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New data on crack and cocaine use

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Trends in drug-related deaths in Ireland

The Health Research Board published the first analysis of data from the National Drug-Related Deaths Index (NDRDI) in November 2008.[1] The NDRDI is an epidemiological database which records cases of death by drug and alcohol poisoning and deaths among drug users and alcoholics. The NDRDI was established in September 2005 to comply with Action 67 of the current National Drugs Strategy.[2] The aim of this action was to put in place a system for recording drug-related deaths to enable the State to respond in a timely manner, with accurate data, on drug-related deaths and deaths among drug users.

Ena Lynn and Simone Walsh (NDRDI) chatting to Enda Connolly, chief executive of the HRB (Photo: Fennell Photography)

In order to ensure a complete and accurate database, the NDRDI records information from several different sources: the Coroner Service, the acute hospital sector through the Hospital In-Patient Enquiry scheme, the Central Treatment List (CTL) and the General Mortality Register. Only deaths which were either directly or indirectly attributable to drug use are included in the analysis presented in this first NDRDI publication.

Directly drug-related deaths (poisonings) are deaths in individuals directly due to the toxic effect of the consumption of a drug and/or other substance. Deaths arising from adverse reactions to prescribed medication are not included in the NDRDI. Indirectly drug-related deaths (non-poisonings) are deaths in individuals with a history of drug dependency or non-dependent abuse of drugs (ascertained from toxicology results, CTL, medical or coronial records) whether or not the drug use was directly implicated in the death.

Between 1998 and 2005, a total of 2,442 drug-related deaths were entered on the NDRDI database. Of these, 1,553 were poisonings and 889 were non-poisonings (Table 1). The annual number of deaths by poisoning increased from 242 in 1998 to 400 in 2005.

Table 1 Poisonings and non-poisonings by year of death, 1998 to 2005 (N = 2,442)

	1998	1999	2000	2001	2002	2003	2004	2005
	242	271	261	276	336	296	360	400
Poisonings (n = 1553)	178	187	182	175	210	184	205	232
Non-poisonings (n = 889)	64	84	79	101	126	112	155	168

Two-thirds (1,047, 67%) of deaths by poisoning in the eight-year period were male and more than half were in people aged 20 to 40 years. Over half (839, 54.0%) were due to two or more drugs and/or substances. Opiates (heroin, methadone, analgesics containing an opiate compound, and other unspecified opiates) were responsible for many of these deaths. Opiates accounted for 43% (305) of single-drug poisonings and were involved in 67.3% (565) of polysubstance poisonings.

Cocaine, alone or in conjunction with another drug, was implicated in 100 deaths by poisoning over the period, an increase from five in 1998 to 34 in 2005.

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Drug-related deaths *(continued)*

Authors: Jean Long, Simone Walsh, Suzi Lyons and Ena Lynn at the launch of the NDRDI report (Photo: Fennell Photography)

Prescription and over-the-counter medications were implicated in many of the deaths by poisoning. Benzodiazepines played a major role in polysubstance poisonings, and were involved in 30% of all deaths by poisoning.

Overall, alcohol in conjunction with another drug or substance was involved in one-quarter (380, 24.5%) of all deaths by poisoning. This is an underestimation of the total number of alcohol-related deaths as cases of poisoning by alcohol alone are not included in this analysis.

Since 2003, the annual number of deaths by poisoning outside Dublin has surpassed the number reported in Dublin (city and county), illustrating that drug use is now a nationwide issue.[3]

Calculating indirectly drug-related deaths allows, for the first time, the illustration of the total burden of mortality related to drug use in Ireland. The number of deaths indirectly related to drug use increased over the period, from 64 in 1998 to 168 in 2005. This may be an underestimation of the true figures, as details of drug using history are not always recorded in cases of death indirectly related to drug use. The number of non-poisoning deaths increased steadily over the reporting period both inside and outside Dublin.

The number of non-poisoning deaths reflects the increasing numbers of people in the population who are consuming drugs, taking risks, developing dependencies, or who have developed other illnesses associated with drug use.

(Suzi Lyons, Ena Lynn and Simone Walsh)

This report may be downloaded from the publications section of the HRB website at www.hrb.ie.

1. Lyons S, Lynn E, Walsh S and Long J (2008) *Trends in drug-related deaths and deaths among drug users in Ireland, 1998 to 2005.* HRB Trends Series 4. Dublin: HRB.
2. Department of Tourism Sport and Recreation (2001) *Building on experience: National Drugs Strategy 2001–2008.* Dublin: Stationery Office.
3. National Advisory Committee on Drugs and Public Health Information and Research Branch (2008) *Drug use in Ireland and Northern Ireland 2006/2007. Drug prevalence survey: Regional Drugs Task Force (Ireland) and Health and Social Services Board (Northern Ireland) results.* Bulletin 2. Dublin: NACD.

Suzi Lyons presenting the media briefing at the launch of the NDRDI report (Photo: Fennell Photography)

Crack cocaine in the Dublin region

On October 22 the Alcohol and Drug Research Unit of the Health Research Board (HRB) launched *Crack cocaine in the Dublin region: an evidence base for a crack cocaine strategy* on board the naval vessel the *LE Eithne*.[1] The research was commissioned by the Intersectoral Crack Cocaine Strategy Group in response to a number of seizures of crack cocaine made by An Garda Síochána in the north inner city.

The report indicates that the number of people using crack in Ireland remains low, with current users representing just 1% of drug users who present for treatment and 0.1% of the general population. However, the report also makes the point that, despite targeted garda interventions, crack use has increased and availability has spread throughout the Dublin region. Launching the report, Minister of State John Curran TD said: 'It is good news that the crack cocaine market has not taken hold in Ireland to the extent it has in other countries. However the report highlights the need to remain vigilant to ensure that this remains the case.' The Minister also stated that the report will be central to the development of a timely strategic response through the new National Drugs Strategy which is being developed for 2009–2016.

Authors: Jean Long, Anne Marie Carew, Johnny Connolly, Sinead Foran and Anne Marie Donovan with Minister John Curran TD (centre) and Fergus McCabe (r) at the launch of the crack cocaine report (Photo: JJ Berkeley)

The HRB conducted the research over a nine-month period beginning in August 2007, using a rapid situation assessment technique developed by the World Health Organization. This involved a multi-method approach which brought together existing research and drug treatment and criminal justice data, supported by interviews with key informants such as drug users, gardaí, outreach workers and treatment specialists.

The emergence of crack

Crack cocaine is produced from powder cocaine using readily available chemicals such as ammonia and baking soda. A number of factors may explain the rise in crack cocaine use in Dublin. These include the increased availability of powder cocaine; the presence of problematic opiate users who have used crack cocaine in the UK or in Europe and have resumed crack consumption while living in Dublin; and the presence of non-Irish nationals who have access to cocaine supply routes and experience of preparing crack cocaine.

Drug-using characteristics of crack users

The majority of crack users used more than one drug, opiates (mainly heroin) were the most common drugs used alongside crack. Smoking was the predominant route of administration. A proportion of intravenous users made a transition from injecting powder cocaine to smoking crack cocaine because of the physical harms of injecting. Frequency of use ranged from daily to weekly and was largely dependent on available financial resources.

Dublin crack market

The north inner city remains the primary crack market in Dublin. The market is dominated by non-Irish national dealers who import small amounts of cocaine via couriers. However, a growing number of Irish dealers are reported to be involved in the distribution of crack throughout the Dublin region, and prepared crack has been available throughout the city since 2006. Findings indicate that the crack market is a closed market, meaning that dealers do not sell to strangers, exchanges are generally arranged using mobile phones, and buyers are directed to exchange points outside the inner city. The price of crack is relatively stable and uniform, with prepared quantities or 'rocks' being sold for €50 or €100. Crack houses were reported as locations where crack was used and in some cases prepared in exchange for free crack; they were not reported as major venues for crack dealing or as sites for sex work.

Social profile and consequences of crack

A high proportion of crack users are homeless, unemployed and do not have formal educational qualifications. According to data from treatment services, the majority of crack users were male and half were aged between 20 and 29 years. However, females involved in sex work and single mothers were reported to develop the most chaotic addiction. Common physical side effects of crack use are breathing problems, heart problems and rapid weight loss, and the most common psychological consequences are paranoia, aggressiveness and depression. Compulsive crack users reported neglecting their children, often diverting their financial resources towards buying crack. Shoplifting, burglary and robbery were reported as common means for

Crack cocaine in Dublin *(continued)*

users to sustain their crack cocaine habit. Service providers also reported an increase in the numbers of women returning to or beginning sex work to fund their crack use.

Intervention strategies

International evidence indicates that effective intervention strategies are those which combine attempts to disrupt local markets, making them less predictable to buyers and sellers, with attempts to divert drug offenders into treatment services. The most successful approaches to reducing or ceasing crack use are psychosocial interventions such as cognitive behavioural therapy. However, these interventions can only be successful if the user is attracted to and retained in treatment.

A conference will take place on 24 February 2009 in Croke Park to further assess the findings of this report, with a view to developing a strategic response involving key agencies and local communities.

(Anne Marie Donovan and Johnny Connolly)

This report is available in the publications section of the HRB website at www.hrb.ie. For further information about the conference, contact jconnolly@hrb.ie.

1. Connolly J, Foran S, Donovan AM, Carew AM and Long J (2008) *Crack cocaine in the Dublin region: an evidence base for a crack cocaine strategy.* HRB Research Series 6. Dublin: Health Research Board.

Cocaine use in Ireland

The fourth bulletin of results from the 2006/2007 all-Ireland general population drug prevalence survey focuses on cocaine use in the adult population (15–64 years) and patterns of cocaine use.[1] The Minister of State with responsibility for drugs strategy, Mr John Curran TD, launched the findings for Ireland. The final achieved sample was 4,967 in Ireland. This represented a response rate of 65%. This article highlights some of those findings and, in addition, presents unpublished data from the National Drug Treatment Reporting System (NDTRS) and the National Drug-Related Deaths Index (NDRDI).

Cocaine use increased in 2006/7 compared to 2002/3.[2] The proportion of **adults** who reported using cocaine (including crack) at some point in their lives increased from 3% in 2002/3 to 5% in 2006/7 (Table 1). The proportion of **young adults** who reported using cocaine in their lifetime also increased, from 5% in 2002/3 to 8% in 2006/7. As expected, more men reported using cocaine in their lifetime than women, 7% compared to 3.5%.

The proportion of **adults** who reported using cocaine in the last year (recent use) increased from 1% in 2002/3 to 2% in 2006/7 (Table 1). The proportion of **young adults** who reported using cocaine in the last year increased from 2% in 2002/3 to 3% in 2006/7.

The proportion of adults who reported using cocaine in the last month (current use) remained stable at under 1%.

Of the 4,967 survey respondents, 5% had used cocaine powder; crack cocaine use was rarely reported (0.6%). Half of all cocaine powder users commenced cocaine use before they were 22 years old, while half of all crack users commenced before they were 20 years old.

Of the 25 current cocaine powder users, just over 68% used cocaine less than once per week, while 25% used it at least once per week. All of the current cocaine powder users reported snorting the drug.

Of the 79 recent cocaine powder users, only 9% obtained their cocaine from a person who was not known to them. Cocaine powder was most commonly obtained at the home of a friend (43%) or at a disco, bar or club (36%). Almost two-thirds of recent cocaine powder users said that cocaine powder was easy to obtain within a 24-hour period.

Of the 35 self-defined 'regular' cocaine powder users, almost 82% had successfully stopped taking cocaine. The most common reasons for discontinuing were: concerns about its health effects (28%), could no longer afford it (17%), impact on employment, family and friends (11%), did not enjoy it any more (8.7%), attended a rehabilitation programme (8.2%) and did not want to continue using it (8.2%).

The findings of this survey should be interpreted with care in view of the small number of responses on which the patterns of cocaine use are based. The socially excluded population is unlikely to be represented in a general population survey of this kind; its members may not live at a fixed address or, if listed, may be difficult to locate for interview.

