drugnet IRELAND

Newsletter of the Alcohol and Drug Research Unit

Issue 29
Spring 2009

The NDC
Directory of courses and training programmes on drug misuse in Ireland 2009
has now been published.

See details on p. 20.

Drugnet Ireland **online**
http://hrb.newsweaver.ie/

- Agreed Programme for Government - progress report
- Cannabis use in Ireland
- HSE plans for drug and alcohol services
- Alcohol pricing and promotion
- Assessment of early interventions
- Youth homelessness
- Treatment needs in North Eastern RDTF
- Review of the evidence base in drug prevention
- EU Drugs Action Plan evaluated
- EU sets priority for drug policy 2009–2012

Crack cocaine seminar

The Inter-Sectoral Crack Cocaine Strategy Group (ISCCSG), established by the late Tony Gregory through the North Inner City Community Policing Forum, hosted a seminar in Croke Park on 24 February 2009. The purpose of the seminar was to try to plan a co-ordinated response to crack cocaine use in Ireland. Much of this response will be based on the findings of a recent Health Research Board (HRB) report, *Crack cocaine in the Dublin region – an evidence base for a crack cocaine strategy*. A detailed report of the seminar will appear in the next issue of *Drugnet Ireland*.

Thierry Charlois, manager of the Democracy, Cities & Drugs project, part of the European Forum on Urban Safety, speaking at the crack cocaine seminar in Croke Park (Photo: JJ Berkeley)

HRB Overview 8: Development of Ireland's drug strategy 2000–2007

Published in December 2008, *Development of Ireland's drug strategy 2000–2007*, the eighth in the Health Research Board's Overview series,[1] analyses how the *National Drugs Strategy 2001–2008* (NDS) was designed and developed, and how strategic management processes and governance arrangements were used to support implementation during its first seven years. The objective is to gain insights into how these infrastructural elements may influence the realisation of the intended strategy and to explore options for the effective management of these elements.

The analysis is based on the work of strategy theorist Henry Mintzberg.[2] Over the course of a 30-year project researching and thinking about the strategy process, Mintzberg reached the conclusion that *intended* strategy is almost never the same as *realised* strategy. He explored how organisational leadership, structure and resources, as well as developments in the external environment, conspire to alter the course of the best-laid plans. He identified five 'strategic forms': strategies as intended plans, before action, and as realised patterns, after action; as deliberate strategy, when the intentions are more or less realised in the actions; as unrealised strategy, when the intentions are not realised; and as emergent strategy, when the patterns realised in action were never intended (see figure on p. 3). In analysing the development of Ireland's drugs strategy within this framework, the overview highlights some underlying tensions.

First, in setting direction, it is apparent that there has been an ongoing disconnect between the strategic objective and goals, which express an aspiration to reduce the harm to individuals, families and society from illicit drugs, and the operational objectives and key performance indicators, some of which have directed effort towards the prohibition of the illicit drug market and a drug-free society. Arguably, this 'duality of approaches' has

contents

1 Crack cocaine seminar
1 HRB Overview 8: Development of Ireland's drug strategy 2000–2007
3 Illicit drugs, alcohol and tobacco – understanding the policy issues
5 Tenth annual Service of Commemoration and Hope
5 Family Matters seminar
6 Agreed Programme for Government – progress report 2008
7 Cannabis use in Ireland
9 Cannabis again reclassified in the UK
10 HSE outlines plans for drug and alcohol services in 2009
11 British–Irish Council meeting on drug misuse
12 Review of the evidence base in drug prevention
13 Tony Gregory 1947–2009 – an appreciation
13 Substance use among Ireland's children
14 Alcohol Implementation Group report 2008
15 Alcohol pricing and promotion
16 Maggie Bowen – an appreciation
17 Assessment of early interventions for at-risk youth
18 The process of youth homelessness
19 An assessment of treatment needs in the North Eastern RDTF
20 Directory of courses 2009
20 Study on drug use in Clondalkin
21 Kerry Life Education evaluation report
22 Trends in alcohol and drug admissions to psychiatric facilities
23 Four cases of botulism among drug users
24 The State Laboratory annual report 2007
24 EU Drugs Action Plan evaluated
25 EU sets priorities for drug policy 2009–2012
27 Irish Prison Service annual report 2007
28 From ***Drugnet Europe***
29 In brief
30 Recent publications
31 Upcoming events

