the banning of alcohol. With regard to tobacco, 80% of Irish respondents believed that it should continue to be regulated, while 20% believed it should be banned.

Access to illicit drugs, alcohol and tobacco

With regard to illicit drugs, Irish respondents were among the most likely to say that it was easy to obtain heroin, cocaine, ecstasy and cannabis, if they wanted to. Young people in Ireland were among those most likely to say that they could easily obtain alcohol and tobacco. Cross-tabulating respondents' perceptions of the health risks associated with drug use and their answers relating to the ease of obtaining the drugs showed that young people who found it easier to obtain the substances also perceived the health risks associated with drug use to be less serious.

(Brigid Pike)

1. The Gallup Organization (2008) *Young people and drugs among 15–24 year-olds: analytical report.* Flash Eurobarometer 233. European Commission. Retrieved 11 July 2008 at http://ec.europa.eu/public_opinion/archives/flash_arch_en.htm#233 This survey built on two earlier surveys of young people and drugs in

Eurobarometer *(continued)*

the old EU15 in 2002 and 2004 (Special Eurobarometer No 172 and Flash Eurobarometer No 158). The topics covered ranged from the consumption of various drugs and young people's involvement in the drug culture to the dangers associated with various products and young people' opinions about the effectiveness of policies aimed at solving society's drug-related problems.

2. To correct for sampling disparities, a post-stratification weighting of the results was implemented, based on socio-demographic variables.

Safetynet pilot methadone programme evaluated

In December 2007 the Dublin Simon Emergency Shelter started to implement a methadone programme being piloted by the Safetynet service.[1] The results of an internal evaluation undertaken after the programme had been running for six months were presented in a recent report.[2]

The Shelter provides accommodation to homeless people for up to six months. A large majority of residents are active drug users, most of them injecting heroin. The direct consequences of their drug use include high levels of morbidity, often leading to hospitalisation, a significant number of evictions from the Shelter for unsafe drug use, and generally chaotic drug-using behaviour. Most residents were not receiving any form of treatment prior to joining the Safetynet programme, partly because of the waiting lists in many methadone clinics. Long waiting lists mean that many clients are not able to start treatment before their time in the Shelter is up, and the opportunity to address their drug problem and their homelessness at a time of relative stability is lost.

By providing on-site medical and nursing services, as well as a needle-exchange service, the Safetynet methadone programme has had a major impact on the residents and staff of the Shelter. Fourteen residents started the methadone programme during the six-month period. With little more additional budget than the standard cost for dispensing methadone, the first six months of the programme proved to be successful and the evaluation highlighted many benefits, such as:

- marked reduction in drug use
- marked reduction in morbidity, especially skin conditions and abscesses, largely attributed to the decrease in injecting by clients
- reduction in the number of evictions
- reduction in crime involvement
- improvement in social functioning
- improved opportunities to move to more permanent accommodation.

The report makes the following recommendations:

- Increase the number of places on the programme from 10 to 55, with 25 of those allocated to residents of the Shelter.
- Facilitate the transfer of clients to HSE drug treatment centres when that is deemed a more suitable option.
- Provide an addiction counselling service linked to the programme.

(Delphine Bellerose)

1. Safetynet is a primary care network that provides GP and nursing services to homeless people. It was established in 2007 and is funded by the HSE.
2. Geraghty C, Harkin K and O'Reilly F (2008), *Evaluation of the Safetynet methadone programme pilot at the Dublin Simon Emergency Shelter.* Dublin: Dublin Simon Emergency Shelter.

National Poisons Information Centre – 2007 report

The National Poisons Information Centre (NPIC), located in Beaumont Hospital, provides a national telephone information service on the toxicity, features and management of cases of poisoning. This 24-hour service is offered mainly to doctors and other health care professionals. Queries are dealt with by poisons information officers at the Centre between 8 am and 10 pm, while out-of-hours calls are automatically diverted to the UK National Poisons Information Service (NPIS).

According to its annual report,[1] NPIC received 11,011 enquiries in 2007, a decrease of 7.5% on the 2006 figure. Of these, 2,459 were dealt with by NIPS in the UK and are not included in the analysis presented in the report. Of the 8,552 calls answered by NPIC, 8,277 (96.8%) were about human toxicology. The remaining calls concerned poisoning in animals (1.2%) and non-emergency requests for information (2.0%).

Of the 8,552 calls dealt with by NPIC, the highest proportion were from the HSE Eastern Region (28.4%), of which 79.8% were from Dublin city and county.

The most frequent enquiries were from hospitals (35.1%), general practitioners (34.9%) and members of the public (23.0%). The other sources of enquiries were community pharmacists, carers, vets, industry/manufacturers, schools, emergency services, media, and government agencies. The increased use by Irish emergency departments of TOXBASE, the online clinical toxicology database of the UK NPIS, is reflected in a 2.2% drop in the proportion of enquiries from hospitals since last year.

NPIC 2007 report *(continued)*

Table 1 Age and gender of human cases

Age group	Gender			Total	%
	Male	Female	Unknown		
<1	159	152	114	425	5.1
1–4	1,921	1,588	66	3,575	43.2
5–9	208	160	7	375	4.5
10–14	80	109	4	193	2.3
15–19	136	241	3	380	4.6
20–49	706	726	9	1,441	17.4
50–69	159	206	3	368	4.4
>70	91	112	1	204	2.5
Unknown	434	499	383	1,316	15.9
Total	**3,894**	**3,793**	**590**	**8,277**	

More than half of the enquiries about cases of poisoning in humans concerned children under 10 years of age (Table 1). The main agents involved in these cases were household products, cosmetics and personal hygiene products, and plants. The majority (88.5%) of all human poisoning incidents occurred in the home.

The enquiries about human toxicology involved 13,538 agents, mainly drugs, industrial chemicals and household products. The most common enquiry concerned substances containing paracetamol (1,082). Alcohol was next most common (376), and in the majority of cases was ingested with other substances. The third most common agent was ibuprofen (363). Only a small proportion of cases (395, 4.8%) were followed up. Although most recovered completely, 21 cases suffered adverse effects, a further 17 cases died, while the outcome of 68 cases could not be determined.

(Simone Walsh and Suzi Lyons)

For a copy of this report, see the NPIC website at www.poisons.ie, or telephone 01 837 9964 or 01 809 2566.

1. Poisons Information Centre of Ireland (2008) *Annual report 2007.* Dublin: NPIC.

ISSDP annual conference

The second annual conference of the International Society for the Study of Drug Policy (ISSDP) took place in Lisbon on 3–4 April 2008. It was supported by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the Instituto da Droga e da Toxicodependência (IDT).

The publicly available papers and presentations from the conference are listed below.[1]

The third annual conference of the ISSDP is planned to take place in Vienna on 2–3 March 2009.

(Brigid Pike)

1. These papers and presentations are available in PDF or PowerPoint format at www.issdp.org

Evaluating policy

Development of an Australian drug policy index	Alison Ritter
Drug policy in world historical perspective: The five stages of regulation	David T Courtwright
Evaluating Danish cannabis policy change	Kim Møller
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Service users to have greater voice in the health service

On 6 May 2008 the *National strategy for service user involvement in the Irish health service 2008–2013 was launched.*[1] Comprising seven goals, the Strategy will build on current good practice in involving service users (i.e. patients, their families, voluntary and community organisations) across the country. The goals are outlined as follows:

1. **Commitment and leadership.** Managers and clinicians at all levels will demonstrate their commitment to the development of service user involvement in the planning, development, delivery and evaluation of the health services and will report on the implementation of the strategy to the HSE Management Team.
2. **A systematic approach to effective service user involvement.** The planning of service user involvement will be carried out in a systematic manner in which strategy development and methods of involvement are based on a clear understanding of desired outcomes.
3. **Patient involvement in their own care.** Models of patient care delivery must continue to develop the role of the 'expert patient', especially those with long-term illnesses, in developing their own care plan and in looking after their own condition.
4. **A Patients Charter.** A rolling programme setting out what patients should expect from the health services will be developed with service quality standards for service users.
5. **Specific work will ensure the involvement of children, young people and socially excluded groups.** All involvement work must make specific efforts to ensure the participation of children, young people and socially excluded groups.
6. **Develop existing service user structures.** The HSE will evaluate existing mechanisms for service user involvement to ensure best practice is implemented throughout the country.
7. **Performance and development.** Learning and development programmes aimed at meeting the development needs of service users and of health service staff will be an integral part of HSE training programmes.

Produced by the Department of Health and Children and the HSE in consultation with the Health Services National Partnership Forum, HIQA, advocacy groups and service users, the principles of the strategy apply to all who use health and social services, those who participate in health programmes and services and those who work in the health service. The HSE will implement the strategy nationally and will evaluate its success on an annual basis.

The Patients Charter will be based on models from other countries and will provide guarantees of service quality that patients can expect when using our health services.[2] The HSE will develop clear strategic plans to promote and encourage service users, particularly those with chronic illnesses, to be active participants in their own care. These measures will lead to the review of consumer panels (in existence in many parts of the country), building on good practice and the development of a system of advocacy to support patients and clients.

(Brigid Pike)

1. Department of Health and Children and the Health Service Executive, in consultation with the Health Services National Partnership Forum (2008) *National strategy for service user involvement in the Irish health service 2008–2013.* www.hse.ie/eng/Your_Service_Your_Say/Documentation/Strategy/Service_User_Involvement.html
2. With regard to patient charters, action 46 of the National Drugs Strategy called for the development of a 'service-user charter specific to treatment and rehabilitation facilities which would lead to a greater balance between the service user and the service provider'. Such a charter was seen as being particularly beneficial for drug misusers presenting for treatment with low levels of educational attainment or low self-esteem. In the mid-term review of the National Drugs Strategy, the Steering Group recommended that in future, where these charters were being developed, services should consult more widely with service users in the drafting of the charters (para. 5.17).

Human rights and illicit drugs policy

The year 2008 marks the 60th anniversary of the signing of the Universal Declaration of Human Rights (UDHR) as well as the conclusion of the UN's 10-year action plan on drugs. Several international non-governmental organisations (NGOs) have taken the opportunity to set out their policy positions on the relationship between human rights and drug control, as has the Commission on Narcotic Drugs (CND), the central policy-making body of the UN in drug-related matters. There has been some debate on the relationship between the two policy domains in Ireland.

International NGOs

The International Drug Policy Consortium has called for the drug control agencies to clearly condemn any activities undertaken in the pursuit of drug control that contravene international human rights and judicial standards.[1] The International Harm Reduction Association has gone further, calling for international human rights commitments and obligations to be used to support the promotion of harm reduction programmes and the rights of people who use drugs to respect and dignity.[2] The Beckley Foundation Drug Policy Programme has highlighted the inconsistencies and contradictions between the international human rights and drug control systems, and has called for greater system-wide cohesion.[3] The authors note that the human rights obligations imposed on UN bodies and member states in the UN Charter override any conflicting obligations in any other international agreement.