Analysis from the NDTRS indicates a sustained increase between 2001 and 2007 in the number of cases who entered treatment and reported cocaine as a problem drug. The number of treated cases reporting cocaine as a main problem drug increased considerably, from 81 in 2001 to 770 in 2007 (Table 2), of whom 79% used one or more additional drugs. The number of cases reporting cocaine as an additional problem drug doubled from 624 in 2001 to

Table 1 Lifetime, last-year and last-month prevalence of cocaine use (including crack) in Ireland, 2002/3 and 2006/7

Cocaine use	Adults 15-64 years		Males 15 - 64 years		Females 15-64 years		Young adults 15-34 years	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
Lifetime	3.0	5.3	4.3	7.0	1.6	3.5	4.7	8.2
Last year	1.1	1.7	1.7	2.3	0.5	1.0	2.0	3.1
Last month	0.3	0.5	0.7	0.8	0.0	0.2	0.7	1.0

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2006, 2008)

Cocaine use in Ireland *(continued)*

1,362 in 2007 (Table 3). When cocaine was reported as the main problem drug, cannabis, alcohol and ecstasy were the most common additional problem drugs, whereas when cocaine was reported as an additional problem drug the most common main problem drugs associated with its use were opiates and cannabis (Table 4).

In 2007, of the 770 cases who reported cocaine as their main problem drug, 81% snorted it, 13% smoked it, and 4% injected it. Cocaine use by the same 770 cases in the month prior to treatment was reported as follows: 13% used it daily, 44% used it between two and six days per week, 11% used it once per week or less and 30% had not used it. Of note, no respondent participating in the NACD population-based survey reported injecting cocaine, compared to 4% of the treated cases. As expected, the frequency of cocaine use among treated cases was considerably higher than that among the general survey population.

In 2007, half of the treated cases for whom cocaine was the main problem drug had commenced its use before they were 20 years old, and 85% were men. In 2007, there were 2,643 treated cases who reported cocaine as one of their problem drugs, of whom 1,107(41%) lived in the eastern region (Dublin, Kildare or Wicklow) and 1,536 (58%) lived elsewhere in Ireland. The demographic characteristics indicate that cocaine is available throughout Ireland.

According to data from the National Drug-Related Deaths Index, the number of poisoning deaths in which cocaine was implicated, alone or with another drug, increased steadily from five in 1998 to 34 in 2005.[3] In that eight-year period, cocaine was involved in 100 (6.4%) deaths by poisoning. Of these, 29 (29.0%) were due to cocaine alone. Heroin and/or methadone were often associated with cocaine in cases of polysubstance poisoning.

Table 2 Cases entering treatment for cocaine as a main problem drug, 2001 to 2007

	2001	2002	2003	2004	2005	2006	2007
	Number (%)						
All cases entering treatment	**4797**	**4948**	**5054**	**4506**	**4877**	**5191**	**5684**
Cases reporting cocaine as main problem drug	81 (1.7)	128 (2.6)	253 (5.0)	331 (7.3)	467 (9.6)	552 (10.6)	770 (13.5)
Of whom:							
New cases	43	61	148	195	275	342	462
Previously treated cases	31	56	96	119	175	194	290
Treatment status not known	7	11	9	17	17	16	18
Source: Unpublished data from the NDTRS							

Table 3 Cases entering treatment who reported cocaine as an additional problem drug, 2001 to 2007

	2001	2002	2003	2004	2005	2006	2007
	Number (%)						
All cases reporting an additional problem drug	**3,459**	**3,582**	**3,760**	**3,157**	**3,401**	**3,692**	**3,816**
Cases reporting cocaine as an additional problem drug	624 (18.0)	829 (23.1)	1095 (29.1)	1029 (32.6)	1144 (33.6)	1362 (36.9)	1368 (35.8)
Of whom:							
New cases	223	304	421	355	401	477	502
Previously treated cases	377	490	650	648	717	827	836
Treatment status not known	24	35	24	26	26	58	30
Source: Unpublished data from the NDTRS							

Cocaine use in Ireland *(continued)*

Table 4 Main problem drug and associated additional drugs used by new cases entering treatment, 2001 to 2007

New cases	4,708	769	1,064	99	228	160	4,999
	Main problem drug						
	Opiates	Ecstasy	Cocaine	Amphet-amines	Benzo-diazepines	Volatile inhalants	Cannabis
Additional problem drug(s) used*	Number (%)						
Opiates	751 (16.0) †	16 (2.1)	78 (7.3)	1 (1.0)	36 (15.8)	2 (1.3)	128 (2.6)
Ecstasy	447 (9.5)		394 (37.0)	49 (49.5)	32 (14.0)	11 (6.9)	1,897 (37.9)
Cocaine	1,029 (21.9)	206 (26.8)	12 (1.1)†	25 (25.3)	37 (16.2)	3 (1.9)	865 (17.3)
Amphetamines	89 (1.9)	183 (23.8)	109 (10.2)		4 (1.8)	2 (1.3)	528 (10.6)
Benzodiazepines	1,029 (21.9)	20 (2.6)	67 (6.3)	2 (2.0)	9 (3.9)†	1 (0.6)	117 (2.3)
Volatile inhalants	17 (0.4)	15 (2.0)	5 (0.5)	1 (1.0)	3 (1.3)	8 (5.0)†	118 (2.4)
Cannabis	1,866 (39.6)	489 (63.6)	611 (57.4)	60 (60.6)	56 (24.6)	47 (29.4)	6 (0.1)†
Alcohol	466 (9.9)	341 (44.3)	497 (46.7)	36 (36.4)	103 (45.2)	57 (35.6)	2,389 (47.8)

* By cases reporting use of one, two or three additional drugs
† Additional problem drug(s) used may be a form of drug in the same family as the main problem drug.
Source: Unpublished data from the NDTRS

(Jean Long)

1. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2008) *Drug use in Ireland and Northern Ireland. 2006/2007 drug prevalence survey: cocaine results.* Bulletin 4. Dublin: National Advisory Committee on Drugs.
2. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2006) *Drug use in Ireland and Northern Ireland. 2002/2003 drug prevalence survey: cocaine results.* Bulletin 4. Dublin: National Advisory Committee on Drugs.
3. Lyons S, Lynn E, Walsh S and Long J (2008) *Trends in drug-related deaths and deaths among drug users in Ireland, 1998 to 2005.* HRB Trends Series 4. Dublin: Health Research Board.

2008 report on the drugs problem in Europe

There are between 1.3 and 1.7 million problem opioid users in the EU and Norway, with heroin responsible for Europe's largest drug-related health and social costs, according to the *Annual report 2008: the state of the drugs problem in Europe,* published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in November.[1] Data suggest that heroin use across Europe is stable but no longer diminishing. Some 12 million Europeans (15–64 years) have tried cocaine in their lifetime, compared with around 11 million for amphetamines and 9.5 million for ecstasy. While the latest European data confirm reports of a stabilising or even declining trend in the use of amphetamines and ecstasy, they point to a continued rise in cocaine use, albeit in a small number of countries. The Health Research Board (HRB) provides the Irish figures for the EMCDDA.

Opioids

Ireland, like more than half of all EU countries, reported an increase in new opioid cases entering treatment since 2005, with 1,032 new cases reported in 2007. Opioid use (principally of heroin) accounted for 63% of cases entering drug treatment in Ireland, compared to an average of 47% across Europe. In Ireland 9,769 cases received substitution treatment for opioid use in 2007. Figures from 2001 indicate that there are between 13,405 and 15,819 problem opiate users in Ireland. As in most other European countries, there was an increase in drug-related deaths in Ireland in 2004 and 2005. The increase was largely due to an increase in opiate and cocaine-related deaths. There were 159 drug-induced deaths in Ireland in 2005, of which 88% were associated with opiate use. Research shows that the risk of overdose decreases substantially when heroin users are in substitution treatment.

2008 report on the drugs problem in Europe *(continued)*

Cocaine

Around 3.5 million young Europeans (15–34 years) have used cocaine in the last year, and 1.5 million in the last month. In Ireland the proportion of young adults who reported using cocaine in the last year increased from 2% in 2002/3 to 3% in 2006/7. The European rate ranged between 0.2% and 5.4%, placing Ireland among the high prevalence countries, such as the UK, Spain, Denmark and Italy, which have all seen a rise in the use of cocaine. Many EU countries report an increased demand for treatment for problem cocaine use. Data from Ireland's National Drug Treatment Reporting System (NDTRS) show a considerable increase in cases reporting cocaine as a main problem drug, from 81 in 2001 to 770 (of which 462 were new cases) in 2007. Some 500 (12%) drug-induced deaths associated with cocaine use were reported to the EMCDDA for 2006; there were 34 (21%) such deaths in Ireland in 2005. As in many EU countries, the number of cocaine seizures in Ireland has increased with time, from 515 in 2003 to 1,500 in 2006.

Ecstasy and amphetamines

The proportion of young adults in Ireland who reported using ecstasy in the last year remained relatively stable at 2.3% in 2002/3 and 2.4% in 2006/7. The European rate ranged between 0.4% and 7.7%, placing Ireland among the medium prevalence countries. The number of treated cases who reported ecstasy as a main problem drug decreased considerably, from 219 in 2001 to 129 in 2007. The number of deaths in which ecstasy was implicated, alone or in conjunction with another drug, averaged 10 a year between 2002 and 2005. Amphetamine use is relatively uncommon in Ireland, with the percentage of adults who reported use in the last year remaining stable at 0.4% in 2002/3 and 2006/7.

Cannabis

Cannabis use has not declined in Ireland, as it has in other parts of Europe, and remains the most commonly used illegal drug in this country. The proportion of adults who used it in the last year increased from 5% in 2002/3 to 6.3% in 2006/7, placing Ireland just below the EU average of 7%. While cannabis seizures account for the majority of all drugs seized in Ireland, the number of cases reporting cannabis as a main problem drug decreased steadily, from 1,370 in 2001 to 967 in 2007, of which 16% were new cases, compared to the EU average of 21%.

Vulnerable young people

While EU countries increasingly prioritise the risk of problem drug use to vulnerable young people, this political commitment is not matched by practical responses to reduce these risks. The existing responses favour office-based or centre-based services over outreach work.

In Ireland young people vulnerable to drug use include children leaving state care and those in juvenile detention or special care facilities, early school leavers, homeless youth, people whose parents have a history of problem substance use, young people living in marginalised urban communities and, to some extent, Travellers. A number of Irish policy documents, including the National Development Plan, the Plan for Social Inclusion and the National Children's Strategy, as well as the National Drugs Strategy, contain measures to help vulnerable young people through education, sport and recreation. Primary prevention measures are delivered through the school programmes Walk Tall and SPHE and the Young People's Facilities and Services Fund (YPFSF). Arrest referral schemes provide information about appropriate services to young drug-using offenders and facilitate referral to treatment.

(Brian Galvin)

1. The full report and all related media material are available on the EMCDDA website at www.emcdda.europa.eu/events/2008/annual-report

The supply of heroin to Europe – update

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) recently published a technical data sheet, *Monitoring the supply of heroin to Europe*.[1] This review is based on the latest data and analysis available from specialised European and international organisations.

The review states: 'The sustainability of a general or improving situation in heroin use in Europe has been called into question by a series of record opium harvest in Afghanistan' (p. 4). Although estimates suggest that the prevalence of opioid use has been relatively stable in recent years, rising numbers of both heroin seizures and heroin-related deaths indicate the likelihood of increased heroin availability in Europe. The review notes that there are a number of alternative explanations for this development, such as the success of enhanced and targeted law enforcement initiatives, the use of synthetic opioids, the concomitant use of opioids and other psychoactive substances, and the vulnerability of aging heroin users to sustained problematic use of the substance.