Development of Ireland's drug strategy *(continued)*

created a space in which politicians have been able to manoeuvre, responding to different needs and audiences at different times. A critical challenge for effective strategic management is to achieve a balance between the competing demands for ambiguity and for precision, to ensure that political expediency does not crowd out consideration of the evidence base or, equally, that a slavish adherence to analytical certainty does not preclude innovation and bold policy. Two activities which would help to ensure effective management of this ambiguity are the formulation of a more rigorous system of performance measurement, for example a drug harm index, and a drive for more integrated performance through measuring and evaluating outputs and outcomes, rather than inputs and processes.

Second, with regard to informing strategic choices, two broad information types have been drawn on – scientifically derived, or evidence-based, information, and public opinion. These two streams of information reflect the rational and the non-rational aspects of the decision-making process. During the lifetime of the NDS considerable effort has gone into building up the evidence base, but little comprehensive, systematic, scientific investigation of the nature of public opinion and the role of the media, has been undertaken. Furthermore, while there have been significant strides in building the evidence base, there have been gaps in the use of overt analytical, modelling or evaluative approaches to policy development.

Third, an exploration of the mechanisms for co-ordinating the implementation of the NDS, and the allocation of responsibilities to individual entities for implementation, has highlighted some complex governance issues. While the various actors may share common aspirations with regard to the implementation of the NDS, they have other organisational priorities as well, which can run counter to the NDS objective. The recent OECD review of the Irish public service,[3] suggests ways of overcoming such tensions, for example through adopting networked organisational forms and integrated performance management systems.

Fourth, during the lifetime of the NDS, changes in the external environment have been amenable to control through means such as project planning, the mid-term review of the NDS, and the creation of the Emerging Needs Fund. Other changes, however, usually in the wider public policy environment, have had a more oblique connection to the NDS. It is not clear whether or how the intention behind initiatives, such as shifts in social inclusion policy or the introduction of drug testing in various contexts, has been compared with, or assessed against, the intentions behind the NDS. Steps to develop a system of strategic control that incorporates both emerging and intended strategies are canvassed.

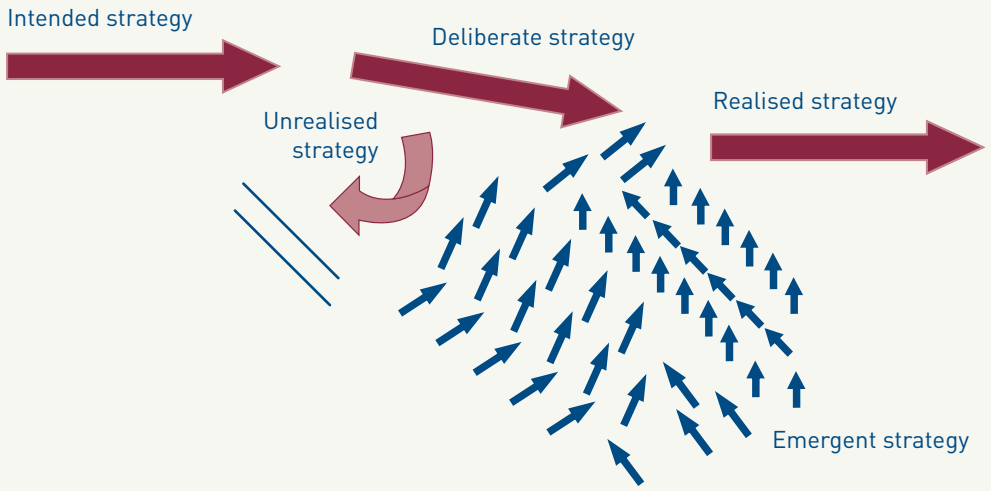
Although formal strategic plans are useful in ensuring the future is taken into account and in co-ordinating activities, they can never entirely remove the types of tensions outlined above, and neither can they eliminate uncertainty. In order to realise a strategic plan, Henry Mintzberg believed it is crucial to recognise that strategy development is a continuous process, based on real-time learning. Accepting this premise, this Overview on the development of Ireland's drug strategy identifies two requirements for effective strategy formation:

- It is through continuously working with and managing the instabilities and conflicts which are an inherent part of strategy, that strategy moves forward in an effective manner. The tendency to reduce uncertainty, to seek stability by focusing on that which is amenable to control, distracts from the real task of the strategist.
- Continuous and inclusive debate and deliberation on the direction and contents of strategy is at the heart of effective strategy formation. It is through open, informed and critical debate, involving all players and drawing on all possible sources of information and all perspectives, that the insights gained from strategic implementation, and practical and acceptable options for resolving critical strategic tensions, are found.