Commission on Narcotic Drugs

In March 2008, at the 51st session of the CND, which saw the launch of the year-long review of the UN 10-year action plan, the CND passed a resolution reaffirming that countering the world drug problem must be carried out in full conformity with the purposes and principles of the UN Charter and other provisions of international law and, in particular, with full respect for, among other things, all human rights and fundamental freedoms, and on the basis of the principles of equal rights and mutual respect.[4]

Ireland

The Working Party on Drug Abuse, which reported in 1971, is the only body tasked with developing national policy on illicit drugs in Ireland to have explicitly mentioned the rights of the drug user: in the context of supply reduction measures, the working party commented that there should be 'no undue interference with the freedom of the individual as far as any changes in procedures relating to search and arrest' (para. 3.2).[5] In the mid 1990s Tim Murphy, in a critique of Ireland's prohibitionist drug policy, commented that 'another highly significant social cost of drug prohibition is the abuse of civil liberties which inevitably accompanies the active criminalisation of basically "victimless" conduct' (p. 54).[6] He cited the discussion in the Government strategy to prevent drug misuse (1991) about the detention of individuals suspected of concealing drugs in body cavities, and the provision for seven-day detention for suspected drug dealers in the Criminal Justice (Drug Trafficking) Act 1996, as examples of 'active criminalisation'. In a recent publication, in which he makes a case for the abolition of drug prohibition in Ireland, Paul O'Mahony argues that individuals have a right to use drugs.[7] Far from promoting a laissez-faire approach to this human right, O'Mahony argues that implementation of this right would bring two sets of gains– 'negative' gains by eliminating or at least diminishing the ills associated with prohibition, and 'positive' gains by changing the relationship between citizens and the state, and thereby strengthening the impact of drug education, treatment and social relations.

In 2007, in a report released to coincide with the 60th anniversary of the UDHR, the Irish section of Amnesty International assessed the 'reality' of human rights in Ireland.[8] The report described how Ireland has championed human rights on the international stage but identified areas at home where the Irish state 'has not respected, protected or fulfilled all rights or the rights of all' (p. 1). The report suggested that these gaps were the result of the state's failure to follow human rights principles in its planning and decision-making processes. While drug users were not included among the 'vulnerable groups' considered in this report, drug use was mentioned as an exacerbating factor among those experiencing human rights violations because of imprisonment or homelessness. Amnesty International concluded its report with a series of recommendations on how Ireland could move towards a human-rights-based approach in its social and economic policies.

In 2007 the Irish Human Rights Commission announced in its strategic plan for 2007–2011 that, as well as continuing to review relevant legislation, its strategic focus would now be to influence policy formulation and legislative drafting at an earlier stage than hitherto:[9] 'The Commission believes that by encouraging Ministers and civil servants to place increasing emphasis on human rights at policy development and "heads of bill" stages, it can be more productive and efficient in shaping relevant sections of legislation' (p. 22).

(Brigid Pike)

1. International Drug Policy Consortium (2008) *The United Nations review of global policy on illegal drugs – an advocacy guide for civil society.* Version 3. Retrieved on 5 August 2008 at www.idpc.org.
2. Lines R and Elliott R (2007) Injecting drugs into human rights advocacy. Editorial. *International Journal of Drug Policy* (18/6): 453–457.
3. Barrett D, Lines R, Schleiffer R, Elliott R and Bewley-Taylor D (2008) *Recalibrating the regime: the need for a human rights-based approach to international drugs policy.* Report Thirteen. The Beckley Foundation Drug Policy Programme. Retrieved on 5 August 2008 at www.beckleyfoundation.org/policy/
4. Commission on Narcotic Drugs (2008) Report on the fifty-first session (28 November 2007 and 10–14 March 2008). Economic and Social Council Official Records, 2008, Supplement No. 8. E/2008/28, E/CN.7/2008/15. Retrieved on 5 August 2008 at www.unodc.org/unodc/en/commissions/CND/index.html
5. Working Party on Drug Abuse (1971) *Report of working party on drug abuse.* Dublin: Stationery Office. Retrieved on 5 August 2008 at www.ndc.hrb.ie/attached/643-0601.pdf
6. Murphy T (1996) *Rethinking the war on drugs in Ireland.* Cork: Cork University Press. p. 54
7. O'Mahony P (2008)*The Irish war on drugs: the seductive folly of prohibition.* Manchester: University of Manchester Press.

Human rights and drugs policy *(continued)*

8. Amnesty International–Ireland (2007) *Mind the gap: human rights and human dignity in Ireland.* Retrieved on 5 August 2008 at www.amnesty.ie

9. Irish Human Rights Commission (2007) *Promoting and protecting human rights in Ireland: strategic plan 2007–2011.* p. 22. Retrieved on 5 August 2008 at www.ihrc.ie

Drug treatment and employment

McIntosh *et al.* report on an analysis of follow-up data collected in the course of the Drug Outcome Research in Scotland (DORIS).[1] The data were collected at the DORIS 4 stage, 33 months from baseline data collection. The study found that recovering drug users who had received assistance that was specifically employment-related were three times more likely to have found paid employment than those who had received no such assistance.

Of a total study population of 695 at 33-month follow-up, 140 respondents (20%) said that they had had paid employment since their interview at 16-month follow-up (DORIS 3 stage).

The analysis identified, through logistic regression modelling, which aspects of the treatment process facilitated or promoted the achievement of paid employment by recovering drug users. The co-variable that had the strongest independent association with the achievement of paid employment was the individual's receipt of focused assistance from their treatment agency to obtain a job, employment skills or education. The analysis also showed there was a non-significant relationship between the different treatment modalities and the achievement of paid employment.

These are useful findings in the context of the recommendations of the Working Group on Drugs Rehabilitation,[2] which endorses the role of employment-focused training for recovering drug users in treatment. Currently, the main vehicle for such training is the FÁS Special Community Employment scheme; however, reviews by Bruce[3] and Lawless[4] highlight the limitations of this intervention. Both reviews concluded that, rather than focusing on the original, vocational objectives of the scheme, the intervention was mainly fulfilling a supportive therapeutic function.

One intervention that has shown effectiveness in improving employment prospects for recovering drug users is the customised employment supports (CES) model. This model involves a skilled vocational counsellor working intensively with a small caseload of clients to overcome the vocational and non-vocational barriers that hinder employment.[5]

Consideration should be given to piloting the CES model in local drugs task forces areas, or adapting the FÁS model to include CES elements, to provide viable options for individuals who want to work with a more intensive model.

Service providers should not be disheartened that the objective of progressing recovering drug users into paid employment may not be achieved at the first attempt, even when education and skills are improved and employability has been enhanced. Some recovering drug users may wish to take a more gradual approach to entering the labour market and can be supported in a phased but structured way. This report discusses the option of using intermediate employment models that reintroduce individuals to the discipline and routines of the workplace in a gradual way, and provide them with evidence of their competence and reliability to present to prospective employers.

Improving the employability of recovering drug users should become a key component of drug policy and practice. Research has identified a number of ways in which being in paid employment can contribute to an individual's ability to create and sustain a drug-free life. According to this report, being in paid employment

- enables the recovering drug user to fill his or her time constructively
- promotes economic independence
- helps reintegration to wider society by removing the individual from the drug-using network and towards drug-free social relationships
- enhances self-esteem and helps build new sense of self, which protects against relapse
- conveys status, which acts as an important symbol to the individual of their ability to return successfully to a conventional life.

It is encouraging for policy makers and service providers that the evidence base for effective interventions to improve employability for recovering drug users is increasing. Ultimately, this evidence can contribute to the development of effective care plans for recovering drug users and form an important element in the future of drug rehabilitation and drug-related social reintegration in Ireland.

(Martin Keane)

1. McIntosh J, Bloor M and Robertson M (2008) Drug treatment and the achievement of paid employment. *Addiction Research and Theory,* 16(1): 37–45.
2. Working Group on Drugs Rehabilitation (2007) *National Drugs Strategy 2001–2008: Rehabilitation. Report of the Working Group on Drugs Rehabilitation.* Dublin: Department of Community, Rural and Gaeltacht Affairs.
3. Bruce A (2004) *Drugs task force project activity for FÁS Community Employment and Job Initiative participants.* Dublin: FÁS.
4. Lawless K (2006) *Listening and learning: evaluation of Special Community Employment programmes in Dublin North East.* Dublin: Dublin North East Drugs Task Force.
5. For a description of the model and its evaluation, see Keane M (2007) Innovative job placement model for methadone-maintained clients. *Drugnet Ireland,* (24): 7–8.

Bridge-to-Workplace inter-agency initiative

On 26 May 2008, the operational management group of the Bridge-to-Workplace project launched its progress report.[1] Bridge-to-Workplace is an inter-agency initiative aimed at facilitating the reintegration of individuals with a history of illicit drug use through a programme of training and work experience.

This project is seed funded by FÁS and the Finglas Cabra Local Drugs Task Force. The other agencies involved are: Ballymun Job Centre Co-operative, Blanchardstown Local Employment Service Network (LESN), Dublin Inner City Partnership, Finglas Cabra Partnership LESN, HSE Rehabilitation/Integration Service (RIS), Inner City Employment Service, and Northside Partnership LESN.

Customised reintegration plan

The primary aim of Bridge-to-Workplace is to facilitate access to mainstream education and to provide clients with work placement opportunities. The project also provides a wider range of services, such as counselling, life-skills training, career guidance and housing support. Clients referred to the project must be drug free (unless on methadone maintenance), stable, motivated and committed. Key workers from both the employment and the rehabilitation services assess and agree on a client's suitability. A progression plan is developed based on the client's needs, interests, stability and skills, and this plan is monitored and reviewed on an ongoing basis through three-way meetings with the client and RIS and LESN officers.

Between August 2005 and December 2006, a total of 74 clients participated in the programme, of whom 39 (52.7%) have completed or are presently engaged in a work placement. The majority of placements have been within the commercial sector, lasting between two and 25 weeks, with an average of 12 weeks. Feedback from team members, employers and clients has been very positive and participants have referred to their work experience in terms of increased confidence and motivation, and as a catalyst for progression.

A multi-agency model

By combining the expertise of two key agencies, Bridge-to-Workplace provides a more cost-effective and cohesive service to address the complex and multiple issues presented by the target group. This holistic approach and the provision of daily or weekly support throughout each individual progression plan require a high level of integration and co-operation. The implementation of practical protocols was paramount to the development of an effective and transparent working relationship between agencies. While this collaborative effort allowed ongoing assessment of the clients' stability and motivation, appropriate timing of training or placement and prompt identification of potential

issues, it also highlighted the political and practical difficulties to be overcome.

Bridge-to-Workplace offers a valuable insight into the challenges and benefits of an inter-agency approach, and has the potential to set standards for a more integrated service provision for the social reintegration of individuals with a history of problem drug use.

(Delphine Bellerose and Vivion McGuire)

1. Bridge-to-Workplace (2008) Bridge-to-Workplace: an inter-agency initiative. *Working together: progress report.* Dublin: Bridge-to-Workplace. Available at www.fcp.ie.

An evaluation of the WRENS project in Killinarden

The Killinarden Drugs Primary Prevention Group (KDPPG) established the WRENS[1] project in 2002, initially to assist women who experienced marginalisation from their communities as a result of the anti-social behaviour of a family member. Based on the principles of community development, the project has continued to work with parents and families and has developed specific services for young people within the school system and for clients of the Probation Service. The work of WRENS was recently evaluated by Duggan[2] using documentary analysis and in-depth interviews with project staff, parents, school staff and probation and welfare personnel.

According to parents and school staff, the programme for young people is contributing to a reduction in disruptive behaviour and improvements in school retention rates. Disruptive behaviour and early school leaving are indicators of drug use and, in this context, the programme is seen to benefit young people at risk of engaging in drug use. In particular, the intensive one-to-one work with young people was identified as an effective approach.

Participants in the family programme reported having gained a better understanding of the issues adversely affecting them, improved problem management techniques in the family, increased participation in the community and in some cases the attainment of new skills applicable to a range of settings. However, the evaluation noted that some parents were potentially becoming dependent on the support from the programme and that, in the long run, measures ought to be taken to empower these parents to progress to independent management of the issues affecting them.