The supply of heroin to Europe *(continued)*

However, increasing availability is indicated by a substantial escalation in opium production in south-west central Asia, in Afghanistan in particular. In recent years, more than 90% of the opium output detected worldwide has come from Afghanistan and it is estimated that the total 2007 production of Afghan opium allowed the manufacture of 733 tonnes of heroin. Afghan opium production doubled between 2005 and 2008 despite international eradication efforts. The continuing political instability of the region is considered a likely explanation for the growth in opium production (in tandem with very favourable weather conditions). The bulk of Afghan heroin destined for the Western European market is believed to travel through Iran and Turkey before entering various Balkan states, from where its is transported overland to the Netherlands and, to a lesser degree, to Belgium.

This review highlights the continuing need to monitor the impact of the Afghan situation in Europe. In particular, 'answers are needed to questions of where opioids production is going; whether stockpiles are being constituted; whether there are signs of increased availability of heroin from Afghan origin in European consumer markets; whether the purity of heroin is being influenced; and whether consumer markets may be emerging or expanding along trafficking routes and elsewhere' (p. 17).

(Anne Marie Donovan)

1. EMCDDA (2009) *Monitoring the supply of heroin to Europe.* EMCDDA technical data sheets. Luxembourg: Office for Official Publications of the European Communities. Available online at www.emcdda.europa.eu

GPs' attitudes to the Methadone Treatment Protocol

As demonstrated in the ROSIE study,[1] methadone treatment reduces drug use, crime and death among opiate users in Ireland. Almost one-third (32%) of opiate users prescribed methadone substitution are cared for in private general practice. In light of this information, the Irish College of General Practitioners (ICGP) conducted a postal survey in 2006 to determine the attitudes of GPs to the Methadone Treatment Protocol (MTP).[2]

A questionnaire was sent to 600 GPs who were recorded on the ICGP's drug misuse database as having received training in the management of methadone clients. Just under 35% (207) responded. It is notable that 247 GPs had patients on the Central Treatment List at the time of the study.

Almost half of the GPs who responded were aged between 46 and 60 years and 29% were female. Two of every three practices were situated in an urban area. Just over two-fifths

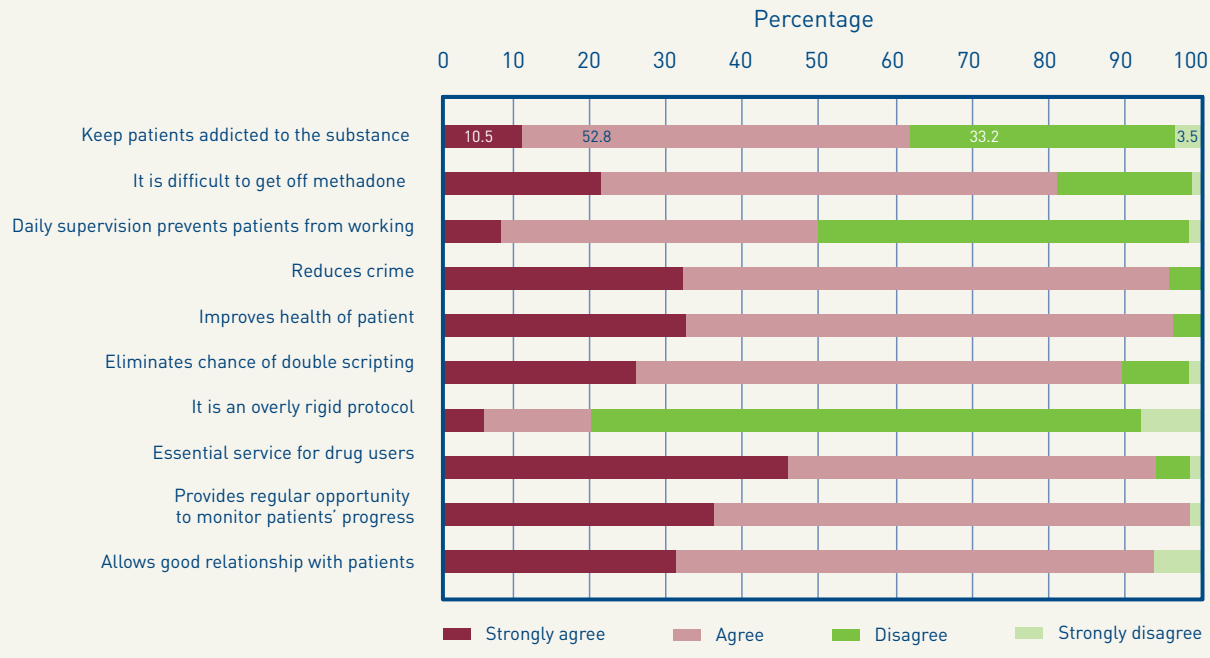


Figure 1 General practitioners' attitudes to methadone treatment, 2006

GPs attitudes to the MTP *(continued)*

of the GPs said that illicit drugs were a major problem in their practice area; the majority of these GPs practised in an urban location. Ninety-two per cent confirmed that they had attended special training in methadone treatment.

Of the 207 GPs who completed the questionnaire, 72% were providing patients with methadone treatment at the time of the survey. Over half had 10 or fewer patients. Only 35 prescribing doctors or their staff did not want any more patients. Forty-six GPs were willing to take more patients, which suggests that there is capacity that could be used to transfer additional suitable clients to a normal health care environment.

The vast majority of GPs thought that the MTP was beneficial to patients, though some said that methadone was addictive and difficult to get off (Figure 1). It was also noted that patients who attended daily might be prevented from working.

Only 3% of GPs reported that their training was not sufficient to stabilise patients receiving methadone substitution. One-third reported that their training was not sufficient to manage the complications of drug use. Over two-fifths reported that their training was not sufficient to manage patients who continued to use illicit drugs.

Just under two-thirds reported that their training was not sufficient to manage patients with alcohol problems, while over half reported that their training was not sufficient to manage patients with benzodiazepine problems. These responses point to issues that could be dealt with in future training programmes.

The types of training that GPs considered most useful to them were small, locally based continuing education networks, individual mentoring, and distance learning. Consideration can be given to these preferences in the design of future training.

The additional services most desired by GPs were addiction counselling, in-patient detoxification and rehabilitation beds, and employment schemes

(Jean Long)

1. Cox G, Comiskey C and Kelly P (2007). *ROSIE Findings 4: summary of 1-year outcomes: methadone modality.* Dublin: National Advisory Committee on Drugs.
2. Delargy I (2008) *Survey of general practitioners participating in the methadone treatment programme.* Dublin: Irish College of General Practitioners.

GPs' role in methadone treatment

Two national registers record drug treatment data in Ireland: the National Drug Treatment Reporting System (NDTRS) is an epidemiological database that records demand for treatment for problem alcohol and drug use, and the Central Treatment List (CTL) is an administrative database to regulate the dispensing of methadone treatment.

The NDTRS is co-ordinated by staff at the Alcohol and Drug Research Unit (ADRU) of the Health Research Board (HRB) on behalf of the Department of Health and Children.

The CTL was established following the *Report of the Methadone Treatment Services Review Group 1998*.[1] This list is administered by the Drug Treatment Centre Board on behalf of the Health Service Executive and is a complete register of all patients receiving methadone as treatment for problem opiate use in Ireland.

According to these data sources, the total number of cases receiving methadone treatment increased by 32% between 2002 and 2007 (Table 1). The number receiving treatment in private general practice increased by 36% during the same period. In each of the six years, at least 30% of cases who received methadone treatment were treated in private general practice.

The proportion of cases continuing in methadone treatment each year was higher among those attending private general practice than among those attending other treatment providers (Table 2). The cases attending general practice were older than those attending other treatment providers. There was no difference in the gender profile.

Table 1 Total cases in methadone treatment, and number, treatment status and percentage of cases treated in private general practice, 2002–2007

Cases in methadone treatment	2002	2003	2004	2005	2006	2007
Total cases	7,419	7,736	8,800	9,354	9,675	9,769
Cases treated in general practice	2,323	2,494	2,699	2,827	2,890	3,161
Cases continuing in treatment in general practice from the previous year*	1,875	2,113	2,292	2,488	2,642	2,872
Cases entering treatment in general practice during the reporting year†	448	381	407	339	248	289
Cases treated in general practice as a percentage of total cases	31%	32%	31%	30%	30%	32%

*Numbers obtained from the Central Treatment List
†Numbers obtained from the National Drug Treatment Reporting System

GPs' role in methadone treatment *(continued)*

Table 2 Proportion of cases in methadone treatment in Ireland, by treatment status, gender and age group, 2002–2007

	Treatment service	
	General practice	Other
	%	%
Cases continuing in treatment from the previous year	87	75
Cases entering treatment (either new or returning)	13	25
Male	69	67
Female	31	32
Age group		
10–14 years	0	0
15–19 years	1	2
20–24 years	13	18
25–29 years	31	32
30–34 years	24	24
35–39 years	15	13
40–44 years	9	7
45–49 years	5	3
50–54 years	2	1
55–59 years	1	0
60–64 years	0	0
65 years or over	0	0

(Jean Long, Anne Marie Carew and Vivion McGuire)

1. Methadone Treatment Services Review Group (1998) *Report of the Methadone Treatment Services Review Group.* Dublin: Department of Health and Children. Available as Appendix 4 in: Methadone Prescribing Implementation Committee (2005) *Review of the Methadone Treatment Protocol.* Dublin: Department of Health and Children. www.dohc.ie/publications/methadone_review.html

Illicit methadone use among young people

The latest issue of *European Addiction Research* contains a paper on illicit methadone use and abuse in young people accessing treatment for opiate dependence in Ireland.[1]

At the time of publication, no research into methadone diversion had been conducted in Ireland. This study examines illicit use of methadone in a group of clients aged 25 and under attending a treatment programme for opiate dependence in the Drug Treatment Centre Board clinic in central Dublin in May 2005.

Data were obtained through a structured interview covering demographic information, family background, treatment history, current and prior drug use, current and prior reasons for illicit methadone use, details of methadone supply, and experiences of selling methadone.

Of the 81 people studied, the average age was 22 years, and 51% were female. The average age of first drug use was 13 years, and 70% of participants reported cannabis as the first illicit drug used.

More than half of the participants (51%) reported that other family members had also used heroin. Thirty-one per cent of participants were homeless or living in a hostel.

The average age of first use of heroin was 15; one participant reported never having used heroin. The majority (91%) reported smoking as the first route of administration of heroin, while the remaining 9% reported injecting as their first route of administration. Almost four-fifths (79%) reported having injected heroin at some point in their lives.

The average prescribed daily methadone dose reported by participants was 66mg. Almost one-third (31%) reported that this dose did not control the symptoms of heroin withdrawal.

More than half of participants reported the use of illicit methadone both prior to and during treatment. Counteraction of opiate withdrawal symptoms was the most common reason given. During treatment, failure to attend the clinic was the most common reason for withdrawal symptoms. Forty per cent obtained illicit methadone in order to do their own detox or maintenance. One-third reported using methadone for hedonic effects prior to commencing treatment. Participants reporting the misuse of benzodiazepines were more likely to report use of illicit methadone.

Despite strict controls, 73% of participants reported that illicit methadone was easy to obtain. The most commonly listed marketplace was outside the treatment clinic, while other locations included the participants' local areas, the quays, and outside city centre train stations.

Of those buying methadone, 42% reported having a regular source. The majority of participants (82%) reported the supplier as someone on a methadone maintenance programme. The vast majority (93%) of participants who had received their methadone prescription as take-aways in the past reported being asked to sell it on; only 6% reported having done so.

(Anne Marie Carew)

1. Roche A, McCabe S and Smyth BP (2008) Illicit methadone use and abuse in young people accessing treatment for opiate dependence. *European Addiction Research,* 14(4): 219–225.