(Brigid Pike)

1. Pike B (2008) *Development of Ireland's drug strategy 2000–2007*. HRB Overview Series 8. Dublin: Health Research Board.
2. Henry Mintzberg (1994) *The rise and fall of strategic planning,* New York: Prentice Hall, and (2007) *Tracking strategies: towards a general theory.* New York: Oxford University Press.
3. Organisation for Economic Co-Operation and Development (2008) *Ireland: towards an integrated public service*. OECD Public Management Reviews. Retrieved on 1 April 2008 at www.oecd.org

Development of Ireland's drug strategy *(continued)*



Mintzberg's representation of the five strategic forms

Illicit drugs, alcohol and tobacco – understanding the policy issues

A recently published report on the development of national policies on illegal drugs, alcohol and tobacco in 17 member countries of the Council of Europe, including Ireland, shows that the policies lie along a continuum between one umbrella substance-use policy (e.g. Switzerland, France and Norway) and separate policies for different substances (e.g. the Netherlands and the United Kingdom). Ireland lies near the midway point, with three separate policies but a tendency to combine elements of illicit drugs and alcohol policy and practice.[1]

Having presented a synthesis of the 17 national reports, which are all included in the published document, the co-ordinator of the project, Richard Muscat, draws two main conclusions.

Develop a global policy framework

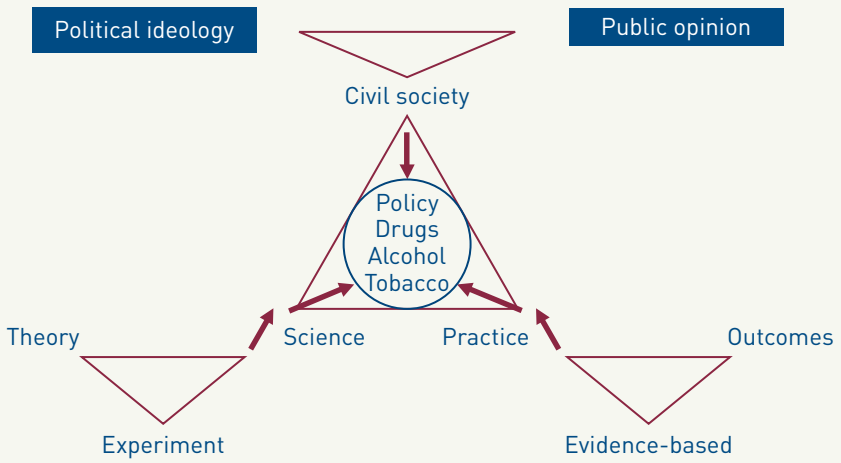
The common denominator among all the national policies is an overarching concern with health: this is the prime factor guiding most policy choices. To help analysis and understanding of the policy options, Muscat suggests that, in future, it may be appropriate to frame substance use policy within the context of health, and that the Council of Europe should take a lead in developing such a global policy framework.

Muscat proposes that the model used to analyse the 17 national policies on illicit drugs, alcohol and tobacco should be developed further in order to support the operation of such a framework. The model is based on the assumption that policy formulation in the area of substance use is influenced by three 'proximal' factors – civil society, science and practice – and that these in turn may be modified by six 'distal' factors – public opinion, political ideology, theory, experiment, evidence base and outcomes (see diagram overleaf).

The Irish case study contained in the report[2] illustrates how the model can enhance our understanding of the nature of the policy issues.

- **Civil society** reflects the standpoint of citizens of a country, which in turn reflects public opinions and political ideologies. The Irish case study contains examples of the contradictory views that can be taken. For example, while public opinion and political ideology converge regarding the nature of the illicit drug problem, they differ regarding how to respond. Although there is public support for a combined illicit drugs and alcohol strategy, there is continuing political reluctance to combine illicit drugs and alcohol in the one substance-use policy.