Among the small number of participants who were supervised by the Probation Service, a number of notable changes in behaviour and lifestyle were reported. For example, participants reported a greater awareness of the consequences of their offending behaviour and of ways of changing such behaviour. They also reported greater structure in their lives, increased awareness of alcohol and drug addictions and improved relations with the Probation Service.

Overall, the evaluation reported that KDPPG, through the WRENS project, was doing excellent work in delivering community development interventions to individuals and families with specific needs. These interventions benefited the individuals, the families and their communities, and added value to the work of the statutory sector. However, it was noted that the KDPPG could improve its strategic planning and begin systematic data collection so as to monitor and evaluate its own service and to share its experience with other agencies responding to drug use.

A lack of strategic planning and systematic data collection is common among drug prevention interventions based on community development principles. This is often influenced by the fluid and organic nature of community development, where the aim is to empower individuals and families through face-to-face interventions in the community so that they can resolve their own problems and contribute to greater community cohesion, rather than to provide evidence of effectiveness.

(Martin Keane)

1. WRENS stands for Women Reviewing Equality Networking Standards.
2. Duggan C (2007) *An evaluation of the WRENS project implemented by KDPPG.* Dublin: Killinarden Drug Primary Prevention Group.

Court-prescribed drug education for first-time offenders

The Drug and Alcohol Programme (DAP) run by Crosscare works with small numbers of individuals referred either by the courts or by their legal teams for drug education following arrest for first-time and minor drug-related offences. Such offences often occur in the context of outdoor concerts and music festivals. Crosscare recently commissioned research to investigate two key questions:

- Is the DAP service the appropriate mechanism to meet the needs of this target group and, if so, how can it be developed further?
- What is best practice in meeting the needs of this target group?

This research has now been published, and draws attention to an area that has received little attention so far.[1] The report notes that in 2007 fewer than five individuals referred to the DAP had been arrested for minor cannabis or ecstasy offences at music festivals. However, this number may be an underestimate as the DAP does not usually record the reasons for referral. It is claimed that individuals are often referred to the programme on an ad hoc basis, with no clear links developed between the courts and the drug education providers and no attempt to monitor or evaluate the service. The report recommends improved collaboration between the courts, the Probation Service and drug education providers, and questions whether the current service run by Crosscare is the appropriate mechanism, in the absence of the necessary collaborative supports outlined.

The author states that drug education is unlikely to be effective unless it is begun at the point of arrest and set within the context of a continuum of care from first point of engagement through treatment and into recovery. However, this claim is made on the basis of findings from one study[2] of drug arrest-referral schemes in the UK which dealt with problematic drug users requiring treatment, rather than with recreational drug users referred to drug education services

Court-prescribed drug education *(continued)*

as in the Crosscare programme. Individuals arrested for first-time or minor drug-related offences are unlikely to share characteristics or needs with the kind of clients dealt with by arrest-referral schemes such as those in the UK study. Drug education plays a peripheral part in such schemes, where the main focus is on getting individuals into treatment as an alternative to a custodial sentence.

The Crosscare report recommends that the best way to meet the drug education needs of recreational drug users in Ireland is through multi-agency partnerships, so that participants can be referred to appropriate services, such as drug treatment, housing support, mental health, primary care, training, education and employment. The author concludes that a UK programme, Dependency to Work (D2W), is a model of best practice in this regard and that agencies such as Crosscare could draw on the approaches adopted in the model if they wish to continue providing a service to individuals referred by the courts.

The comparison between the DAP and the D2W is inappropriate because the D2W programme was developed to target offenders with multiple complex needs, including problematic drug use; it was not designed to engage with individuals arrested for once-off, minor drug-related offences. Therefore, one can argue that the D2W programme is not a suitable model for dealing with the small numbers of individuals referred by the courts and engaging with the DAP.

An evaluation of the D2W programme over the five-year period 1999–2004 concluded that it was only partially successful. While the programme succeeded in getting some clients into drug treatment, it suffered implementation failure, with relations between the statutory and voluntary sectors becoming strained around issues such as assessment protocols and the sequencing of service delivery and programme management, with different actors pursuing targets that often conflicted with those of the D2W programme. Because of differences between the target groups and weakness within the D2W programme itself, it would appear that this is not an appropriate example of best practice in the case of the DAP programme.

(Martin Keane)

1. Giaquinto F (2008) *Court appointed drug education: the perspective of the voluntary sector.* Dublin: Crosscare.
2. O'Shea J and Powis B (2003) *Drug arrest referral schemes: a case study of good practice.* London: Home Office Research Development and Statistics Directorate.
3. McSweeney T and Hough M (2006) Supporting offenders with multiple needs: lessons for the 'mixed economy' model of service provision. *Criminology and Criminal Justice.* 6(1): 107–125.

George's Hill Step-Down programme for recovering drug users

In 2004, the Health Service Executive Rehabilitation/ Integration Service (RIS) and the Keltoi residential drug rehabilitation service recognised that some people who had taken part in drug rehabilitation in Keltoi did not have a secure and safe living environment to return to and were exposed to the risk of relapse. Also, some were not ready to move to independent living after rehab and needed the help of supported accommodation. Keltoi clients reported difficulties in sustaining accommodation, and at least two-thirds experienced episodes of homelessness. In response, the RIS and Keltoi, in conjunction with Focus Ireland, a voluntary service provider to the homeless, developed an inter-agency response, known as the George's Hill Step-Down programme, providing six months' supported accommodation.

The Step-Down programme has seven self-contained apartments. Clients are responsible for payment of rent and other domestic services such as electricity and phone bills. A tenancy support worker is available to clients for six months after they leave George's Hill. The RIS continues to work with individuals for at least one year to assist them to access further education, training or employment. Support is provided by a key worker, a caseworker, aftercare sessions and monthly review meetings. Day-time vocational programmes and facilitated group sessions are also provided. The latter include modules on practical skills, education, and stress management, managing accommodation, communication and health care.

The results of an external evaluation of the programme in 2007 have now been published.[1] Data were collected from 10 former and current clients, and from staff members of the three partner agencies, using semi-structured interviews.

Between the time of its launch in September 2005 and August 2007, 15 clients participated in the programme, of whom 12 completed and three left before the end of the six months. A further seven clients were on the programme during the evaluation period in 2007. Of the 22 former and current clients, 15 (68%) were male, 15 (68%) were in the 26–40 age group, and the majority (18) were single.

Of the 12 clients who had completed the programme, six were living independently, two were living with a family member or a partner and four were living in transitional housing. In addition, the evaluation reported that anecdotal information gathered by Focus Ireland key workers, either through direct contact with former clients or through RIS and Keltoi sources, suggested that all former clients remained drug free and all were in education, training, employment or were travelling.

(Martin Keane)

1. Juniper Consulting (2008) *Step-Down programme, George's Hill: evaluation report.* Dublin: Focus Ireland.

A study of 'out of home' young people in Cork city

Research by Mayock and Carr[1] highlights, once again, the association between substance misuse and homelessness. This research was designed to generate in-depth knowledge and understanding of the experiences of homelessness among young people in the south of Ireland, particularly in Cork city.

Life-history interviews were conducted with 37 young people (20 males and 17 females) between April and October 2006. Participants ranged in age from 16 to 25 years and were recruited from residential settings, emergency hostels, drop-in centres and the street. Aspects of the group profile were:

- Twenty reported a history of state care.
- Seven were either parents (3) or expectant parents (4).
- Five reported a learning disability and had attended a special school.
- Ten had left school without formal qualifications.
- The majority (21) described themselves as unemployed.
- Nine were attending a skills training scheme (FÁS).
- Twenty-four reported depression; 20 reported substance misuse; 15 reported stress or anxiety; 13 reported one or more episode of self-harm; and six reported attempted suicide.

Study objectives and key findings

The first objective was to identify young people's pathways into homelessness. Four distinct pathways were identified:

- Having spent time in state care (13 participants)
  Features of this pathway were multiple care placements in residential and/or foster care, inadequate preparations for leaving the care setting and lack of aftercare.
- Abusive family situation (10 participants)
  Characterised by abuse or violence directed at the respondent, or between other family members, creating an unstable environment.
- Family conflict (10 participants)
  Typically, these accounts described difficult relationships within the family home, often with a parent, and sometimes of long standing.
- Problematic behaviour (4 participants)
  Accounts described patterns of behaviour that led to family relationship problems, including problem substance use, criminal activity, gambling and aggression.

A second objective was to examine participants' experiences of living out of home. The experiences reported were characterised by movement from one insecure setting to another, resulting in instability and insecurity. For example, participants reported running away from home and care placements, difficulties with living in different accommodation settings and problems with tenancy sustainment in private rented accommodation. The majority of participants who accessed adult hostels experienced a sense of stigma, which confirmed a homeless identity for some. Substance misuse issues, mental health issues and learning difficulties often predominated when young people were exposed to this setting. Six participants reported moving between prisons and psychiatric hospitals, and some reported a pattern of movement between Ireland and the UK.

A third objective was to examine the challenges young people experience on becoming homeless. One of the main challenges facing participants was their use of alcohol and illegal substances. All except one of the 37 participants had consumed alcohol at some point. Thirty-one had used an illegal drug at some point, of whom two-thirds reported the use of four or more substances in their lifetime. Nine had used heroin but only two were current users. The early- to mid-teenage years was the peak period of initiation for both alcohol and illegal drug use. Substance use was associated with coping mechanisms: some participants, particularly those in hostels, tended to drink and use drugs to 'pass the time'; and many used substances to counteract anxiety and depression. Some reported using substances to 'chill out' with peers, and stated that managing their use of alcohol and drugs was important as they did not want to develop the kind of negative relations with these substances that they had often seen in their parents. A total of 22 reported either past or ongoing problems with their use of alcohol and/or drugs.

In general, substance use did not emerge as a factor leading to homelessness for the majority of the young people. However,it did exacerbate the challenges faced by some participants in their efforts to secure and sustain accommodation, and often caused crises with regard to their tenancies.

(Martin Keane)

1. Mayock P and Carr N (2008) *Not just homelessness: a study of 'out of home' young people in Cork city.* Cork: Health Service Executive South.

Substance use among Irish women expecting their first baby

Between April 2003 and May 2004 Donnelly and colleagues interviewed 1,011 Caucasian women attending a maternity hospital in Dublin city centre to determine their use of illegal drugs, tobacco and alcohol.[1] The definition of illegal drugs used in the survey is not presented in the published paper. The study participants were expecting their first baby, were less than 20 weeks pregnant and were aged between 16 and 40 years. They were interviewed at private, semi-private and public antenatal clinics. The study response rate was very high, at 95%.

Of the 1,011 women interviewed, 235 (23.5%) reported that they had taken an illegal drug at some point prior to this pregnancy. As expected, cannabis was the most commonly used illegal drug, with 214 respondents (21.2%) reporting that they had used it at some point prior to this pregnancy. Seventy respondents (6.9%) had used ecstasy at some point prior to this pregnancy, while 64 (5.8%) had used cocaine. Ninety women (8.9%) had used more than one illegal drug prior to this pregnancy. Eleven women (1.1%) had used an illegal drug during this pregnancy.

In relation to tobacco use, 574 (57%) of the women interviewed reported that they had smoked cigarettes at some point in their lives; 282 (28%) reported that they were current smokers, of whom 87 smoked more than 10 cigarettes a day.