Minister attends tenth anniversary of DROP

Mr John Curran, Minister of State with responsibility for drugs strategy, attended an open day to celebrate the tenth anniversary of the Dun Laoghaire Rathdown Outreach Project (DROP) on 17 September 2008. The Minister talked to staff, service users and visitors about the importance of having community-based responses to addiction. He emphasised the need to support the families of those with addiction problems.

DROP provides a range of responses to meet the needs of individuals, families and communities who are affected by drugs and related issues. These include a three-year structured rehabilitation programme for drug users, one-to-one supports for people who cannot yet commit to rehabilitation, an evening service for people using cocaine, and a facilitated drug-free support group. All of DROP's services are client-centred, free and confidential. DROP liaises with local agencies to support a continuum of care in areas such as parenting and housing supports, educational and skills development, work placements and training to support career progression.

Through its own community employment scheme, DROP provides supported work placements with voluntary or community host agencies. DROP also hosts the local drugs task force's education and development staff.

Minister John Curran and Edwina Kane, DROP receptionist, cut the cake at the DROP open day. The message on the cake reads 'A Decade of Support'.

(Brian Galvin)

For further information about DROP's services, contact the Manager, Ruth McClaughry, on 01 280 3187 or by email at dropmanager@eircom.net

ROSIE study shows positive impact of opiate treatment

On 9 October 2008 the NACD published a summary of opiate treatment outcomes at one year and at three years after entry to treatment.[1]

At baseline, the 404 opiate users recruited to the study were entering treatment for the first time, or were returning to treatment after a period of absence, at any one of 54 services nationwide. Of these, 289 individuals completed all three interviews – at baseline (2003/4), at one year (2004/5) and at three years (2006/7). These individuals (the *per-protocol* population) were asked the same questions at the three time points. The interview schedule examined key outcome measures, including:

- drug use in the 90 days preceding the interview – specifically, type, frequency, quantity and cost;
- measures of harmful practices and consequences;
- health status, using a self-rated physical and psychosocial health assessment;
- social functioning, including accommodation, employment, and involvement in crime; and
- mortality, using information obtained from the participants' contacts and the General Mortality Register. (Six of those who entered treatment died during the three-year period.)

The proportion of participants who reported using heroin in the 90 days preceding data collection fell from 81% at intake to 47% at one year, and was sustained at 47% at three years. The average frequency of heroin use in a 90-day period reduced from 42 out of 90 days at intake to 15 out of 90 days at one year but increased to 20 out of 90 days at three years. The average quantity of heroin consumed each day over a 90-day period decreased from 0.9 grams at intake to 0.3 grams at one year, and this lower consumption rate was sustained at three years. There was a corresponding reduction in the average amount spent on heroin on a typical day, from €75 at intake to €24 at one year; the average spend at three years was not reported.

There were reductions in the proportions of participants who reported use of non-prescribed methadone, cocaine powder, crack cocaine, cannabis, alcohol and non-prescribed benzodiazepines at one year compared to the baseline interview. The reduced levels were maintained between one-year and three-year follow-up for all drugs except benzodiazepines.

Impact of opiate treatment *(continued)*

The proportion of participants who reported use of more than one drug decreased from 78% at intake to 50% one year later and to 45% three years following intake.

The proportion of participants who reported injecting drug use in the 90 days preceding data collection decreased from 46% at intake to 29% at one year and 27% at three years. There was a small overall decrease in the proportion reporting an overdose, from 7% at intake to 4% at one year, to 5% at three years.

In relation to mental health symptoms experienced in the three months prior to each interview, there was no reduction at three years in the proportion who reported symptoms of anxiety and some reduction in the proportion who reported three of five symptoms of depression.

The proportion of participants living in unstable accommodation decreased from 25% at intake to 21% at one year and to 18% at three years. The proportion attending training courses in the six months prior to interview increased from 15% at intake to 29% at one year and to 33% at three years. In addition, the proportion currently employed increased from 15% at intake to 20% at one year and to 31% at three years. The largest achievements between one and three years were in the areas of housing, training and employment.

The proportion of participants who reported involvement in acquisitive crime decreased from 31% at intake to 14% at one year and this decrease was sustained at three years. In addition, the proportion who reported selling or supplying drugs reduced from 31% at intake to 11% at one year and this decrease was sustained at three years.

At the time of entry to treatment, 7% of the 289 participants were not using drugs; the proportion had improved to 29% at one year and was sustained at 29% at three years. Of those for whom treatment status at three years was reported, 201 (70%) were still in treatment, of whom 173 were in methadone treatment.

(Jean Long)

1. Comiskey C, Kelly P and Stapleton R (2008) *ROSIE Findings 7: Summary of outcomes for the* per-protocol *population.* Dublin: National Advisory Committee on Drugs.

Frankfurt's response to open drug scenes and drug-related harm

On the initiative of the Finnish Presidency of the EU in 2006, a European network of multi-agency partnerships tackling drug problems at front-line level was established in 2007. Called EXASS Net, the network is managed by the Pompidou Group of the Council of Europe.[1]

The third EXASS Net meting was held in Frankfurt/Main, Germany, in May 2008. It began with the screening of a short film on the city's open drug scene in the 1980s and early 1990s. During those years, between 700 and 1,000 injecting drug users were present in the city, day and night, making it one of the largest open drug scenes in Europe. An average of 16 injection-related medical emergencies a day required ambulance/doctor assistance and cost the city over €50,000 a week. Intensified policing of the situation merely led to its displacement to other locations in the city. There were almost 6,000 drug users registered with the police at the time, with a hidden figure estimated at three to four times that number. The incidence of drug-related crime, particularly property offences, was high and the number of drug-related deaths reached nearly 150 a year.

In the past 20 years, concerned stakeholders at frontline level (including law enforcement and social and health services) have been involved in a new approach to drug use in Frankfurt. Central to this new approach was the establishment of new partnerships between stakeholder agencies, called the Monday Round (1988) and the Friday Round (1989). The latter initiative initially involved consultation with street workers who were trying to cope with the open drug scene. Round-table partnership discussions started to provide solutions to the problems faced. The process involved:

- building up crisis centres to attract those users who were being moved on from the street;
- an acknowledgement that the client group was high demand and difficult;
- the movement by police of out-of-town drug users back to their own residential areas and the movement of Frankfurt drug users into crisis centres;
- an emphasis on basic needs at the initial stage of intervention, including accommodation and medical support, followed by diversion to treatment programmes as appropriate.

There are currently 1,300 clients on methadone programmes in Frankfurt. Approximately 650 are treated in clinics, and the remainder in general practice. There is a range of low-threshold services throughout the city dealing with different types of drug use and associated health and social problems. The first drug consumption room, where drug users were provided with sterile injecting equipment and other services and where they could consume drugs under supervision, was opened in 1994. Crack-smoking facilities have been provided in consumption rooms since 2002.

The fourth meeting of EXASS Net took place in Moscow in October 2008; future meetings are scheduled for Budapest, Oslo and Amsterdam. These meetings will consider subjects including youth drug cultures, party drugs and club scenes, the role of outreach in response to drug problems and the role of drug users in developing responses.

(Johnny Connolly)

1. More information about the EXASS Network and online reports of its activities can be found at www.exass.net/index.php.

Dial to Stop Drug Dealing – launch of national campaign

On 30 September the Dial to Stop Drug Dealing campaign was officially launched by Minister of State John Curran TD with the assistance of Superintendent Barry O'Brien of the Garda National Drug Unit (GNDU), Assistant Garda Commissioner Al McHugh and Mr Joe Doyle of the Health Service Executive (HSE). Individuals and communities affected by drug dealing were urged to pass on information relating to drug dealing in their local communities by dialling 1800 220 220. Individual names or numbers are neither requested nor recorded. Calls will be routed to call centres staffed by non-locals, separate from Garda barracks. All information will be passed on to An Garda Síochána.

The campaign is being funded by the Dormant Accounts Fund, the Department of Community, Rural and Gaeltacht Affairs and the Department of Justice at a total cost of €450,000 for a three-phase campaign over nine months. Phase one will run from 1 November 2008 in communities in the areas of Tallaght LDTF, Blanchardstown LDTF, South West RDTF, North Inner City LDTF, and Dublin North East LDTF. In the second phase, to be rolled out in January 2009, the initiative will be promoted throughout the country. However, Minister Curran and Superintendent O'Brien strongly emphasised that, though the initiative will be promoted only within the Greater Dublin Area initially, all calls will be answered regardless of location and all information will be passed on to An Garda Síochána. Details of phase three have yet to be announced.

The project has already reported success in Blanchardstown LDTF where it was launched in 2006 as a part of the Blanchardstown LDTF's supply reduction programme. After a successful six-week pilot phase, the campaign was extended. An evaluation of the Blanchardstown pilot initiative revealed that over 296 calls were received over the six-week period, over two-thirds of which were regarded as useful by An Garda Síochána.[1] Assistant Commissioner McHugh commented that 'court actions are pending because of the success of that campaign. This initiative is about getting at the big dealers who are targeting our young people and destroying communities. People can reclaim their communities by using this safe and confidential mechanism to pass on their information.' The Minister was also optimistic that the campaign would assist in promoting greater links between local communities and the gardaí.

Minister John Curran at the launch of the campaign

(Anne Marie Donovan)

1. Connolly J (2006) Blanchardstown Dial to Stop Drug Dealing campaign. *Drugnet Ireland,* (20): 17–18. See also Blanchardstown Local Drugs Task Force (2006) *Blanchardstown Dial to Stop Drug Dealing: campaign evaluation executive summary report.* Blanchardstown: BLDTF.

Ana Liffey Drug Project

On 20 August 2008, the Ana Liffey Drug Project (ALDP) began operating an outreach programme in Dublin's north inner city. This programme was developed in response to concerns raised about people with drug problems congregating on the Boardwalk along the north bank of the river Liffey.[1] In addition, unpublished research by ALDP indicates that over 50% of individuals accessing ALDP services do so only once in any given month.[1]

The aim of the programme is for ALDP outreach staff to engage with people on the streets who are problem drug users and/or homeless. Outreach staff provide a variety of services with the objective of reducing the harm associated with drug use and/or homelessness. Services include: harm reduction and health promotion information; referrals to ALDP or other health and social care services; brief solution-focused interventions; and promotion of the ALDP freephone number (1800 78 68 28) to encourage people to access ALDP services. Staff levels permitting, outreach is conducted every day.

The ALDP is in the process of developing a peer-led outreach service. Members of the ALDP peer group have created a leaflet with tips for staying safe on the street. The next step is for the peers to go on outreach together with ALDP staff. The peers will provide people who are problem drug users and/or homeless with information about keeping safe on the streets, and will advertise the ALDP peer group. The aim of this peer group is to provide harm reduction information and an opportunity for people to discuss any issues that are relevant to their lives.

(Janet Robinson)

For further information about the ALDP, contact Marcus Keane on (01) 8786899 or marcus.keane@aldp.ie, or drop in to the service at 48 Middle Abbey Street, Dublin 1.

1. Keane M, ALDP, personal communication, October 2008.

National Registry of Deliberate Self Harm annual report 2006–2007

The sixth annual report from the National Registry of Deliberate Self Harm was published in September 2008.[1] The report contains information relating to every presentation of deliberate self-harm to general hospital and paediatric hospital A&E departments in Ireland in 2006 and 2007, giving complete national coverage of hospital-treated deliberate self-harm. The Registry defines deliberate self-harm as 'an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or physical consequences'.

According to the report there were 10,700 presentations of deliberate self-harm, involving 8,200 individuals, to hospital A&E departments in 2006. There were 11,100 presentations by 8,600 individuals in 2007, a rate 2% higher than in 2006. Reviewing data collected by the Registry for the six-year period 2002–2007, the report indicates that the rate of presentation of deliberate self-harm is relatively stable.

The national rate of deliberate self-harm in both 2006 and 2007 was one-third (32% and 33%) higher among females than among males. Concordant with previous reports, deliberate self-harm was largely confined to the younger age groups. Almost half of all presentations (46% in 2006 and 47% in 2007) were by people aged under 30, and 88% were by people aged under 50.