Drugs, alcohol and tobacco - policy issues *(continued)*



Model of the proximal and distal factors influencing substance use policies (after Muscat 2008)

- **Science** comprises two main disciplines that are beginning to yield evidence that needs to be taken into account in formulating policy – epidemiology, which studies the incidence and prevalence of drug use, and neuroscience, which explores why psychoactive substances seem so attractive. Like the majority of countries, Ireland mainly considers the evidence from epidemiological studies. Muscat does not regard this as surprising as the questions posed by politicians are principally about the size of the problem and whether it is growing. Since 2004, data on problem alcohol use and on alcohol-related deaths in Ireland have been included alongside data on illicit drugs in the two national epidemiological databases administered by the Health Research Board (the National Drug Treatment Reporting System and the National Drug-Related Deaths Index). This new departure has the potential to influence the future development of illicit drugs and alcohol policy.
- **Practice** refers to the day-to-day management of problems associated with substance use: health, psychological, social or matters within the justice system. Modern practice is based on 'good practice', i.e. practice based on evidence and on the achievement of specific outcomes. Practice and policy may not always coincide, as demonstrated by the ongoing debate, in Ireland as elsewhere, as to whether harm-reduction practices are contrary to the 1988 UN Convention on Drug Abuse, and as to their appropriateness and acceptability.
- **Tobacco** control is another interesting example of the interface between practice and policy. The Irish case study cites the conclusions of the Tobacco-Free Policy Review Group that reported in 2000 and which has determined the shape of Ireland's tobacco policy ever since. While acknowledging that tobacco products, when used in the manner intended by the manufacturers, cause addiction followed by illness and premature death, the review group argues that prohibition is not an option: 'A complete ban would, in our opinion, lead to the emergence of a substantial black market in smuggled products with its associated criminality.'

The policy model focuses on information inputs to the policy process. It does not factor in constraints, which may also influence policy. The Irish case study outlines how factors such as cultural attitudes, political processes, and structural and resourcing arrangements can restrict the options available to policy makers.

Improve the use of research evidence in policy making

Muscat found that science plays a minor role in the decision-making process. In order to support the better use of research evidence in policy and practice, and thus facilitate the development of evidence-based policy, he identifies three issues that need to be addressed: the co-ordination of research efforts, access to information and the communication of findings in a format that is digestible by policy-makers and the public at large. He outlines steps that the Research Platform of the Pompidou Group is taking in this regard: it has launched a second version of the Research Register, which aims to provide information on who is doing what in drug research, and in 2008 held a first summer workshop for young drug researchers on communicating results.[3]

(Brigid Pike)

1. Muscat R and Members of the Pompidou Group Research Platform (2008) *From a policy on illegal drugs to a policy on psychoactive substances*. Strasbourg: Council of Europe Publishing.
2. Pike B (2008) Irish drug policy and its link with alcohol and tobacco policies. In R Muscat *et al.*, see Note 1 above, pp. 91–107.
3. Information on the work of the Pompidou Group Research Platform, and the Research Register, may be found at www.coe.int/t/dg3/pompidou/Activities/research_en.asp

Tenth annual Service of Commemoration and Hope

Members of the congregation at the service (Photo: JJ Berkeley)

Frances Black at the Service of Commemoration and Hope (Photo: JJ Berkeley)

On Sunday 1 February, the Family Support Network held its tenth annual Service of Commemoration and Hope, entitled 'A decade of Hidden Grief, a Future of Hope?', in remembrance of loved ones lost to drugs and related causes and to publicly support families living with the devastation that drug use causes.

The service in Our Lady of Lourdes Church, Sean McDermott Street, was preceded by a procession from the spire on O'Connell Street led by the Garda brass band. The service was attended by Mr John Curran TD, Minister of State with responsibility for drugs strategy, a representative of the Taoiseach, Garda Commissioner Fachtna Murphy, the Lord Mayor of Dublin, Eibhlin Byrne, Archbishop Diarmuid Martin and other religious representatives, as well family members, friends and representatives from family support groups throughout the island of Ireland and many people working in this area.

Sadie Grace of the Family Support Network highlighted the importance of this annual service in allowing families to grieve openly while also celebrating the lives of the children they lost to drug use. She spoke of the achievements of the Family Support Network, including the involvement of the Network in establishing the National Drug-Related Deaths Index. She also voiced her fear of an increase in drug use in the current climate of recession.