In relation to alcohol use, 545 women (54%) said that they had drunk alcohol on at least one occasion since their first positive pregnancy test, of whom 500 (91.7%) had drunk between one and four units, 33 (5.1%) between five and 10 units and 12 (2.2%) more than 10 units.

Alcohol consumption and cigarette smoking were associated with illegal drug use: smokers were 2.8 times more likely to use illegal drugs than non-smokers, while women who drank alcohol were 1.8 times more likely use illegal drugs than non-drinkers. The type of clinic attended or the level of education achieved were not associated with the use of illegal drugs. High levels of alcohol use among pregnant women in Ireland has been reported elsewhere.

This survey does not report confidence intervals so it is not possible to estimate the prevalence of substance use among the population of women expecting their first baby.

(Jean Long)

1. Donnelly JC, Cooley SM, Walsh TA, Sarkar R, Durnea U and Geary M (2008) Illegal drug use, smoking, alcohol consumption in a low-risk Irish primigravid population. *Journal of Perinatal Medicine,* 38: 70–72.

European data-collection protocol for harm reduction agencies

Correlation, the European network on social inclusion and health, published a protocol for collecting data on harm reduction services in May 2008.[1] The main purpose of this protocol is to increase the reliability and comparability of information on harm reduction across Europe by using standardised methods to collect data on availability of and access to services.

The core element of the protocol is an agency inventory, a questionnaire to be completed by each agency describing its operational framework, characteristics and services provided. The inventory includes administrative information on staffing, management and funding, and data on the range of facilities and services offered, quality standards and data-collection routines. It also contains information on the target population and on new drug-use patterns that have come to the attention of the agency's staff in the course of their work with current drug users. The protocol includes a technical section that gives instructions on how to complete the inventory and defines the terms used.

Part I of this booklet outlines the development and piloting of the protocol. It lists core services representing different areas of activity at harm reduction agencies across Europe and describes different approaches to monitoring the level of access to these services. It also describes the field test conducted in Summer/Autumn 2007 with 15 voluntary agencies from Austria, Bulgaria, France, Hungary, Spain, Poland and Portugal, as well as by the main harm reduction agency in Iran, and presents an evaluation of the results. Part II contains the final version of the data-collection protocol.

(Jean Long)

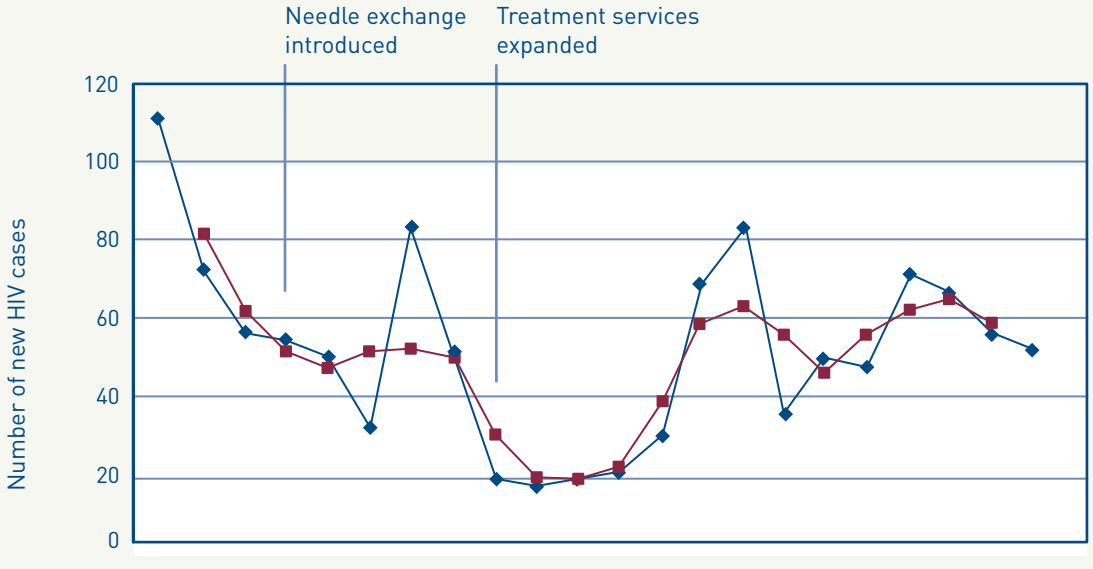
1. Working Group on Data Collection within the Correlation network (2008) *Data collection protocol for specialist harm reduction agencies.* Amsterdam: Foundation Regenboog.

New data on the incidence of HIV

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

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1985. According to the most recent report of the Health Protection Surveillance Centre (HPSC), at the end of 2007 there were 4,781 diagnosed HIV cases in Ireland, of which 1,381 (29%) were probably infected through injecting drug use.[1]

Figure 1 presents the number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland; data from 1982 to 1985 were excluded from the figure as these four years were combined in the source records. Figure 1 is based on data reported to the Department of Health and Children, the National Disease Surveillance Centre and its successor, the HPSC.[2] There was a fall in the number of new cases between 1994 and 1998, with about 20 cases per year, compared to about 50 cases each year in the preceding six years. In 1999 there was a sharp increase, which continued into 2000, with 69 and 83 new cases respectively. Annual figures for the next seven years were lower than the 2000 figure, but did not return to the levels of the mid-1990s. It was difficult to interpret the trend because of the relatively small numbers diagnosed each year, so a smoother curve (red plot line in Figure 1) was calculated using a rolling centred three-year average. This curve presents a true increase in the annual number of HIV cases in 1999; this higher level of cases was sustained between 2000 and 2007 and a new baseline derived.



	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07
◆ Actual number	112	72	58	57	50	34	82	52	20	19	20	21	26	69	83	38	50	49	71	66	57	54
■ Rolling average number		81	62	55	47	55	56	51	30	20	20	22	39	59	63	57	46	57	62	65	59	

Figure 1 Actual number and rolling average number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland, 1986 to 2007
Source: Long (2006)[2]

Of the 54 new HIV cases among injecting drug users reported to the HPSC in 2007, 35 were male and 15 were female and the average age was 31 years. All 39 cases for whom place of residence was known lived in the HSE Eastern Region (Dublin, Kildare and Wicklow).

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

(Jean Long)

1. Health Protection Surveillance Centre (2008) *Newly diagnosed HIV infections in Ireland: quarters 3 & 4 2007, and 2007 annual summary.* Dublin: Health Service Executive.
2. Long J (2006) *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005.* HRB Overview Series 4. Dublin: Health Research Board.

World Hepatitis Day

On 19 May 2008, the Blood Borne Virus Forum (BBVF) marked World Hepatitis Day with an Open Day at the premises of the voluntary agency Community Response in Dublin 8. The purpose of the event was to raise awareness about hepatitis in general and hepatitis C in particular.

Service users and health and social care professionals attended the Open Day. Nicola Perry from Community Response and Olivia Carr from the BBVF welcomed everyone. Dr Shay Keating from the Drug Treatment Centre Board at Trinity Court applauded the positive work of Community Response and other voluntary agencies over the last 10 years in raising awareness about hepatitis C. Attention was drawn to the fact that almost 20,000 Irish people could be infected with hepatitis C, and most do not know that they are infected. Information on the symptoms of hepatitis C, its routes of transmission, and testing and treatment procedures was provided using educational posters, leaflets and interactive activities.

Two short films, *Hidden I* and *Hidden II,* were shown. Both were produced by Community Response Drama Group and developed through improvisation and role play. *Hidden I* is an educational drama about drug use, pregnancy and hepatitis C, while *Hidden II* continues the story and educates the viewer about testing and treatment for hepatitis C.

A new hepatitis C awareness board game, called Hidden, and DVD were launched at the event. The board game can be played by up to 10 people and requires players to answer a possible 29 questions about hepatitis C. The questions are divided into three topics:

- Basic information
- Testing, treatment, sex and pregnancy
- Social, health promotion and support.

Dr Shay Keating of the Drug Treatment Centre Board and Dáire Ryan of Roche Products (Ireland) Limited

There were opportunities for people to play the board game on the day and to test their knowledge of hepatitis C.

Dara Ryan of Roche Products Ireland launched postcards which provided information on the risk factors for hepatitis C infection. The postcards are soon to be available in cafés nationwide. Antonia Leslie, journalist from the *Sunday Independent,* supported the event and presented members of Ban Óg in Tallaght and Youthreach on Pleasants Street with certificates for having completed a four-week health promotion course on HIV and hepatitis awareness.

(Davina Swan, researcher at UCD School of Medicine and Medical Science)

For further information on hepatitis C please contact 01 - 473 6615 or visit www.hepinfo.ie.

Health promotion plan to address HIV

On 17 June 2008 Mary Wallace TD, Minister for Health Promotion and Food Safety, launched the *HIV and AIDS Education and Prevention Plan 2008–2012,* presented by the Education and Prevention Sub-Committee of the National AIDS Strategy Committee.[1]

The Minister said that she was pleased to mark Irish AIDS Day (15 June) with the launch of this plan which demonstrates the commitment of all key stakeholders to continuing and enhanced efforts to prevent HIV and AIDS. The plan was developed over an 18-month period and was the result of a review of the evidence and a national consultation process. It will build on the report of the National AIDS Strategy Committee (2000). Under six key action areas, the plan addresses the needs of seven high-risk population groups. Injecting drug users and prisoners are identified as two such groups.

Injecting drug users

According to the authors, 'injecting is an even more effective way of spreading HIV than sexual intercourse. In most developed countries, including Ireland, the second most common transmission route for HIV is among men and women who inject drugs.' In 2006, 2,104 of the 4,992 cases entering treatment in Ireland had injected an illicit drug at some point in their lives, of whom 59% had shared injecting equipment. The proportion of injecting drug users who engage in prostitution is unknown.

In 2004 the World Health Organization acknowledged that needle-exchange programmes (which include proactive outreach and sexual health interventions) are extremely effective in reducing HIV transmission among injecting drug users.

The Plan recommends:

- continued delivery of safer injecting and sex messages through drug treatment services, drugs task force projects and relevant non-governmental organisations;
- actions to prevent drug users who do not currently inject from starting to do so;
- interventions to increase testing, screening and treatment for HIV; and
- completion of NACD research on sex work among drug users.

World Hepatitis Day *(continued)*

Prisoners

According to the authors, 'prisoners' human rights must be respected under both national and international legislation. Prisoners need protection from contracting diseases and, if infected, from any form of discrimination. Efforts to prevent infections in prisons are beneficial for inmates, staff and the wider public. Studies in the 1980s found indications that extensive HIV transmission could occur in prisons and had the potential to affect the wider community.' It is accepted that the use of drugs in prisons increases the risk of blood-borne infections. Although 'prisoners may be injecting less frequently than when outside prison, each injection is far more risky due to the scarcity of injecting equipment and hence the greater prevalence of sharing syringes.'

The authors note that in order to protect prisoners from blood-borne viral infections, HIV and HCV preventative measures must be available in prisons. 'Since the early 1990s, community needle and syringe programmes within the prison system in Europe have been evaluated and found to reduce the spread of HIV among injecting drug users without increasing drug injecting.' Other measures include the provision of appropriate broad-spectrum treatment interventions.

The Plan recommends:

- delivery of HIV information to prisoners and staff;
- provision of condoms to prisoners;
- confidential and comprehensive HIV testing for prisoners who request it; and
- review of current HIV and drug programmes with a view to linking them with similar HSE programmes.

(Jean Long)

1. Education and Prevention Sub-Committee of the National AIDS Strategy Committee (2008) *HIV and AIDS education and prevention plan, 2008–2012.* Dublin: Stationery Office.