The peak age range for females presenting was 15–19 years, at 600 per 100,000. This indicates that one in every 165 Irish adolescent girls was treated in hospital each reporting year as a result of deliberate self-harm. The peak age range for males presenting was 20–24 years, at 392 per 100,000.

Increased deprivation and social fragmentation were associated with increased rates of deliberate self-harm. Rates were higher in urban settings, with the highest rate reported in HSE Dublin/North East Region.

Repetition of deliberate self-harm accounted for almost one in four (23.1% in 2006 and 22.4% in 2007) of all presentations, with men more at risk of repeated self-harm.

Drug overdose was the most common form of deliberate self-harm, representing 74% of all such episodes reported in 2006–2007. Overdose rates were higher among females (80%) than among males (65%). On average, 31 tablets were taken in episodes of drug overdose. The total number of tablets taken was known in 78% of cases. Forty-two per cent of all drug overdoses involved a minor tranquilliser, 30% involved paracetamol-containing medicines and 22% involved anti-depressants/mood stabilisers. According to the report, the withdrawal of the analgesic, Distalgesic, in January 2005 has had a positive effect. Distalgesic was involved in approximately forty cases of self-harm in 2007 compared to approximately four hundred cases reported annually between 2002 and 2005.

There was evidence of alcohol consumption in 41% of all episodes of deliberate self-harm, emphasising the strong association between alcohol consumption and suicidal behaviour.

Self-cutting was the second most common method of deliberate self-harm, representing 21% of all episodes, and was more common among males than among females.

The emergency department was the only treatment setting for more than half (53%) of all deliberate self-harm patients, that is, they did not proceed to further treatment.

The report recommends the following measures to reduce the incidence of deliberate self-harm:

- continued support of the national mental health awareness campaign and related mental health promotion initiatives to reduce levels of psychiatric and psychological morbidity in the population;
- additional resources to support mental health promotion, and specialist mental health services for adolescents aged 15–19 years;
- evidence-based interventions targeting people who repeatedly self-harm, with a focus on high risk groups;
- restriction of the availability of minor tranquillisers;
- development of a mechanism for linking data collected by the Registry with data on suicide mortality to improve understanding of the relationship between deliberate self-harm and the risk of suicide in the future; and
- extension of the core Registry dataset to support evaluation of progress on actions in the strategy document on suicide prevention, *Reach out,*[2] and increase our understanding of deliberate self-harm.

(Ena Lynn)

1. National Registry of Deliberate Self Harm Ireland (2008) *Annual report 2006–2007.* Cork: National Suicide Research Foundation.
2. HSE, National Suicide Review Group and Department of Health and Children (2005) *Reach out: national strategy for action on suicide prevention 2005–2014.* Dublin: Health Service Executive

Non-fatal overdose of known illicit drugs

Data used in the following analysis were extracted from the Hospital In-Patient Enquiry (HIPE) scheme. The Economic and Social Research Institute (ESRI) manages the HIPE scheme in Ireland. HIPE is a computer-based health information system designed to collect data on all discharges and deaths from acute general hospitals in Ireland. Each HIPE discharge record represents one episode of care; patients may be admitted to hospital(s) more than once with the same or different diagnoses. The records therefore facilitate analyses of hospital activity rather than of the incidence of disease. HIPE does not record information on cases that attend accident and emergency units but are not admitted as inpatients. In 2005 a new version (ICD-10-AM) of the International Classification of Diseases codes used by HIPE was issued. Data pertaining to the year 2005 only are included in the following analysis.

There were 264 cases of overdose involving known illicit drugs[1] in 2005. Six of these cases died, and are not included in this analysis.

Age group and gender

Figure 1 shows that the 20–24-year age group is at highest risk, with the number of overdoses of known illicit drugs decreasing in older age groups. It is important to note the significant number of cases in the 15–19-year age group. Males accounted for 80% (207) of cases.

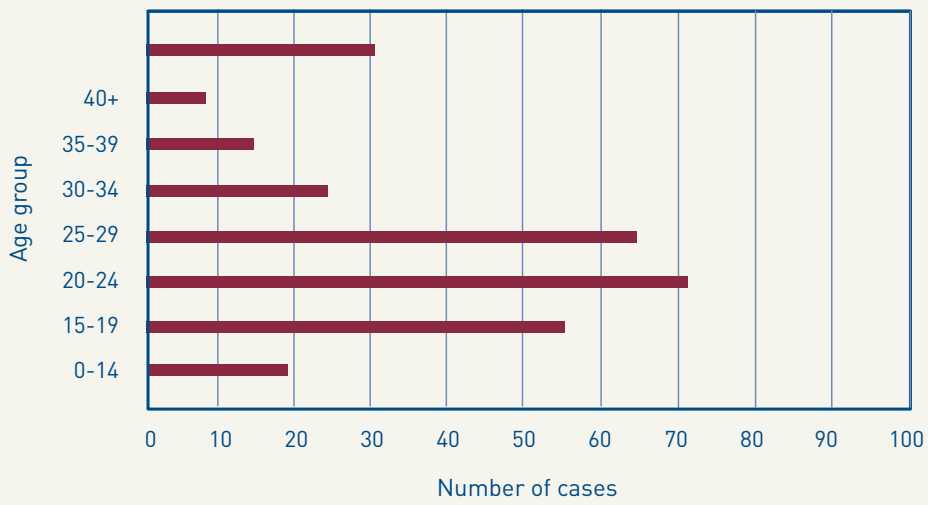


Figure 1 Number of cases of overdose of illicit drugs, by age group, 2005

Area of residence

More than one-quarter (26.4%, 68) of all overdose cases involving known illicit drugs were among persons resident in Dublin (city and county). Thirty-five (13.6%) cases resided in Co Tipperary, a predominantly rural area.

Poisoning intent

The poisoning was intentional in 37.6% (97) of cases. Accidental poisoning accounted for over one-quarter of cases (27.9%, 72), while the intent of the remaining cases was undetermined.

Illicit drugs most commonly used in overdose cases

There were 264 overdose cases involving known illicit drugs in 2005. In 16% (41) of these cases more than one known illicit drug was used. Hallucinogens were involved in 38.4% (99) of cases, of which 15% had taken at least one other illicit drug. Opiates were involved in 29.5% (76) of cases; cocaine was involved in over a quarter (27.5%, 71); and cannabis was present in almost one-fifth (19.4%, 50). Benzodiazepines were used in conjunction with a known illicit drug in 15% (39) of cases (Figure 2).

Non-fatal overdose of illicit drugs *(continued)*

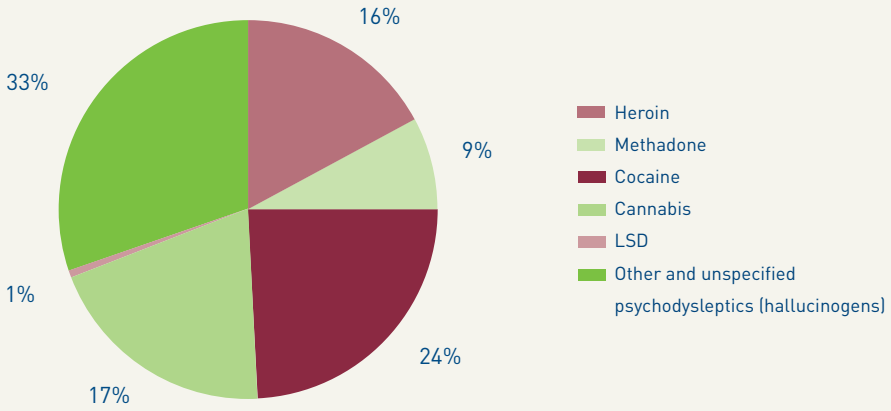


Figure 2 Types of known illicit drugs used in overdose cases, 2005

(Ena Lynn)

1. Only cases involving drugs that are known to be illicit are included. This analysis excludes opiates and other narcotics where provenance is unknown.

Profile of needle exchange services in Ireland

Needle and syringe exchange services were first provided in Ireland in 1989, when five exchanges were established. There are now 34 exchanges in the country, operating three models of service: fixed-site exchanges, home visit exchanges, and exchanges in public locations. Peer-based, pharmacy, prison-based or vending machine exchange services are not available in Ireland.

This article presents a profile of 31 needle and syringe exchange services operating between November 2007 and February 2008. A service-inventory questionnaire was used to collect the data. The questionnaire comprised six sections: administrative details, profile of target population, profile of staff and volunteers working in the service, activities, management issues and new phenomena in relation to drug use.[1] The 31 services provided exchanges at fixed sites (28), on home visits (3) and in public locations (2); two services provided exchanges in two settings.

Of the exchanges surveyed, 17 were operated by government, 11 by a partnership of government and non-government organisations, and three by non-government organisations. Two services provided social and medical care; six provided social care only and four provided medical care only. All provided services without charge to the client.

Weekly opening times ranged from 24.75 hours over five days in one service to one hour on one day in three services. Twenty of the services were open on one day a week for 1–2.5 hours. One service was open on seven days a week for one hour each day; this was the only service that operated a weekend provision. Eight of the services were open after 5 pm on one night a week.

Of the 31 services, 20 provided services in urban locations, 12 in inner city locations and three in rural locations; some services operated in more than one location. The majority reported a dispersed open drug scene and/or a hidden scene in their areas.

Seven of the services had no formal data-collection procedures, and two services were not open for all of 2007. A total of 22 services reported 7,069 client attendances in 2007.

Overall, between 10% and 30% of clients were female. The youngest clients were aged between 16 and 20 years. Twenty-five services were open to any person aged over 18; five of these also dealt with 16–18-year-olds. Two services catered for women and sex workers; two served residents only; and two operated specific services for ethnic minorities. Twenty-nine services reported that a significant minority of their clients were homeless.

Twenty-nine services reported heroin as the drug most commonly used by clients; 18 services reported cocaine as the most common. As expected, injecting was the most common route of administration (reported by

Exchange services *(continued)*

19 services). Benzodiazepine injecting was reported as a common practice by 11 services. Nineteen services reported that clients attending their service injected steroids.

Thirty services reported that the outreach workers had an academic (but not a professional) qualification. The remaining service reported that staff did not have formal qualifications. Thirty services were operated by two or more staff during a session; 15 had a general assistant present. Six services provided on-site access to health services, usually provided by a nurse; four provided on-site access to counsellors.

All 31 services reported that staff received training on the assessment of clients' sexual risk practices and injecting practices, and on emergency responses such as overdose prevention techniques. Twenty-six services had a written document about staff training.

A variety of policy and procedural documents have been developed to guide the operation of needle and syringe exchange services in Ireland. A written document for service providers in relation to health and safety issues was available in all services. A written document in relation to the health and safety of clients was available in 20 services. Thirty services offered staff vaccination against hepatitis A and B, and seven offered staff vaccination against tetanus.

All 31 services completed an assessment when a client accessed the service for the first time. The majority of services recorded clients' drug use, drug history and sexual health practices in the past year. The majority also recorded the blood-borne viral (BBV) infection status of their clients as well as their BBV test and treatment history. The amount of information recorded at the initial visit depended on how comfortable the client was in divulging this information. In some cases, service providers recorded basic client information (such as name, date of birth, drug of choice and mode of administration) at the initial visit and obtained additional details at subsequent visits. No service developed a written care plan for clients. However, 28 services reported reviewing clients' needs after a number of visits – in some services after every two visits and in others after every 10 visits.

The majority of services recorded the following data at each return visit: date, used injecting equipment returned, sterile equipment received, client's sharing of injecting equipment (since last visit), drug(s) used (since last visit), condoms received, and length of visit.

Information was recorded on client assessment forms in 30 services and on a computer system in 19 services; some services recorded the data in both ways. Of the services recording data on computer, 16 used the Drugs/Aids Information System (DAIS), two used Microsoft Excel and one used a specially designed client-information system.