Ruaidhri McAuliffe addressed the audience on behalf of the drug-users' forum, Uisce (Union for Improved Services Communication and Education). He acknowledged the role that families play in both the treatment of and recovery from drug addiction.

Minister Curran, Archbishop Martin and Fr Edmond Grace also addressed the gathering. Prayers and poems were read, accompanied by music provided by the Dublin West Community Church Music Group and singer Frances Black.

(Ena Lynn)

Contact the Family Support Network at 175 North Strand Road, Dublin 1. Tel: 01 836 5168 or email: sadietgrace@gmail.com

Family Matters seminar

Ballymun Local Drugs Task Force hosted a policy seminar, Family Matters, on 21 October 2008. The aim was to explore key concepts, principles and practices in relation to addiction and the family with a view to influencing future development of drug and family policy.

Dr Paul Quigley outlined the evolution of methadone treatment in Ireland from a model focused on a quick detox in a central location followed by abstinence to one encompassing community-based clinics, with more GP involvement, partnership working and the inclusion of family members. He outlined the benefits of 'home maintenance', where family members are involved in dose supervision and risk reduction.

Dr Paul McArdle discussed mental health and substance use in adolescents and described the influence of family structure and family relationships on young drug users. He said that mental health issues, especially conduct disorder, are important determinants of drug use among adolescents.

Dr Marguerite Woods spoke about the experiences of female drug users and their interactions with children, partners, families, drug treatment providers and social workers. Female drug users had varying degrees of success in preserving their role, identity and motherhood status, with some having lost all contact with their children. Women who had retrieved their motherhood role generally did so with the help of family members who had 'held the fort' and 'kept social services away'. Some women suggested that family disapproval was greater for drug-using daughters than for drug-using sons, and a significant number experienced a lack of family support or variations in support over time. Many women felt that asking for help made things more difficult for them in the struggle to preserve their motherhood roles.

An audio-visual presentation portrayed the reactions of fathers to drug use and suggested that men are less likely to talk about what's happening to them and often suffer in silence.

Three concurrent workshops focused on drug use from a family perspective. Attendees also spoke of their own experiences and discussed a number of issues, including the lack of services and supports for siblings and partners of drug users, how best to inform drug users of available services and supports, and the length of time spent on methadone treatment.

(Ita Condron)

Agreed Programme for Government – progress report 2008

On 24 September 2008 the first annual reports on progress in relation to the Agreed Programme for Government 2007–2012 were posted on the website of the Department of the Taoiseach.[1] Progress in relation to drug- and alcohol-related initiatives is noted in the reports by the departments of Community, Rural and Gaeltacht Affairs, Health and Children, and Justice, Equality and Law Reform. A summary of the main achievements, as reported, follows.

Drug-free prisons

An additional 155 prison staff have been appointed to allow for a drug-detection-dog service in the prisons, operational support units for search and intelligence gathering purposes, and enhanced security screening and searching of all persons entering prisons. Drug rehabilitation programmes for prisoners are being implemented with the support of specialist professionals such as nurses, psychologists and 24 addiction counsellors.

Drug Treatment Court

The Department of Justice is examining the operation of the Court and officials are looking at best practice elsewhere to see how the Court's throughput levels might be increased to the benefit of recovering drug addicts and the wider community.

Irish Sentencing Information System (ISIS)

The feasibility of providing a computerised information system on sentences and other penalties imposed for criminal offences is being examined. An appropriate IT system has been developed, a pilot has been operating since June 2006 in Dublin Circuit Criminal Court, and a further pilot commenced in Cork Circuit Court in 2008.

Mandatory sentencing

In the course of 2009 a mechanism will be introduced for undertaking a formal annual review of the effectiveness of the new stringent mandatory sentence regime for drug crime introduced in the Criminal Justice Act 2007.

'Date rape' drugs

The creation of a new offence of supplying and administering date rape drugs is being considered in the context of the current provisions of the Non-Fatal Offences Against the Person Act 1997.