Hepatitis B surveillance: risk factor reporting in 2007

Hepatitis B is a vaccine-preventable disease which is transmitted through contact with blood or body fluids of an infected person. The main routes of transmission are mother-to-baby, child-to-child, sexual contact and unsafe injections. The number of cases notified to the Health Protection Surveillance Centre (HPSC) increased each year between 1996 and 2005, and decreased by 7% (to 811) in 2006 (Table 1). There were 863 cases in 2007, of whom 705 had a chronic infection, 52 had an acute infection and the disease status of 106 cases was unknown. The surveillance system has recorded risk factor data since 2004, but the number of cases notified to the HPSC that include data on risk factors is low (although it had increased in 2007 when compared to 2005). In 2007 half (353) of all cases had risk factor data reported, of whom six (2%) reported injecting drug use as their main risk factor. The number of such cases remained consistently low between 2005 and 2007, indicating the effectiveness of routine administration of the hepatitis B vaccine.

(Jean Long)

Table 1 Number (%) of acute and chronic hepatitis B cases reported to the HPSC, by risk factor status, 2005–2007

	Hepatitis B status																	
	2005						2006						2007					
	Acute		Chronic		Unknown		Acute		Chronic		Unknown		Acute		Chronic		Unknown	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
All cases	72	8.2	688	78.7	114	13.0	93	11.5	659	81.3	59	7.3	52	6.0	705	81.7	106	12.3
Cases *with* risk factor data	52	72.2	218	31.7	14	12.3	70	75.3	184	27.9	5	8.5	43	82.7	297	42.1	13	12.3
Of which:																		
Injecting drug users	0	0.0	3	1.4	1	7.1	0	0.0	4	2.2	1	20.0	1	2.3	5	1.7	0	0.0
Cases *without* risk factor data	20	27.8	470	68.3	100	87.7	23	24.7	475	72.1	54	91.5	9	17.3	408	57.9	93	87.7
Total	874						811						863					

Source: Unpublished data from the HPSC

First reports of risk factors from hepatitis C surveillance

Hepatitis C is one the most common blood-borne viral infections among injecting drug users and is transmitted through contact with the blood of an infected person. The main routes of transmission are mother-to-baby, unsafe injections, transfusion of blood and blood products, and unsterile tattooing and skin piercing. Murphy and Thornton reported that 1,558 cases of hepatitis C were recorded by the Health Protection surveillance Centre (HPSC) in 2007 (Table 1), compared to 1,130 cases in 2004, and 85 cases of hepatitis 'type unspecified' in 2003.[1]

Table 1 Number of cases of hepatitis C and age-standardised rates (ASR) per 100,000 population, 2004–2007

Year	Number of cases	ASR
2004	1130	25.5
2005	1433	33.4
2006	1222	28.5
2007	1558	36.8

Source: Murphy and Thornton (2008)

Of the cases reported in 2007, 77% were notified by services in Dublin, Kildare and Wicklow and the remainder by services in HSE areas outside these counties. The authors calculated age-standardised hepatitis C rates per 100,000 of the population living in each former health board area for the years 2004 to 2007. The rate increased in all of those areas in 2007 compared to 2004, and was highest in the east (over 70 per 100,000) and lowest in the north west (at 10 per 100,000). Sixty-three per cent of hepatitis C cases reported were male. Of the cases for whom age was known, 92% were aged between 20 and 54 years.

An enhanced surveillance system for hepatitis C was introduced in Ireland in 2007. Enhanced surveillance is essential to identify risk factors and for planning prevention and treatment strategies. In 2007, 42% of newly reported hepatitis C cases had their risk factor status recorded (Table 2) (N Murphy, HPSC, personal communication, 2008). As expected, the majority of these cases (75.3%) reported injecting drug use as the main risk factor. Just over 5% of cases reported that they had been recipients of blood or blood products at some time in the past and, according to the HPSC, were late reports to the system.

Table 2 Number and percentage of hepatitis C cases reported to the HPSC, by risk factor status, 2007

	Hepatitis C	
	2007	
Risk factor status	n	%
Total number of cases	1558	
Cases *with* reported risk factor data	658	42.2
Of which:		
Injecting drug users	496	75.3
Recipients of blood/blood products	34	5.2
Other risk factors	89	13.5
No known risk factor identified by patient or doctor	39	5.9
Cases *without* reported risk factor data	900	57.8

Source: Unpublished data from the HPSC

Data from blood-borne viral prevalence studies between 1995 and 2005 indicate that around 70% of injecting drug users attending drug treatment tested positive for antibodies to the hepatitis C virus.[2] Injecting practices and prison history were associated with hepatitis C status in some of these studies.

The National Immunisation Advisory Committee and the Department of Health and Children recommended significant changes to Ireland's national childhood immunisation programme in 2008.[3] These changes, published in the revised Immunisation guidelines for Ireland in July 2008,[4] include the addition of a hepatitis B vaccine to the routine 5-in-1 childhood immunisation programme, which will now become a 6-in-1 programme. The Immunisation guidelines for Ireland 2002 recommended the hepatitis B vaccine for several high-risk groups only, including prisoners and injecting drug users, rather than for the child population.

(Jean Long)

1. Murphy N and Thornton L (2008) Epidemiology of hepatitis C infection in Ireland. *EPI-Insight,* 9(7): 2–3.
2. Long (2006) *Blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005.* HRB Overview Series 4. Dublin: Health Research Board.
3. Cotter S (2008) Changes to the Irish primary childhood immunisation programme. *EPI- Insight,* 9(8): 1.
4. National Immunisation Advisory Committee (2008) *Immunisation guidelines for Ireland.* 2008 edition. Dublin: Royal College of Physicians of Ireland.

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

In May 2008 the European Foundation of Drug Helplines (FESAT) published the results from its twelfth monitoring project.[1] Since the beginning of 2001 FESAT has been collecting information every six months on the types of person contacting helplines, the content of these calls and how this has changed compared to the previous six months. According to the author, the main objective of this monitoring is to identify early the emergence of new drugs and new drug trends; the data collected cannot quantify the size of any change. Of the 31 relevant FESAT helplines, 20 helplines in 13 European countries, including Ireland, participated in the project. This article will describe some of the main changes that were reported by the helplines during the first half of 2007.

The smallest of the 20 participating helplines answered an average of one call per day, and the largest, 121 calls. Four helplines answered five or fewer calls per day, 13 helplines answered between five and 20 calls per day, and three helplines answered 21 or more calls per day. The Drugs/HIV Helpline in Ireland answered an average of 15 calls per day, though this figure included calls about sexual health. There were 1,905 calls between January and June 2007.[2] Some European helplines provide services by email as well as by phone, which makes their advice more accessible; the Irish helpline does not have this facility.

The FESAT report notes a continuation of the upward trend in the number of calls about cannabis (6 helplines) and about cocaine (6 helplines). The number of calls about alcohol also increased. The numbers of calls about injecting heroin and about ecstasy decreased.

The Irish Drugs/HIV Helpline reported a large increase in the number of calls about intravenous heroin use in the first half of 2007 compared with the second half of 2006. There was also a large increase in the number of calls referring to benzodiazepines. There was some increase in the number of calls referring to cannabis and certain opiates (methadone, Subutex, codeine and DF118). There was no significant change in the number of calls referring to cocaine. Calls from male drug users aged between 20 and 25 years, and from parents or guardians, increased considerably during the first half of 2007. The number of calls referring to alcohol decreased.

Three helplines received calls about drugs that had not been reported to them before. A helpline in Norway reported a call about a substance called Polarmine, which is an antihistamine with sedative effects. The helpline in Belgium reported calls about LSA, or morning glory, which has hallucinogenic effects. The German helpline reported calls about fentanyl, which is a synthetic opiate. The Drugs/HIV Helpline in Ireland did not report any calls about new drugs during this period.

(Jean Long)

1. Hibell B (2008) *FESAT Monitoring Project- Changes during the first half of 2007.* Brussels: FESAT (The European Foundation of Drug Helplines).
2. Aileen Dooley provided the author with data from the Drugs/HIV Helpline in Ireland.

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

The Drugs/HIV Helpline in Ireland is a confidential, freephone, active listening service offering non-directive support, information, guidance and referral to anyone with a question or concern related to substance use or HIV and sexual health. In its 11 years, the helpline has dealt with over 48,000 calls, and it offered information on over 300 relevant services nationwide. The freephone number is 1800 459 459. The Helpline manager is Aileen Dooley (a FESAT board member).

HRB overview of suicide in Ireland

This publication, the seventh in the HRB Overview Series, looks at the rates of self-harm and suicide in Ireland from 1864 to 2006, discusses possible motives for suicide and reviews prevention measures.[1]

The author notes that suicide in Ireland has been greatly under-reported in the past, and that the recorded rate fluctuated widely in the period under review. The rate increased steadily between 1968 and 1989, and then accelerated to a peak in 1998, followed by a slow decline between 2001 and 2006.

According to the report, the incidence of suicide among Irish males is three to four times greater than that among females; this finding is in line with international research. Significant mental illness is a factor in a proportion of suicides. Alcohol consumption was found to have a link to suicide, with European research showing that as many as one in six suicides are alcohol-related.[2] The author of this overview suggests that the control of alcohol-related problems may be the only evidence-based approach to the prevention of suicide and self-harm.

The overview may be downloaded from the publications section of the HRB website at www.hrb.ie/publications. To request a hard copy of the report, email Fiona Bannon at fbannon@hrb.ie or phone +353 1 2345148.

(Simone Walsh and Suzi Lyons)

1. Walsh D (2008) *Suicide, attempted suicide and prevention in Ireland and elsewhere.* HRB Overview Series 7. Dublin: Health Research Board.
2. Anderson P and Baumberg B (2006) *Alcohol in Europe.* London: Institute of Alcohol Studies.

EU civil society forum discusses new EU action plan on drugs

On 20–21 May 2008 the Civil Society Forum on Drugs in the European Union assembled in Brussels for its second meeting.[1] Its purpose was to give constructive feedback to the European Commission for the new EU Action Plan on Drugs 2009–2012.[2]

The key points to emerge from the two-day session, as summarised in the final report, were:

- EU drug policy must be based on the principles of public health and human rights. The principles of non-stigmatisation and non-discrimination need to be emphasised.
- Co-ordination between civil society, EU institutions and member states should be strengthened and encouraged.
- Specific attention should be paid to the needs of particularly vulnerable groups, gender differences, parents, youth and adolescents, migrants, ethnic minorities and drug users.
- The new action plan should promote the development of quality standards in demand reduction, including prevention, treatment, harm reduction and social rehabilitation and reintegration.
- The quantity and quality of data collection should be improved.
- Responses to polydrug use need to be strengthened and the links between drugs, alcohol and prescription drugs should be further explored.
- The action plan should pay attention to the relationship between drug use and mental health problems.
- In co-operation with third countries, the new action plan should advocate alternative development, while taking into account poverty and social deprivation.
- The action plan should try to improve the situation in prisons, important places for prevention, education and rehabilitation programmes, and the support to drug users after release from prison.
- Efforts should be made to reduce drug-related deaths by making available treatment or harm reduction services.
- Coverage of, access to and effectiveness of drug demand reduction measures should be improved.
- Substitution programmes should be made more effective and integrated with other programmes.

In conclusion, the report outlined the steps to be taken to finalise the action plan. The European Commission will publish a draft EU action plan on drugs 2009–2012 in the third week of September. This document will go to the European Council, where it will be discussed by the Horizontal Drugs Group. By the end of the year the plan should be adopted and should be part of the conclusions of the European Council. The next civil society forum will probably be held in 2009.