Services provided a range of sterile injecting equipment and materials. All 31 services provided different sizes and types of needle and syringe, as well as alcohol swabs and citric or acetic acid. All services also provided condoms. Thirty services provided stericups or cookers and sterile water; 28 provided non-toxic foil (for smoking heroin); eleven provided syringe identifiers; and seven provided tourniquets. No service provided single-use injecting packs, crack pipes or straws.

All 31 services provided information on safer injecting practices, overdose prevention and blood-borne viruses; 29 provided information on safer sexual health. All services discussed with clients the importance of safely disposing of needles and syringes.

All 31 services reported either providing social care and crisis counselling services on site or referring clients to other services that provided the necessary interventions. Accompanied referrals to either social care or health care services occurred infrequently in the majority of services. However, accompanied referrals to an emergency department were provided if a client presented to the service in a suicidal state.

Some services provided facilities in addition to needle and syringe exchange: 11 had a drop-in, club, lounge or open-access service, of which five had tea and coffee making facilities, nine provided meals (a sandwich at minimum), seven had leisure facilities (games, television), nine had telephone facilities and three had internet facilities available to service users.

Day-bed facilities were not provided by any service, though two provided night-bed facilities, with 17 and 20 beds available respectively. Lockers for personal belongings were available in two services. Eight services had personal hygiene facilities available to service users, of which seven had bath or shower facilities, seven had laundry facilities and four had clothes distribution facilities.

(Janet Robinson, Sarah Gibney, Martin Keane and Jean Long)

The authors are grateful for the help of exchange service managers and outreach workers in preparing this article.

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

Responsible serving of alcohol (RSA) programmes evaluated

The Heath Service Executive (HSE) recently published an evaluation of its responsible serving of alcohol (RSA) programmes – Club Cork and Smart Serve – in Cork city and its environs.[1]

The Club Cork alcohol and drug awareness training programme is a partnership between significant stakeholders involved in alcohol and drug awareness and health promotion in Cork city. This partnership comprises representatives of the health promotion department of HSE South, the Cork Local Drugs Task Force, the Garda Síochána, emergency departments, the emergency medical response team and a private security company. Club Cork is funded by the Cork Local Drugs Task Force. Initially devised to train nightclub staff to deal with alcohol- and drug-related issues on their premises, its remit has extended to training of personnel in pubs and clubs in Cork city. A total of 286 participants from nightclubs and pubs have been trained since its inception in 2003. The Smart Serve initiative was developed to promote responsible serving practices in off-licences; to date, approximately 60 personnel have completed this programme.

A mixture of quantitative and qualitative methods was used to evaluate Club Cork and Smart Serve. Semi-structured interviews were conducted with representatives of licensed premises who had completed the training programme and with Club Cork organisers and trainers. In addition, a postal questionnaire was sent to 302 people who had done the RSA course; the response rate was a disappointing 10%, mainly explained by a high turnover in bar staff. Telephone and face-to-face interviews were conducted with off-licence staff who had participated in the Smart Serve training programme.

The results indicate strong support for the Club Cork initiative. Its local partnership model was recognised as one of its main strengths. There was widespread support for RSA training becoming mandatory. The evaluation highlighted the need to explore the level of co-ordination between the Club Cork programme and other national RSA programmes, for example the Fáilte Ireland programme, to prevent unnecessary duplication.

The evaluation noted that the future of the Smart Serve RSA programme for off-licences needed to be critically evaluated, given the existence of the National Off-Licence Association (NOffLA) Responsible Trading in the Community programme, which is compulsory for its members. The lack of participation by the major supermarket chains in RSA programmes was also noted as a major issue given the significant volume of alcohol sales in these premises.

It is hoped that the recommendations outlined in this report will contribute to the proposed further roll-out of training for management and staff of licensed premises, both locally and nationally. These initiatives are currently being developed to respond to local needs in Cork county and in Co Kerry with support from the Southern Regional Drugs Task Force.

(Deirdre Mongan)

1. Houghton F and Fitzmaurice E (2008) *Responsible serving of alcohol: an evaluation of the Health Service Executive's Club Cork and Smart Serve initiatives in the Cork region.* Cork: HSE South.

The geography of prisoner reintegration

The geographical distribution of prisoners released in 2004 has been mapped to 'set out what is known about the community contexts from which prisoners are drawn and to which they will likely return'.[1] The research team, led by UCD Professor of Criminology Ian O'Donnell, used data from the Irish Prison Service's new computer-based records system (PRIS) to track and map the known addresses of 5,057 prisoners (out of a possible 5,588) who were released in 2004.

The method of mapping

The known addresses of released prisoners were coded to the appropriate electoral division (ED) and these divisions were assigned a social deprivation rating according to a deprivation index.[2] This index was computed using census data relating to unemployment, car ownership, overcrowding, local authority housing and social class. A further analytic dimension was provided by the calculation of a standardised prisoner ratio for each ED. This is the ratio of the observed number of prisoners in an ED to the expected number given the age and gender profile of the ED population.

Findings of the research

The most deprived areas in the country had 145.9 prisoners per 10,000 population, compared to 6.3 in the least deprived areas. The authors state that 'the magnitude of this difference is startling and demonstrates unequivocally that it is the areas already marked by serious disadvantage that must

Prisoner reintegration *(continued)*

bear the brunt of social problems that accompany released prisoners' (p. 4). Most prisoners came from city areas – 28.6 per 10,000 population overall, compared to 6.3 from rural areas. Thirty-eight per cent of prisoners released in 2004 had Dublin addresses. A number of Dublin suburbs had high standard prisoner ratios for all crime sub-categories, including: Finglas, Ballymun and Darndale on the north side; Fettercairn and Jobstown in Tallaght; Cherry Orchard, Rowlagh, Moorfield, Palmerstown and Mulhuddart in the south west; Summerhill, Ballybough and Sherriff Street in the north inner city; and Dolphin's Barn, the Coombe and the Liberties in the south inner city. Deprived suburban areas in Cork, Limerick and Galway also had higher prisoner ratios. However, a number of very deprived areas did not have any prisoners, particularly in Donegal, Kerry, Galway and Mayo.

Drugs and deprivation

This study clearly highlights the link between drugs and poverty: in the most deprived areas there were 57.8 prisoners per 10,000 released after serving a sentence for a drug-related crime, compared to 1.8 in the least deprived areas. In terms of the geographic distribution of drug-related crime, Dublin, followed by the mid-west region (Clare, Limerick and North Tipperary) was more likely to have higher numbers of prisoners convicted for drug-related crimes. While the distribution of violent offenders in Dublin was spread evenly between the suburbs and the inner city, prisoners serving sentences for drug offences and, to a lesser degree, for property offences were more likely to emanate from the inner city than the suburbs.

Meeting the challenge of prisoner recidivism

The high rate of recidivism has been empirically demonstrated – more than 25% of offenders are re-incarcerated within 12 months of release and approximately 50% within four years.[3] Mapping the areas that are likely to be home to returning prisoners pinpoints where the challenges are located; the next step is to target these areas with solutions.

(Anne Marie Donovan)

1. O'Donnell I, Teljeur C, Hughes N, Baumer E and Kelly A (2007) When prisoners go home: punishment, social deprivation and the geography of reintegration. *Irish Criminal Law Journal,* 17(4): 3–9.
2. This index was calculated by the Small Area Health Research Unit (SAHRU) in Trinity College Dublin.
3. O'Donnell I, Baumer E and Hughes N (2008) Recidivism in the Republic of Ireland. *Criminology and Criminal Justice,* 8(2): 123–146.

Applying the life cycle approach to social inclusion policy

An article in the Autumn 2007 issue of *Drugnet Ireland* described how illicit drug misuse has been fitted into the new life cycle approach to social inclusion policy in Ireland, as presented in the social partnership agreement Towards 2016, the national development plan 2007–2013, and the action plan for social inclusion 2007–2016. The drugs issue is addressed within the childhood, youth and working age stages of the life cycle, and under the additional heading 'Communities'.[1]

On 1 October 2008 the Economic and Social Research Institute (ESRI) hosted an international seminar on the life cycle approach to social inclusion.[2] The seminar marked the publication of the ESRI's research into the role that life cycle factors play in shaping patterns of poverty and social exclusion in contemporary Irish society.[3] The authors observed that the life cycle approach has been introduced in Ireland without any systematic effort to link its use to the broader literature on the concept, and no detailed consideration of how it should be applied in addressing social issues.[4]

The authors explained how the life cycle approach to social inclusion marks a shift in perceptions of the nature of risk. Traditionally, social policy interventions have focused on risks associated with unemployment, disability, and insufficient resources in childhood and old age, and have tended to redistribute resources across the life cycle, from working age groups to children and to older people. More recently, social policy interventions have begun to focus on risks faced by specific sub-groups at particular stages in their lives, for example risks associated with entering the labour market, remaining in the labour market, or managing care responsibilities. These 'new' risk perceptions have emerged in response to the greater variability and reduced stability in career and family patterns. In essence, the life cycle approach seeks to reconcile social and economic objectives, and to emphasise the 'multidimensional' and 'dynamic' aspects of the social inclusion process: risks of being socially excluded are linked across problem areas, and difficulties experienced in any specific life cycle stage may be a consequence of difficulties in an earlier stage or a precursor of later problems.

The authors commented that while the life cycle approach offers a set of lenses through which to focus on the issues, it does not offer a ready-made set of prescriptions: a 'general analytic framework that accounts for the dynamics and the links

Applying the life cycle approach *(continued)*

between events and the appropriate analytic tools' is needed. To fully understand the nature of the dynamic inter-related risks requires the mapping of social exclusion patterns across the life cycle, and an understanding of the manner in which they combine with other socio-economic characteristics. Longitudinal data such as that beginning to emerge from the EU-SILC[5] and being gathered through the Growing Up in Ireland (GUI)[6] and the Longitudinal Study of Ageing in Ireland (TILDA)[7] studies, are expected to greatly enhance Ireland's capacity to map and analyse the dynamics and inter-related risks. These data will support research into the consequences of various policies and interventions for life cycle outcomes, and will play a critical role in translating the life cycle perspective into specific forms of policy evaluation and prescription.

In the drugs area, longitudinal studies have been undertaken in Ireland that suggest how a 'general analytic framework' for a life cycle approach to the drug-related aspects of social inclusion policy might develop. For example:

- **Irish children and their families:**[8] Conducted in two phases (1990 and 2000), this study investigated social development and family background, and health and well-being, and sought to assess childhood health and behaviour and the adult outcomes. Alcohol and drug use were two variables examined in this study.
- **Young people:**[9] Conducted in two phases (1998 and 2001), this ethnographic study of drug use among young people in a Dublin inner-city community analysed changes in drug use behaviour over the study period. The authors argued that models of risk that rely on individualistic and rationalistic assumptions struggle to accommodate the fluidity and contradiction that characterises much drug use. Implications for strategies and initiatives aimed at reducing drug-related harm were discussed.
- **Research Outcome Study in Ireland (ROSIE):**[10] This longitudinal drug treatment outcome study monitored the progress of opiate users entering treatment between September 2003 and July 2004 at time-anchored points – at treatment intake, at one year and at three years after intake. The study monitored the influence of opiate treatment on key outcome measures, including drug use; general health; social functioning, including employment, accommodation and involvement in crime; harm (injecting behaviour and experience of overdose); and mortality.

According to the authors of the ESRI research, it is these types of studies that will assist policy makers to recognise the varying needs of individuals and to design both services that provide protection against risks and also innovative social policy measures that address unmet needs and pre-empt problems.

(Brigid Pike)

1. Pike B (2007) Where do illicit drugs fit in the new social inclusion policy framework? *Drugnet Ireland,* (23): 5.
2. Copies of the overhead presentations given at the seminar were retrieved on 17 November 2008 at www.esri.ie
3. Whelan CT and Maître B (2008) *The life cycle perspective on social inclusion in Ireland: An analysis of EU-SILC.* Dublin: Economic and Social Research Institute.
4. Whelan CT and Maître B (2008) 'New' and 'old' social risks: life cycle and social class perspectives on social exclusion in Ireland. *Economic and Social Review,* 39(2): 131–156.
5. EU-SILC is an annual, EU-wide survey conducted in Ireland by the Central Statistics Office, in order to obtain information on the income and living conditions of different types of households. It commenced in 2003.
6. Growing Up in Ireland is a government-sponsored national study of children. Commenced in 2007, the study will take place over seven years and follow the progress of two groups of children; 8,500 nine-year-olds and 10,000 nine-month-olds. The aim of the study is to paint a full picture of children in Ireland and how they are developing in the current social, economic and cultural environment.
7. The Irish Longitudinal Study of Ageing is a national study of a representative cohort of up to 10,000 Irish people over the age of 50 years. Commenced in 2006, the study will chart the health, social and economic circumstances of the participants over a 10-year period.
8. Cleary A, Fitzgerald M and Nixon E (2004) *From child to adult: a longitudinal study of Irish children and their families.* Dublin: University College, Dublin.
9. Mayock P (2005) 'Scripting' risk: young people and the construction of drug journeys. *Drugs: education, prevention and policy,* 12(5): 349–368.
10. Further information on the ROSIE study, including the seven ROSIE Findings bulletins published to date, may be found on the website of the National Advisory Committee on Drugs at www.nacd.ie

In brief

Between 7 and 9 July 2008 the **'Beyond 2008' NGO Forum** was held in Vienna. It was the final step in the global consultation of NGOs involved in responding to drug-related problems. The Forum adopted by consensus a Declaration and three Resolutions. These have been submitted to the Commission on Narcotic Drugs and the United Nations Office on Drugs and Crime for consideration as they prepare for the review of the UN's 10-year (1998–2008) action plan against illicit drugs, which is due to take place in March 2009. www.vngoc.org

On 21 August 2008 the government's new homelessness strategy, ***The way home: a strategy to address adult homelessness in Ireland, 2008–2013,*** was released by the Department of the Environment, Heritage and Local Government. www.environ.ie

On 28 August 2008 the **Institute of Public Health in Ireland** and the **Combat Poverty Agency** published ***Tackling health inequalities: an all-Ireland approach to social determinants.*** The report highlights the extent to which health outcomes are influenced by social factors such as poor housing, nutrition and education. The report also demonstrates how health behaviours, e.g. the food we eat, how much exercise we take, whether or not we smoke or drink, have a direct and important impact on our health. The WHO estimates that lifestyle-related factors, including smoking and alcohol misuse, are implicated in at least a third of the total burden of disease in Europe. www.combatpoverty.ie / www.publichealth.ie

On 26 September 2008 the **British–Irish Council** summit meeting agreed to a renewed focus on the families of problem drug users in any future drugs strategies prepared, with a view to providing increased support to those families and to better harness their potential to facilitate life improvements for problem drug users. www.british-irishcouncil.org

On 30 September 2008 the **Dial to Stop Drug Dealing** campaign was launched. It includes a number of local and regional campaigns, organised through the local and regional drugs task forces. The objective is to encourage people to ring a confidential telephone number with any information they may have on drug dealing. Details of the roll-out and operation of this national scheme were provided by Minister of State Curran in response to questions asked in Dáil Éireann on 7 October 2008. www.oireachtas.ie

In September 2008 the **Inspector of Prisons** presented an interim report to the Minister for Justice, Equality and Law Reform. Reporting on his first round of prison visits, the new Inspector reported a number of areas of particular concern, including the prevalence of drugs issues, an area in which he called for 'positive action' by prison management. www.justice.ie

In September 2008 the ***National report for Ireland on strategies for social protection & social inclusion 2008–2010*** was submitted to the European Commission by the Office for Social Inclusion. It sets out Ireland's plans in response to the EU's common objectives with regard to social inclusion, pensions and health and long-term care. The issue of illicit drugs is addressed under the heading of social inclusion. www.socialinclusion.ie

On 2–4 October 2008, the **European Society for Social Drug Research (ESSD)** held its 19th annual conference in Budapest. Fifty researchers from 21 European countries presented some 36 current research projects for discussion with their colleagues about conceptual design and methodological issues. Irish researchers Paula Mayock, Jennifer Cronly and Michael Clatts presented a paper entitled 'The onset of heroin use among "high risk" youth in Ireland: an ethnoepidemiological approach'. (The Pompidou Group provides financial support for the organisation of the ESSD annual conference and the publication of its annual book.) www.coe.int/t/dg3/pompidou

On 7 October 2008 **the role of sport and recreation in preventing drug use** was the subject of a Parliamentary Question. Minister of State Curran responded: 'While the provision of sport and recreational facilities may have a role to play, they will not, in themselves, provide the solution to the misuse of illicit substances. Ultimately, I believe that it is only through addressing the risk factors through both the National Drugs Strategy — and the broader social inclusion agenda — that we can ultimately reduce the prevalence of problem drug use in our society.' www.oireachtas.ie

On 14 October 2008 the **budget for 2009** was announced by Brian Lenihan TD, Minister for Finance. In a statement on the same day Minister Ó Cuív and Minister of State Curran stated that their primary concern is to make every effort to ensure that the daily front-line services, especially those focused on the needs of the most socially deprived communities, are protected. With regard to drugs, the capital allocation of €8.1 million for 2009 includes funding for the Premises Initiative, which provides for the accommodation needs of community-based drugs projects, and also for the Regional Youth Initiative, announced earlier this year. This Initiative will provide capital funding for the development of dedicated youth facilities in regional drugs task force areas, not covered under the Young People's Facilities and Services Fund. Sixteen projects are being supported under this Initiative to the tune of almost €2.3m. On the current side, the focus will be on protecting front-line community-based projects and initiatives delivering vital services in areas worst affected by the drug problem. www.pobail.ie

On 15–16 October 2008 the **Children Acts Advisory Board's 2008 National Conference** was held in Dublin. The theme of the conference was 'More than rhetoric: improving outcomes for children and their families through inter-agency working'. www.srsb.ie

In October 2008 the **National Office for the Prevention of Domestic, Sexual and Gender-based Violence (Cosc)** published a summary of the submissions it had received with regard to the development of a national strategy on domestic, sexual and gender-based violence. Drugs were mentioned under two headings. With regard to ensuring that services meet the needs of various population groups, there was a call for the provision of high-dependency units for women who experience domestic violence and have alcohol and drug dependencies. With regard to legislative provisions, it was observed that the lack of a statutory definition of sexual consent gives rise to a lack of clarity, particularly in cases where capacity to give consent is in question, such as those involving people under the influence of drugs or alcohol. There were calls for an alternative, expanded and more comprehensive definition of the concept, with the principal focus being on the conduct of the accused rather than of the complainant. It was also stressed that the issue of consent and voluntary intoxication should be clarified. www.cosc.ie

(Compiled by Brigid Pike)

MQI annual review 2007

The Merchants Quay Ireland (MQI) annual review for 2007 was launched by Mr John Curran TD, Minister of State for drugs strategy on 12 September 2008.[1]

MQI's needle-exchange service recorded that the number of client visits in 2007 remained steady at just under 40,000; however 1,333 of those visits were by new clients. The report also highlights a continuing high level of demand for homeless services, with an 11% increase in the number of meals provided for homeless people and a 33% increase in the numbers seeking help from MQI's primary health care services

The review describes the national prison-based addiction counselling service introduced in 2007 and run by MQI in partnership with the Irish Prison Service. The service offers structured assessments and evidence-based counselling interventions with clearly defined treatment plans and goals. This occurs in the context of care planning within multidisciplinary teams. By December of 2007 MQI was providing 400 counselling hours per month within the prisons. When fully operational, the service will provide 1,000 counselling hours per month in 13 prisons nationally.

The types of service offered by MQI and the numbers of people accessing them in 2007 are shown below.

Service	Type of intervention	No. of participants	Outcomes
Needle-exchange and health-promotion services	Promoting safer injecting techniques	Not available	Not available
	HIV and hepatitis prevention	(1,333 new clients)	
	Safe sex advice	606 safer injecting workshops	
	Information on overdose		
Stabilisation services	Methadone substitution	30	Not available
	Supportive day programmes	17	Not available
	Gateway programme	48 (monthly average)	Not available
	Counselling	Not available	Not available
Settlement service	Assist service users to access interim and long-term accommodation	52 (monthly average)	36 people were successfully settled
Integration programmes	Access to transitional accommodation (Ballymount House) for up to 24 weeks	15	Not available
	Group and one-to-one therapeutic sessions		
Training and work programmes	FÁS Community Employment scheme Catering training programme	130	45% secured permanent employment or moved to further education
	Catering training programme	Not available	Not available
High Park	17-week, drug-free residential programme including individual counselling, group therapy, educational groups, work assignments and recreational activities	52 (of whom 20 were admitted for detoxification)	16 completed detox
St Francis Farm	Therapeutic facility offering a 6–12 month programme	54	17 completed three months or more

(Vivion McGuire)

1. Merchants Quay Ireland (2008) *Annual review 2007.* Dublin: MQI.

From *Drugnet Europe*

Drugs in prisons — healthcare is crucial

Article by Dagmar Hedrich in Drugnet Europe No. 64, October–December 2008

According to the [EMCDDA] Annual report 2008, survey data show that the EU prison population on a given day is over 600 000, with numbers of prisoners rising in most countries.[1] It is estimated that, in almost all Member States, over 10 % of prisoners are drug-law offenders. And studies show that the proportion of inmates who have used heroin, cocaine or amphetamines in their lifetime can, in some prisons, be as high as 50–60 %.

The fact that drugs find their way into prisons, despite measures taken to reduce supply, is recognised by policymakers and prison experts alike. A challenge for prison systems in Europe is therefore to respond to the specific healthcare needs generated by drug problems, such as the burden of drug-related infectious diseases (e.g. hepatitis B and C, HIV/AIDS). According to the report, there are some indications that prison health policies are being shaped to meet these needs, with more countries than five years ago now reporting prevention activities; infectious disease screening and vaccination; and treatment for drug dependence.

But despite these improvements, much remains to be done. The report states that few prisons, for example, address the acute risk of death among newly released prisoners through overdose. Raising awareness of these risks and providing a seamless transition to external drug treatment, can play a key role in reducing drug-related deaths in this high-risk group.

1. Aebi MF and Delgrande N (2008) *Council of Europe Annual Penal Statistics (SPACE 1): 2006 survey on prison populations.* Strasbourg: Council of Europe Publishing.

National drug-related research in Europe

Cited from article by Margareta Nilson and Maria Moreira in Drugnet Europe No. 64, October–December 2008

Drug-related research is crucial to Europe's understanding of its drug problems. Research enables Europe to learn lessons from the past, sharpens its awareness and monitoring of the present and helps countries prepare for the future. Yet building a picture of drug-related research in Europe remains challenging.

National drug-related research in Europe, published by the EMCDDA on 17 October, aims to respond to this challenge.[1] The publication is based on reports compiled by 27 Reitox national focal points (NFPs) in 2007, which provide an outline of drug-related research at national level. Research was seen to have increased over the last decade in a number of areas, including: prevalence, incidence and patterns of drug use; the evaluation of interventions; and economic aspects.

The report concludes that European drug-related research has seen considerable improvements since 1996. Research is now considered a priority in many EU Member States, being mentioned in the national drug policy documents of 20 of the 27 reporting countries. Also, most countries report relatively stable funding at national level, although concerns about funding availability and sustainability are still expressed.

But despite some improvements, a number of issues remain unresolved. Well-functioning coordination among researchers, research centres and research areas, for example, continues to be a fundamental structural problem in most countries, as was the case in 1996. And, although most national drug strategies and action plans now refer to the need for evidence based policies, the link between research results and policymaking is often difficult to make.