(Brigid Pike)

1. Directorate-General Freedom Security and Justice (2008) *Civil society forum on drugs in the European Union, Brussels, 20–21 May 2008, Final Report.* Retrieved on 21 August 2008 from http://ec.europa.eu/justice_home/fsj/drugs/forum/docs/final_report_2008_en.pdf. For an account of the first meeting of the forum, see Randall N (2008) EU civil society forum on drugs. *Drugnet Ireland*, (25): 24.
2. The final report on the meeting states: 'The current EU Treaty gives the Commission only a limited formal legal basis on drug policy and its chief role is to represent and defend the European interest. The Commission works through consensus building and consultation, acting mainly as a facilitator between member states. Civil society representatives have direct knowledge of the reality in their countries and they can provide the Commission with realistic and useful expertise to feed into the work on the new Action Plan on Drugs 2009–2012' (p. 4).

Understanding drug-related public expenditure

In July 2008 the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published a report Towards a better understanding of drug-related public expenditure in Europe.[1] It reports on a study undertaken by the EMCDDA in conjunction with 23 member states, including Ireland, in pursuit of the aim in the EU drugs action plan 2005–2008 to produce estimates of public expenditure on drug-related issues.[2] The study tested a methodology that would facilitate the collection and comparison of drug-related expenditure across jurisdictions with different political structures and government accounting systems.

Why is understanding drug-related public expenditure important?

'Quantifying a government's drug-related expenditure is a first step in formulating an economic evaluation of drug policy interventions. This will provide information that can be used to determine whether or not intended benefits are being achieved. Once developed, a standardised classification system for this exercise will provide a useful framework for both policy decision-making and public administration accountability.' (EMCDDA 2008: p. 11)

The study found that, in general, member states have a considerable amount of information on drug-related expenditure. It estimated that the total drug-related

Drug-related expenditure *(continued)*

public expenditure in Europe in 2005 (the year chosen for investigation) was around €34 billion, which was equivalent to 0.3% of the sum of the GDP of all the countries participating in the study. This meant that on average, for each million euro of a European country's GDP in 2005, €3,000 were publicly spent on drug-related matters. This represented an average expenditure of €60 per European citizen per year.

These figures are indicative only. Budget lines on drug-related issues in member states are still too generic, too aggregated, over-inclusive, or simply unidentifiable. The methodological challenge for the EMCDDA was to develop a unified and common classification approach that would maximise the validity and comparability of results across countries. Two approaches were used – labelled and non-labelled expenditure.[3]

Labelled expenditure

Labelled expenditure is the planned ex-ante expenditure that reflects the voluntary commitment of the state in the field of drugs. It can be traced back by a detailed review of budget and/or fiscal year-end accountancy reports. Ireland emerged as the country with the highest proportion of labelled expenditure (€176.8 million, i.e. 0.32% of total public expenditure). However, the authors noted a difficulty with the Irish data in that only a small amount was recorded in public accountability documents:'… details of only around 18% of labelled expenditure are published [i.e. the Drugs Initiative under Vote Community, Rural and Gaeltacht Affairs, and an allocation for drug-related housing measures under Vote Environment, Heritage and Local Government]. The remaining 82% is either subsumed under, but clearly identifiable in, some larger published budget, or it is a clearly defined drug-related programme or activity that receives funding from a range of different labelled budgets. Many departments and agencies involved in drug-related matters do not currently have adequate reporting systems in place to capture and report this budgetary complexity. However, the data is potentially available, particularly in relation to direct expenditure by government bodies.' (pp. 12–13)

The authors noted a further difficulty in that there was no record of regionally- or locally-funded drug-related expenditure in Ireland. Funds were voted at national level and allocated by central departments and agencies for use at regional and local level. The authors commented: 'As this type of expenditure represents a significant portion of drug-related expenditure in Ireland, the issue needs to be addressed. One solution might be to record the expenditure according to both government and non-government activities, but the risk of double-counting would need to be managed.' (p. 14)

Non-labelled expenditure

Non-labelled expenditure is the non-planned ex-post public expenditure faced by the general government in tackling the drugs issue. The study used a top-down, or gross costing, approach to estimating these expenditures. Starting from overall aggregated expenditures, participating countries were invited to estimate the proportion causally attributable to drug use (Non-labelled Drug-related Expenditure = Overall Expenditure x Attributable Proportion). For example, to estimate the prison drug-related expenditures in a given country, two elements were necessary: the overall prison expenditure in the country, for a given fiscal year, and the proportion of inmates in prison because of drug-related issues. The product of the two gives a rough estimate that could be compared across different countries.

Only nine countries attempted this part of the study; Ireland did not participate as there was insufficient data. However, the findings underline the importance of attempting to estimate this type of spending. In comparing the findings on labelled and non-labelled expenditures on health and on public order and safety, the authors reported that labelled expenditure on health exceeded that on public order and safety, whereas non-labelled estimations suggested that public order and safety spending exceeded that on health. The authors concluded:

… despite public order and safety functions attaining higher levels of expenditure than health functions, health expenditure is more present in accountancy documents. Thus it can be said that, in general, health expenditure on drug-related issues is more distinct than expenditure allocated to law enforcement issues. Although this can easily be explained by the fact that expenditure on public order and safety tends to be embedded in broader and more general programmes of action against crime, one must remember that an assessment of the efficiency of government action is not feasible without a clear and well-defined formulation and classification of expenditure, where costs are properly identified in the relevant budget appropriations. The budget is the financial mirror of government policy; if the budget excludes important expenditure, there can be no assurance that scarce resources are allocated to priority programmes and that proper control and public accountability are enforced. (p. 23)

The authors concluded that the twofold methodology proposed and implemented by the EMCDDA, although preliminary, had proved to be 'feasible and scientifically robust' and called for the work to continue.

(Brigid Pike)

1. European Monitoring Centre for Drugs and Drug Addiction (2008) *Towards a better understanding of drug-related public expenditure in Europe.* Selected issue. Lisbon: Office for Official Publications of the European Communities.
2. In Ireland, the Alcohol and Drug Research Unit (ADRU) of the HRB, the Irish national focal point of the EMCDDA, undertook the necessary data-collection and reporting work. The report on the Irish findings is available in the National Report 2007 at www.ndc.hrb.ie/ebooks.php?msel=4
3. This article describes the data-collection and validation methodology that was tested. It does not discuss the approaches that were used to compare expenditures across countries; these approaches included classifying expenditures by governmental function and by drug programme.

Drug policy priorities during the French EU Presidency

In the work programme for its six-month EU Presidency, between 1 July and 31 December 2008, the French Presidency states with regard to illicit drugs that, within the context of making Europe safer for its citizens:

> ... it will be the task of the French Presidency, on the basis of a proposal by the Commission, to bring work on a new EU action plan for the 2009–2012 period to completion. On actions aimed at countries or regions particularly affected by trafficking in narcotics or chemical precursors, it will pay special attention to the Western Mediterranean, where it will propose the creation of an Anti-drugs Coordination Centre, to be known as CECLAD-M. Arrangements for a closer dialogue with Western Africa, which has become a significant transit region for cocaine from South America, will also be explored. [1]

Under the heading 'Commitment to youth', the French Presidency states that it will also pay 'special attention … to the problem of addiction among young people'.

The website of the French government's inter-ministerial mission against drugs (MILDT) identifies two priorities in the drugs area during the French Presidency: (1) facilitating the negotiation of the new EU drugs action plan, and (2) preparing a unified EU position for the next session of the Commission on Narcotic Drugs (CND) in Vienna in March 2009, when the international approach to the drugs issue to succeed the UN's 10-year action plan 1998–2008, will be worked out. In pursuing these objectives, it hopes to strengthen co-operation with third-world countries in combating drugs, and to explore how to enhance the impact of drug policies and to increase public awareness of the policies.[2]

In line with its two priorities the French government has identified three goals:

- to strengthen the stature and political authority of the Horizontal Drugs Group (HDG), in line with the expectations set out in the EU Dugs Strategy 2005–2012;[3]
- to produce an EU drugs action plan 2009–2012 that will have a demonstrable impact across EU member states; and
- to have an agreed EU position at the CND session in Vienna in March 2008 that will add value both to Europe's and to the international community's drug policies

With regard to the HDG and the new action plan, the French will consider the following approaches:

- undertaking a shared analysis on the state of the drugs threat
- simplifying and narrowing the focus of the new drugs action plan
- strengthening the judicial component of drug control co-operation between member states and other countries
- strengthening systems for identification, confiscation, and sharing information on known criminals
- reviewing the HDG with a view to including alcohol within its purview
- better informing the public about drugs
- studying means of spreading primary prevention messages to young people using new media

With regard to external relations, the French will seek dialogue with traditional and with new partners. The focus of these dialogues will be on strengthening the profile of the drug problem in Europe and improving the effectiveness of joint actions.

(Brigid Pike)

1. French Presidency of the Council of the European Union (2008) Work programme 1 July–31 December 2008. Retrieved on 19 August 2008 at www.ue2008.fr
2. This account is based on the information provided on the website of the Mission Interministerielle de Lutte Contre la Drogue et la Toxicomanie (MILDT) at www.drogues.gouv.fr. The information was retrieved on 19 August 2008. A literal translation in to English of the information is available on the website of the International Drug Policy Consortium www.idpc.info. This translation was also retrieved on 19 August 2008.
3. The Horizontal Drugs Group (HDG) is the EU Council's main technical and policy forum to facilitate joint efforts between member states and the European Commission. It meets about once a month, bringing together representatives from member states and the Commission, with a view to analysing, taking measures on and seeking to co-ordinate the drug-related activities of the EU.

International Harm Reduction Association 2008 conference

The International Harm Reduction Association (IHRA) 19th international conference took place on 11–15 May 2008 in Barcelona, Spain. The IHRA promotes evidence-based harm reduction policies and practices on a global basis for all psychoactive substances (including illicit drugs, tobacco and alcohol).

The conference was attended by 1,280 people from some 80 countries. The programme included the screening of 30 film documentaries from around the world as part of the 5th International Drugs and Harm Reduction Film Festival, which was hosted by the conference. At the opening session, the IHRA launched the first in a series of major publications from its new HR2 (Human Rights and Harm Reduction) programme.[1]

The conference theme was to promote a global approach to the policy and practice of harm reduction. The IHRA executive director, Dr Gerry Stimson, addressed this topic in a plenary session and reported that 82 countries currently support or tolerate harm reduction responses; 77 operate needle- and syringe-exchange services and 63 provide opioid substitution treatment. He said that, despite these advances, obstacles remain to the universal implementation of harm reduction, such as the adoption by countries of a 'war on drugs'. He stressed the need for a global approach to increasing the coverage of harm reduction services.

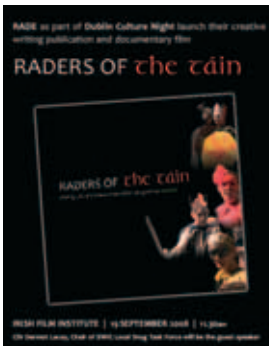
Acknowledging that most harm reduction interventions target opiate-injecting drug use, Dr Stimson pointed to the need for improved interventions to reduce the harm associated with the use of other drugs (including alcohol and tobacco).

The conference programme offered a wide range of experiences and evidence from around the world. The Irish researcher Paula Mayock spoke about an ethno-epidemiological approach to understanding and reducing drug-related harm, as used in her study on the initiation of heroin use among high-risk youth in Ireland. Mayock reported three pathways to initiation: criminal careers, intimate relationships, and homelessness.[2]

Log onto www.ihra.net to view the list of abstracts and presentations from this conference. The 20th IHRA conference will take place in Bangkok, Thailand, on April 19–23 2009. The conference theme will be 'Harm reduction and human rights'.