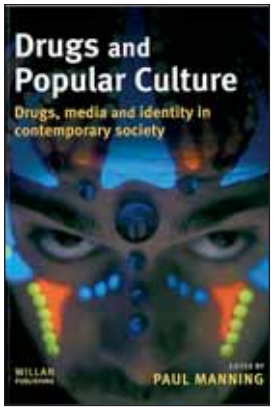
1. Available at www.emcdda.europa.eu/publications/selected-issues.

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

Books

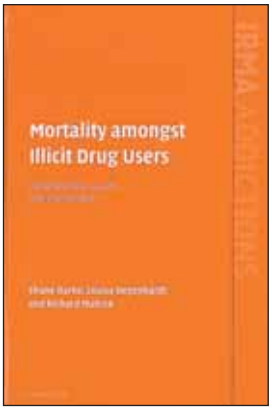


Drugs and popular culture: drugs, media and identity in contemporary society

Manning P (ed.)
Willan Publishing
2007, 290 pages
ISBN: 978 1 84392 210 0 (paperback)

The use of illegal drugs is so common that a number of commentators now refer to the 'normalisation' of drug consumption. It is surprising, then, that to date very little academic work has explored drug use as part of contemporary popular culture. This collection of readings applies an innovatory, multi-disciplinary approach to this theme, combining some of the most recent research on 'the normalisation thesis' with fresh work on the relationship between drug use and popular culture.

The particular focus of the book is upon drug consumption as popular culture, and it offers new and important insights into the cultural significance of widespread drug consumption as a feature of contemporary society. In drawing upon criminological, sociological and cultural studies approaches, this book makes an important contribution to the newly emerging field positioned at the intersection of these disciplines. It provides an accessible collection of chapters and readings that explore drug use in popular culture in each of the main mass media, and in a way that is relevant to undergraduates and postgraduates studying a variety of courses, including criminology, sociology, media studies, health care and social work.



Mortality amongst illicit drug users: epidemiology, causes and intervention

Darke S, Degenhardt L and Mattick R
Cambridge University Press
2007, 192 pages
ISBN: 978 0 521 85506 8 (hardback)

Over the past 40 years the rate of illicit drug use has risen dramatically, and with it the number o deaths reported among drug-using populations. What are the clinical, ethical and psychopathological implications of these deaths? In this book, Shane Darke and his team provide the first full, synthetic review of the epidemiology, causes, prevalence, demography, and associated risk factors of illicit-drug-related mortality. In addition, they examine and evaluate interventions to reduce these deaths. The major causes of death among illicit drug users are overdose, disease, suicide and trauma. Each is independently examined. This is an important book for all clinicians and policy-makers involved in issues relating to illicit drug use.

Journal articles

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

Illicit methadone use and abuse in young people accessing treatment for opiate dependence

Roche A, McCabe S and Smyth B
European Addiction Research 2008; 14(4): 219–225

Recent publications *(continued)*

This study examines illicit methadone use in a group of young people attending a Dublin clinic for treatment of opiate dependence. A structured questionnaire was designed and administered to eligible participants (aged 25 years or under and receiving treatment for opiate dependence). Of the total number of participants (n = 81), 73% reported illicit methadone use before treatment entry and the main reason for use was to manage opiate withdrawals. During treatment 55% reported illicit methadone use and failure to get to the clinic was the main reason given. Some participants reported use for hedonic effects (33% prior to treatment and 12% in treatment). Despite strict controls, most participants reported that illicit methadone was readily available at low cost (EUR 23 per 80 mg). Despite legislative and administrative efforts to curtail methadone diversion in Ireland, we found that it is widespread. Although it is generally used to self-medicate withdrawal symptoms in established opiate addicts, the extent of its use raises concerns as a risk for opiate overdose in the community.

An uncertain dominion: Irish psychiatry, methadone, and the treatment of opiate abuse

Saris AJ
Culture, Medicine and Psychiatry 2008; 32(2): 259–277

This paper investigates some productive ambiguities around the medical administration of methadone in the Republic of Ireland. The tensions surrounding methadone maintenance therapy (MMT) are outlined, as well as the sociohistorical context in which a serious heroin addiction problem in Ireland developed. Irish psychiatry intervened in this situation, during a time of institutional change, debates concerning the nature of addiction, moral panics concerning heroin addiction in Irish society and the recent boom in the Irish economy, known popularly as the Celtic Tiger. A particular history of this sort illuminates how technologies like MMT become cosmopolitan, settling into, while changing, local contexts.

Acute effects of cocaine on the neurobiology of cognitive control

Garavan H, Kaufman JN and Hester R
Philosophical transactions of the Royal Society of London. Series B, Biological sciences. 2008; 363(1507):3267–76

Compromised ability to exert control over drug urges and drug-seeking behaviour is a characteristic of addiction. One specific cognitive control function, impulse control, has been shown to be a risk factor for the development of substance problems and has been linked in animal models to increased drug administration and relapse. The authors present evidence of a direct effect of cocaine on the neurobiology underlying impulse control. In a laboratory test of motor response inhibition, an intravenous cocaine administration improved task performance in 13 cocaine users. This improvement was accompanied by increased activation in right dorsolateral and inferior frontal cortex, regions considered critical for this cognitive function. Similarly, for both inhibitory control and action monitoring processes, cocaine normalized activation levels in lateral and medial prefrontal regions previously reported to be hypoactive in users relative to drug-naive controls. The acute amelioration of neurocognitive dysfunction may reflect a chronic dysregulation of those brain regions and the cognitive processes they

Recent publications *(continued)*

subserve. Furthermore, the effects of cocaine on midline function suggest a dopaminergically mediated intersection between cocaine's acute reinforcing effects and its effects on cognitive control.

Complications of heroin abuse

O'Connor G and McMahon G
European Journal of Emergency Medicine
2008; 15(2):104–6.

A 21-year-old man presented to the emergency department in St James's Hospital by ambulance. He was found collapsed at home by his uncle, complaining of severe pain and swelling to his left lower limb, with reduced sensation to his left foot. He was hepatitis C positive from intravenous drug use, and had most recently used both heroin and cocaine five days previously on his release from prison.

Musculoskeletal exam showed extensive swelling of his left lower limb, with tense calf compartments. Initial laboratory results showed a raised creatine kinase of more than 155,000 IU/l. Urine toxicology was positive for methadone, heroin and benzodiazepines, whereas urinary dipstick was positive for blood, which was confirmed to be myoglobin by subsequent laboratory analysis. Atraumatic rhabdomyolysis is a syndrome characterised by injury to skeletal muscle with subsequent release of intracellular contents, that is, myoglobin and creatine kinase. Drugs have direct toxic effects, but may also cause coma-induced rhabdomyolysis, owing to unrelieved pressure on gravity-dependent body parts. Diagnosis is made with history (i.e. recent heroin or cocaine use), elevated serum CK, plus the possible presence of myoglobinuria.

Aggressive i.v. rehydration remains the mainstay of treatment. If there is any evidence of compartment syndrome, urgent fasciotomy is required. Electrolyte imbalances should be corrected, unless very mildly abnormal. We have learned from our experience with this case that a high index of suspicion and thereby early recognition is crucial to prevent complications in intravenous drug users presenting with unusual symptoms and signs.

(Compiled by Louise Farragher and Joan Moore)

National Documentation Centre on Drug Use

TCD MSc students

TCD Diploma students

Students from TCD's MSc in drugs and alcohol policy and Diploma in addiction studies courses on recent visits to the National Documentation Centre on Drug Use (NDC).

The NDC regularly hosts information sessions for groups of students. We also run day-long seminars comprising sessions on research-related topics and information literacy tutorials. If you are co-ordinator of a drugs or addiction programme and would like to arrange either a visit to the NDC or an external information session, please contact us at ndc@hrb.ie.

Upcoming events

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

January

13 January 2009

6th Annual Drug & Alcohol Professionals Conference
Venue: Royal Institute of British Architects, London
Organised by/Contact: Federation of Drug & Alcohol Professionals (FDAP) and Drink & Drugs News
Email: office@fdap.org.uk
www.fdap.org.uk

Information: This year's plenary presentations will cover:

- The new drug strategy and evaluation of the first drug strategy.
- Working with families.
- Young drinkers and implications for policy.
- Getting people into employment.
- The Independent Safeguarding Authority and implications for our field.
- Diversity and inequality at work.

Practical workshops and seminars will cover a range of issues, including: khat, ketamine and cannabis; diversity and dual diagnosis; Suboxone (buprenorphine/naloxone); staff training and development.

January – March

Drugs & Alcohol at Work: Complying with Section 13 of the Safety Health & Welfare at Work Act 2005
Organised by/Contact: Anita Furlong, Conference Administrator, EAP Institute, 143 Barrack Street,
Waterford, Ireland
Tel: +353 (0)51 855733
Email: anita@eapinstitute.com
www.eapinstitute.com

Thursday 22 January 2009
Venue: Viking Ramada Hotel, Waterford

Thursday 19 February 2009
Venue: Courtyard by Marriott Hotel, Galway

Thursday 12 March 2009
Venue: Carlton Hotel, Dublin Airport

Information: The purpose of these seminars is to outline the impact of drug impairment in the workforce, and practical steps in the recognition and treatment of employees whose behaviour presents risks to themselves and others while at work. Subjects covered will include:

- Directors' responsibilities, risk assessments and control measures to comply with Section 13, Safety, Health and Welfare at Work Act 2005.
- Update on the development of workplace policies, HAS regulations, codes of practice and employment law issues.
- Standard operating procedure (SOP) and laboratory best practice for employee drug testing.

February

11 February 2009

Families, drugs and alcohol: innovations in practice, new insights from research
Venue: Cavendish Conference Centre, 22 Duchess Mews, London
Organised by/Contact: KCA (UK) Training and Professional Development, 43a Windmill Street, Gravesend, Kent, DA12 1BA
Tel: +44 (0)1474 326168
Email: tcw@kca.org.uk
www.kca.org.uk

Information: Children, including the unborn, whose parents misuse alcohol and illicit drugs are at increased risk of developing substance misuse problems in later life, as well as being exposed to an assortment of other threats to their development. Specialised services targeting families have expanded rapidly in recent years, a trend that has been further accelerated by the new drug strategy. This conference will provide a timely opportunity for practitioners, service commissioners, policy makers and researchers to share good practice and new understandings from research.

March

11–14 March 2009

The 3rd International Conference on Fetal Alcohol Spectrum Disorder. Integrated Research, Policy and Promising Practice around the World: A Catalyst for Change
Venue: Victoria Conference Centre, British Columbia, Canada
Organised by/Contact: University of British Columbia
Tel: +1 (604) 822-7524
E-mail: ipad@interchange.ubc.ca
www.interprofessional.ubc.ca

Information: The conference goal is to highlight international research and promising practice as a catalyst for promoting social inclusion and

Upcoming events *(continued)*

creating healthy communities. Participants can expect to:

- Learn about the current practical application of leading research around the world and its potential to effect future change.
- Learn about ways to engage multiple communities at multiple levels and build capacity.
- Promote and nurture linkages across families, communities and international networks.
- Foster clinical and community-based research.

June

2–5 June 2009

12th European Federation of Therapeutic Communities Conference: Eyes on the future
Venue: World Forum Convention Center, The Hague
Organised by/Contact: Brijder Verslavingszorg and Verslavingszorg Noord Nederland (VNN)
Chair of Local Organising Committee: Mark de Haan
www.eftc-bepartofthesolution.eu

Information: The European Federation of Therapeutic Communities invites abstracts for this conference on Rehabilitation and Drug Policy. Further details on the EFTC website. The main conference themes are:

- Effectiveness: evidence based and best practice.
- Organisation and innovation.
- Justice.
- Population mobility and new challenges in treatment and prevention.
- The growth and role of spirituality in addiction treatments.

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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