(Janet Robinson)

1. Cook C and Kanaef N (2008) *The global state of harm reduction 2008: mapping the response to drug-related HIV and hepatitis C epidemics.* London: International Harm Reduction Association.
2. Mayock P (2002) Drug pathways, transitions and decisions: the experiences of young people in an inner-city Dublin community. *Contemporary Drug Problems,* 29(1): 117–156.



Film launch by RADE group

RADE (recovery through art, drama and education) was established in August 2004 as an innovative programme for recovering drug users. Its purpose is to help participants 'find a path forward into personal development and education through participation in the arts'.

Raders of the Tain, a documentary film and book by RADE was launched by Cllr Dermot Lacey, Chairperson of South West Inner City Local Drugs Task Force, as part of Dublin Culture Night on Friday 19 September in the Irish Film Institute, Temple Bar. The documentary illustrates how the RADE scheme works to develop, motivate and guide participants through recovery.

In brief

On 19 May 2008 the **Archways National Conference on the Incredible Years Programme** was held in Dublin. The programme is designed to prevent and treat emotional and behavioural difficulties in children aged 3–10 years. It is being rolled out in Ireland and evaluated by Archways, which promotes and researches evidence-based programmes as interventions for such young people. The Minister for Children, Barry Andrews TD, who opened the conference, said: 'The Government and HSE are committed to rebalancing child welfare services towards early intervention and family support measures. Working with children within their own families and communities is in the best interests of children and is an important factor in ensuring that they reach their full potential'. www.archways.ie

In June 2008 **Eurostat**, the Statistical Office of the European Communities, issued figures on household expenditures, based on the 2005 Household Budget Survey in the 27 member states. The data show that, at 4.1%, household expenditure on alcoholic beverages in Ireland in 2005 was the highest in the EU. The mean EU27 level was 1.2%. It should be noted that the relative level of expenditure in each member state does not simply reflect the level of consumption, but also price levels and the overall level of household expenditure. http://ec.europa.eu/eurostat

On 5 June 2008 ***Alcohol and the Emergency Department – making the difference,*** a new training resource for emergency department staff and the first of its kind to be developed in Ireland, was launched in Cork University Hospital. Developed by the HSE South's emergency department, liaison psychiatry and health promotion staff, the training DVD and associated posters and booklet have been produced to encourage emergency department staff to safely and supportively raise the issue of alcohol use with patients admitted with an alcohol-related injury or illness. www.hse.ie

On 23 June 2008 the **Drug Policy Action Group (DPAG)** published the third in its series of policy papers, entitled **Key issues for drugs policy in Irish prisons.** Author Paul O'Mahony concludes his analysis of the issues with a list of things that should happen 'in order to achieve a more rational, effective and rehabilitative prison system'. They include adjusting current sentencing policy and reducing the number of minor, non-violent, drug-using offenders being sent to prison for short terms, and an increased use of the Drug Court; mandatory drug treatment outside prison and non-custodial sanctions; less emphasis on supply control in prisons and more on reducing the harms caused to prisoners by the current drugs culture in prisons; a greater focus on abstinence-based treatments than on methadone substitution; and improved prison conditions and provision of an environment conducive to the general rehabilitation of offenders. www.drugpolicy.ie

On 26 June 2008, **International day against drug abuse and illicit trafficking**, the UN Secretary-General, Ban Ki-Moon, issued the following message: 'We still have much work to do to reduce our vulnerability to drugs. States with weak criminal justice systems and limited law enforcement capabilities need assistance to reduce illicit drug trafficking, which spreads crime, corruption and instability, and which ultimately endangers the successful realization of the Millennium Development Goals. As we mark the 60th anniversary of the Universal Declaration of Human Rights, I remind all Member States of their responsibility to fully respect the rights of prisoners who are drug dependent or are in custody for drug-related crimes, especially their rights to life and a fair trial. I also call on Member States to ensure that people who are struggling with drug addiction be given equal access to health and social services. No one should be stigmatized or discriminated against because of their dependence on drugs.' www.unodc.org

On 26 June 2008 the ***World drug report 2008***, compiled by the United Nations Office on Drugs and Crime (UNODC), was published. This annual publication provides detailed estimates and trends on production, trafficking and consumption in the opium/heroin, coca/cocaine, cannabis and amphetamine-type stimulants markets. This year's edition reports that 'the drug problem is being contained but there are warning signs that the stabilisation which has occurred over the last few years could be in danger. Notable amongst these is the increase in both opium poppy and coca cultivation in 2007, some growth in consumption in developing countries and some development of new trafficking patterns. There have also been encouraging contractions in some of the main consumer markets.' This year, almost one hundred years since the Shanghai Opium Commission in 1909, the report also gives a historical review of the development of the international drug control system. www.unodc.org

On 26 June 2008 the **European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)** released **A cannabis reader: global issues and local experiences — perspectives on cannabis controversies, treatment and regulation in Europe.** Leading European experts provide informed insight into a wide range of cannabis topics, from political, legislative, economic and social developments to prevention, treatment and healthcare. www.emcdda.europa.eu

On 30 July 2008 the **UK Drug Policy Commission** published **Tackling drug markets and distribution networks in the UK: a review of the recent literature.** This review found that UK drug markets are extremely resilient and increasing drug seizures have had little street-level impact. Despite hundreds of millions of pounds spent each year on UK drug enforcement activity, there is remarkably little evidence of its effectiveness in disrupting markets and reducing availability. The available evidence supports a local partnership approach that focuses on reducing the impact of drug markets as felt by communities. www.ukdpc.org

(Compiled by Brigid Pike)

From *Drugnet Europe*

EMCDDA publishes cannabis reader

Cited from Drugnet Europe No. 63, July–Sept 2008

On International day against drug abuse and illicit trafficking the EMCDDA released its largest scientific monograph to date: *A cannabis reader: global issues and local experiences – perspectives on cannabis controversies, treatment and regulation in Europe.* In two volumes, and over 700 pages, leading European experts provide informed insight into a wide range of cannabis topics: from political, legislative, economic and social developments to prevention, treatment and healthcare.

The monograph describes the concerns expressed, particularly at UN level, that a 'soft line' on cannabis could endanger the overall international effort against drugs. It also traces recent developments in some countries where the balance is 'tipping back' in favour of more restrictive measures.

For the monograph, summary and news release, see: www.emcdda.europa.eu/events/2008/26june

New report on drug-related public expenditure

Article by Luis Prieto and Marie-Christine Ashby in Drugnet Europe No. 63, July–Sept 2008

Producing estimates of drug-related public expenditure is one of the many targets set by the current EU drugs action plan (2005–08). In this light, the EMCDDA launched in July its latest Selected issue publication focusing on Drug-related public expenditure in Europe.[1] Testing a new methodology, combining 'labelled' and 'unlabelled' expenditure,[2] the report presents preliminary estimates of how much European governments are spending on the drugs problem. While figures should be used with caution (methodology needs refining; data remain patchy), estimates from reporting countries, extrapolated to European level, arrive at a total cost of drug-related public expenditure in 2005 of EUR 34 billion. This represents an average expenditure of EUR 60 per European citizen per year.

A considerable amount of quality information is available in Europe on drug-related public expenditure (mostly labelled). One observation made in the report is that the disbursements identified so far mainly refer to public spending at central government level. The future inclusion of sub-national government expenditure on drugs would therefore certainly result in higher figures.

1. EMCDDA (2008) *Towards a better understanding of drug-related public expenditure in Europe.* Selected issue. Luxembourg: Office for Official Publications of the European Communities. Available online at www.emcdda.europa.eu
2. 'Labelled expenditure' refers to planned spending, reflecting a state's voluntary commitment in the drugs field. It can be traced by reviewing official accountancy documents over a given period. 'Unlabelled expenditure' refers to unplanned spending and is estimated through modelling techniques. The twofold approach aims to provide more comprehensive and accurate estimates of public spending in tackling drugs and drug addiction Europe-wide. See *Drugnet Europe* No. 61.

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

Recent publications

Journal articles

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

Opiate-dependent adolescents in Ireland: a descriptive study at treatment entry

Fagan J, Naughton L and Smyth B
Irish Journal of Psychological Medicine 2008; 25 (2): 46–51

The aim of this research is to describe the drug history and psycho-social problems among under-19s accessing treatment for opiate dependency, including methadone maintenance, and examine for any gender differences. A descriptive study of under-19s at the largest drug treatment clinic in Dublin was undertaken between October 2000 and September 2006. Data were gathered by reviewing case notes, assessment questionnaires and urine drug screens.

In total, 86 young people were included. Their mean age was 16.8 years. Forty-six (54%) were female. Only 26 (30%) reported an intact family of origin. Twenty-three (27%) had spent time in care. Mean age for first use of any illicit drug was 12.4 years, and for heroin was 14.8 years. The mean age of leaving school was 14.4 years; 42 (49%) first tried heroin after leaving school. Forty-one (48%) had a history of homelessness. Forty-four (51%) had previously injected; 26 (30%) were currently injecting. Fifty-six (65%) had not been screened for blood-borne diseases; 21 (24%) subsequently tested positive for hepatitis C. Thirty-eight (48%) had

Recent publications *(continued)*

previous convictions; 33 (38%) were facing charges. Forty-five (52%) had previously seen a psychiatrist; nine (11%) had received inpatient psychiatric treatment. In terms of gender difference, boys were more likely to leave school early, have a substance-abusing sibling, and to have a past conviction. Girls were more likely to have a partner, and to have taken a deliberate overdose.

This study highlights the complex and multiple needs of opiate-dependent teenagers. In order to meet their needs, services will require a broad range of interventions and excellent interagency co-operation.

Childhood adversity and substance misuse

Ambreen Taj A, Keenan E and Casey P
Irish Journal of Psychological Medicine 2008; 25(1): 29–30

There is a strong link between childhood adversity and subsequent substance misuse. The authors describe a case of childhood adversity consisting of physical and sexual abuse, experience of homelessness in childhood and adulthood, intimate partner violence and polysubstance misuse in a 32 year-old woman currently attending the methadone maintenance programme in the Drug Treatment Centre Board, Trinity Court, Dublin. Relevant literature is reviewed in relation to the aetiology and symptoms of this complex case.

Alcohol use and misuse in older people: a local prevalence study comparing English and Irish inner-city residents living in the UK

Rao R, Wolff K and Marshall E J
Journal of Substance Use 2008; 13(1): 17–26

Alcohol consumption was assessed among Irish and English men and women aged 65 and over living in an inner-city area of London, using Quantity/Frequency measures and validated questionnaires (SMAST-G, 10-item AUDIT, SF-36). Sixty subjects with a mean age of 77.5 years were recruited. English subjects showed greater changes between lifetime and last-year drinking patterns. Irish subjects had a significantly higher mean AUDIT score and were significantly more likely (14/30 vs. 3/30) to have a family psychiatric history. Irish subjects were more likely to drink at least once a week, showed a higher mean alcohol intake (6.4 vs. 2.4 g) over the previous year and were more likely to show binge drinking (8/30 vs. 1/30) and drinking above sensible limits (8/30 vs. 1/30). The main implication of the study is that closer attention is required in screening for alcohol use in older Irish men in the UK.

The normalisation of substance abuse among young Travellers in Ireland: implications for practice

Van Hout MC and Connor S
Journal of Ethnicity in Substance Abuse 2008; 7(1): 5–21

The aim of this exploratory study was to assess the nature and extent of drug use among a group of 12–18-year-old Travellers in the south east of Ireland. The results are intended to inform Irish policy by providing data on patterns of youth drug use, drug-related risk behaviours, the impact of drug use on the Traveller community and issues regarding access to services. In terms of drug use and attitudes, young Travellers demonstrated similar trends to 'settled' adolescents. However, they reported poor levels of health awareness and knowledge of drug services. The authors conclude that the social exclusion of young Travellers puts them at risk of problem drug use, due to issues of poor literacy levels, family crisis, discrimination, poor knowledge of service provision relating to drug education and treatment, and the location of halting sites in areas of high drug usage.

The impact of opiate dependence on parenting processes: contextual, physiological and psychological factors

Hogan D
Addiction Research & Theory 2007; 15(6): 617–635

This article examines how dependence on opiates affects parenting capacity and family processes. The findings are based on in-depth, semi-structured interviews with 100 parents (50 drug-using [opiate dependent] and 50 non-drug-using) living in Dublin. Qualitative analyses suggest that opiate dependence has a specific impact on parenting processes and particularly on the physical and emotional availability of parents and on parental capacity to provide an emotionally consistent environment. The implications for children's development and well-being, and for support of affected families, are considered. The authors recommend further study on the implications of parental drug use for children's well-being and development.

A community perspective of cocaine use in Ireland: A brief exploratory study

Van Hout MC
Contemporary Drug Problems 2007; 34(1): 103–110

The aim of this exploratory research was to document perceptions of the extent of cocaine use in an inner-city community (of 4,000 households) in Ireland. The study was undertaken in response to community concern at an apparent increase in the availability of cocaine, increased cocaine use as social activity, and the destructive impact on both individual and community. Relevant individuals were interviewed, including: drug-service providers, An Garda Síochána, youth workers, drug counsellors, family-support workers, general practitioners, hospital personnel, night-club owners, publicans, parents and carers, taxi drivers, doormen, community workers, money advice and lending services, outreach workers, prison liaison officers, politicians and a small number of key informants considered to have experience of and insight into common and preferred drug-taking practices in the community.

This research indicates an increased prevalence of polydrug cocaine use among groups of recreational drug and alcohol users, as well as polydrug use among those attending the methadone clinic. This represents a significant challenge for drug education, prevention, and treatment services in this community.

(Compiled by Louise Farragher)

Upcoming events

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

October

2–4 October 2008
19th Annual Conference European Society for Social Drug Research
Venue: Budapest, Hungary
Organised by / Contact: Bernadette Kun, ESSD
Tel: +36 1 237 6732
Email: kun.bernadette@ndi-int.hu

Information: Papers presented will address the following topics :

- **How to collect qualitative data**
  Innovative methodologies. Indigenous fieldwork. Observational studies. Gaining access and gate keepers. Do's and don'ts of snowball sampling.
- **Trends and patterns in drug use**
  'New' drug trends, new users or 'old' drugs. Changing patterns of drug use and changing users' profiles. Similarities and differences in drug use across Europe. Including new EU member states.
- **Drug markets**
  Availability and access to drugs. How and where users get/buy drugs. The structure of drug dealing networks. The dynamics of drug trafficking and drug control.
- **Attitudes and opinions**
  Risk perception. Reasons to use or not use drugs. Opinions about drug policy. Attitudes towards drugs and drug users in the general population and among professionals.
- **Theories and concepts**
  The meaning of theoretical concepts such as normalisation, marginalisation, harm reduction and demand reduction. Theory and concept analysis.

6–8 October 2008
11th International Symposium on Substance Abuse Treatment
Venue: Växjö University, Sweden
Organised by / Contact: European Working Group on Drug Oriented Research (EWODOR) and European Federation of Therapeutic Communities (EFTC)
Email: ylva.benderix@vxu.se
www.vxu.se/iped/events/international_symposium

Information: Attendees will explore the obstacles and possibilities of knowledge development within this field. One aim is to gather both researchers and practitioners within the field of substance abuse treatment in Europe. The conference will be hosted by The Institute for Development of Knowledge about Treatment of Substance Misuse (IKM) at Växjö University. The three themes of the symposium are:

- Knowledge for evidence – when and how?
- Science – how to assure quality and cost effectiveness?
- Practitioners' knowledge – how to make it visible?

13–15 October 2008
The Fourth European Association of Addiction Therapy Conference
Venue: Convitto della Calza, Florence, Italy
Organised by / Contact: European Association of Addiction Therapy (EAAT)
Email: info@eaat.org
ww.eaat.org

Information: EAAT was developed to create dynamic annual conferences covering all topics relating to addiction. EAAT provides a focus for understanding the scientific, medical and social bases of addiction, and a discussion forum to further develop relevant therapies throughout Europe. EAAT also provides a central platform through which information can be disseminated across country and cultural boundaries. EAAT 2007 was attended by over 400 people from nearly 30 countries. The 2008 conference programme contains plenary lectures as well as a choice of interactive seminars.

18 October 2008
Getting it right – Alcohol and Drugs Prevention Education in Primary Schools: The Way Forward
Venue: Red Cow Moran Hotel, Dublin
Organised by / Contact: Substance Misuse Prevention Programme (Walk Tall) and Dublin West Education Centre
Tel: +353 1 452 8017
Email: walktall@eircom.net
www.walktall.ie

Information: This conference is open to primary school principals, SPHE co-ordinators, teachers and others with an interest in alcohol and drugs prevention within the context of the primary school curriculum. The registration form is available on the website. There is no charge for the conference, but it is advisable to book early as places are limited. Speakers include:

- Dr Harry Sumnall, Liverpool John Moores University
- Dr Gregor Burkhart, European Monitoring Centre for Drugs and Drug Addiction
- Dr Mark Morgan, St Partick's College, ESPAD
- Jayne Simms & Deborah Trainor, Education and Library Board, NI.

Afternoon workshops include:

Martin Keane, HRB
The role of theory in planning drug education: unpacking contested assumptions that underpin your work in contemporary society

Ruby Morrow, Psychologist
How teachers can support children affected by alcoholism and drug addiction

Esther Wolfe, HSE
Alcohol, drugs and young people: influences, risk and protective factors

Mary Hough, SMPP
Does alcohol and drugs prevention education raise child protection issues?

Ursula Smyth, SMPP
Implementing the Walk Tall programme: key issues for teachers/schools

Upcoming events *(continued)*

18 October 2008
Family Focused Drug Prevention
Venue: Dublin Castle, Ireland
Contact/Organiser: Bernie Mc Donnell, Community Awareness of Drugs (CAD)
Contact the CAD office for invitation
Tel: +353 1 679 2681
Email: bmcdonnell@cadaboutdrugs.ie
www.cadaboutdrugs.ie

Information: This event is a CAD 25th anniversary update day for parents and guests.

23 October 2008
Fresh Challenges
Venue: Purcell House Conference Centre, All Hallows College, Dublin
Contact/Organiser: Bernie Mc Donnell, Community Awareness of Drugs (CAD).
Download the registration from the CAD website.
Tel: +353 1 679 2681
Email: bmcdonnell@cadaboutdrugs.ie
www.cadaboutdrugs.ie

Information: This event is a CAD 25th anniversary education day for community workers.

27–28 October 2008
2008 National Conference on Injecting Drug Use
Venue: Novotel London West, Hammersmith
Organised by / Contact: Exchange Supplies
Tel: +44 (0)1305 262244
Email: info@exchangesupplies.org
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:

- 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
Society for the Study of Addiction Annual Symposium 2008: Addiction Across the Lifespan
Venue: Park Inn, York, UK
Organised by / Contact: Society for the Study of Addiction
www.addiction-ssa.org

Information: Symposium session themes include: addiction – routes in, routes out; natural recovery and self-change; wider impacts; and outcomes. In a special parallel session, Tom Babor will speak on Alcohol and Public Policy: A Report on the 2nd Edition of *Alcohol: No Ordinary Commodity,* covering:

- Recent epidemiological research in alcohol policy
- The role of the alcoholic beverage industry in alcohol problems and public policy
- Recent developments in intervention research: including pricing and taxation, regulating physical availability, drink-driving countermeasures, regulation of alcohol promotion, treatment and prevention/ education
- New effectiveness ratings for alcohol-related intervention

16–20 November 2008
International Society of Addiction Medicine. 10th Annual Meeting
Venue: Westin Grand, Cape Town, South Africa
Organised by / Contact: International Society of Addiction Medicine
www.isam2008.com

Information: The theme of the 10th ISAM Annual Scientific meeting is 'Understanding Addictions and Providing Comprehensive Care'. The theme is resonant with the need to provide knowledge to those affected by addictions and to make care accessible to all who need it. ISAM, in collaboration with national and international organisations, hopes to make this meeting a memorable experience in terms of delivering evidence-based information on how to manage addictive disorders, how to plan community and hospital services, and how to promote advocacy for education and skills development in management of substance abuse and other addictions.

21 November 2008
Protecting Young People, Families and Communities: Evidence Based Responses to the New Drugs Strategy
Venue: Holiday Inn, Liverpool, United Kingdom
Organised by / Contact: Centre for Public Health, Liverpool John Moores University
Email: l.wilkinson@ljmu.ac.uk
www.drugpreventionevidence.info/web/Conferences248.asp

Information: With the introduction of the new UK National Drugs Strategy and Action Plan (Drugs: protecting families and communities) the Government has emphasised the importance of providing timely support for young people, families, and their communities. Increasingly, emphasis is placed on evidence-based approaches, although developing and delivering interventions based on research is difficult. This is particularly challenging when faced with a range of evidence from different disciplines and of different

Upcoming events *(continued)*

quality. This conference will present the latest evidence and understanding on a range of young people's substance use issues. It will present policy discussions, examples from practice, theory-driven interventions, and wider discussions of the role of substance use in young people's lives today.

March 2009

2–3 March 2009

Third Annual Conference of the International Society for the Study of Drug Policy
Venue: Vienna, Austria
Organised by / Contact: International Society for the Study of Drug Policy (ISSDP)
Email: enquiries@issdp.org
www.issdp.org

Information: The third annual conference of the ISSDP will be hosted by the United Nations Office on Drugs and Crime. Researchers interested in contributing papers that advance analysis of any aspect of drug policy are invited to submit abstracts to the conference organisers. The conference will be of interest to a wide array of disciplines including anthropology, economics, epidemiology, political science, public health and sociology. Participants in previous conferences have come from a variety of institutional backgrounds: universities, national and international agencies active in drug policy and independent research institutions. Practitioners who consider themselves consumers rather than producers of policy-relevant research should also find the conference of interest; they will be particularly welcome as discussants of papers at each session.

25–27 March 2009

Joining the Dots: Criminal Justice, Treatment and Harm Reduction: 1st Conference of the Connections Project
Venue: Krakow, Poland
Organised by / Contact: European Institute of Social Services
www.connectionsproject.eu/conference2009

Information: This first European conference will facilitate the introduction and promotion of more effective, comprehensive, evidence-based policies and services to respond to drugs and infections in prison and within the wider context of the criminal justice system. The conference will build on the learning and networks developed through previous conferences of ENDIPP (the European Network on Drugs and Infections in Prison). It will examine how responses to drugs and infections can incorporate treatment and harm reduction across the criminal justice system. The event is organised together with the Conference Consortium and will combine plenary sessions, presentations and workshops and provide space for networking and sharing of experiences among European and international experts and practitioners in the field.

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 the HRB series 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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