Treatment for cocaine users

Evidence shows that most cocaine users are polydrug users and need to be treated for polydrug misuse and not solely for cocaine use. Consequently, the HSE has re-oriented its addiction services to address the needs arising from the changing patterns of drug use in the population. The HSE is also involved in developing community-based, stand-alone stimulant intervention services. Evidence also indicates that many approaches already in use in general addiction services work well with cocaine users. Funding is being provided for measures at local and regional drugs task force level to strengthen and further develop initiatives aimed at tackling cocaine use in local communities. These include locally-based awareness campaigns that dovetail with the HSE's national campaign.

Rehabilitation

The planning and development of a minimum of 25 detoxification residential beds recommended in the Drugs Rehabilitation report will be addressed by the HSE in conjunction with the recommendation contained in the HSE *Report of the Working Group on Residential Treatment and Rehabilitation Services*. Steps are being taken to increase the numbers on drug-specific community employment scheme places from 1,000 to 1,300. Funding is being provided for rehabilitation initiatives at local and regional drugs task force level, and funding for the Family Support Network is being increased.

Funding for community-based initiatives

Additional funding in 2008 was provided for the local and regional drugs task forces. Over 440 LDTF projects currently receive funding. Funding continued for the Premises Initiative Fund, and capital funding was also provided under the new Regional Youth Initiative, for the development of 16 dedicated youth facilities in RDTF areas not covered under the Young People's Facilities and Services Fund.

Young People's Facilities and Services Fund (YPFSF)

Current funding supports the employment of over 350 youth and outreach workers, centre managers and administration staff, 24 sports development officers, and 13 co-funded 'Football in the Community' development officers. Following announcements earlier in 2008, the YPFSF will be extended to Arklow, Athlone, Dundalk and Wexford, and arrangements to transfer responsibility for the fund to the Office of the Minister for Youth Affairs and Children are being progressed.

Alcohol-related disorder

The Intoxicating Liquor Act 2008 provides for measures to control alcohol-related disorder:

- increased fines relating to alcohol-related disorder and associated anti-social behaviour may be imposed;
- a Garda member may confiscate alcohol from under-18s in a public place;
- a Garda member may direct persons in possession of alcohol in a public place to (a) surrender the alcohol, (b) desist from behaving in a disruptive manner, and (c) leave the area; and
- the fine for supplying alcohol to under-18s has increased from €1,500 to €5,000.

The Garda Síochána have identified areas subject to anti-social behaviour as hot spots, and additional foot and mobile patrols are directed to these areas during times when these offences are more likely to occur.

Alcohol and good health

Strengthened codes aimed at reducing the exposure of young people to alcohol advertising and marketing are due to come into operation soon. A Working Group to examine the extent of alcohol sponsorships and the terms and length of existing contracts is to be established.

(Compiled by Brigid Pike)

1. The Agreed Programme for Government 2007–2012 and the annual reports for 2008 are all available in the Publications section of the ww of the Department of the Taoiseach at www.taoiseach.ie. For a summary of the Agreed Programme, see Galvin B (2007) Draft programme for government. *Drugnet Ireland.* (22): 1.

Cannabis use in Ireland

The third bulletin of results from the 2006/7 all-Ireland general population drug prevalence survey[1] (a follow-on from the first such survey in 2002/3[2]) focuses on cannabis use in the adult population (15–64 years) and patterns of cannabis use. The final achieved sample was 4,967 in Ireland. This represented a response rate of 65%.

This article highlights some of the survey findings and presents unpublished data from the National Drug Treatment Reporting System (NDTRS), the National Drug-Related Deaths Index (NDRDI) and Garda records.

Comparison of survey findings

Cannabis use increased over the four years between the two surveys. The proportion of **adults** who reported using cannabis at some point in their lives (ever used) increased from 17% in 2002/3 to 22% in 2006/7. The proportion of **young adults** who reported using cannabis in their lifetime also increased, from 24% in 2002/3 to 29% in 2006/7.

The proportion of **adults** who reported using cannabis in the last year (recent use) increased from 5% in 2002/3 to 6% in 2006/7. The proportion of **young adults** who reported using cannabis in the last year increased from 9% in 2002/3 to 10% in 2006/7.

The proportion of adults who reported using cannabis in the last month (current use) remained stable at 2.6%.

Table 1 Lifetime, last-year and last-month prevalence of cannabis use in Ireland, 2002/3 and 2006/7

Cannabis 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 (ever used)	17.4	21.9	22.4	27.0	12.3	16.6	24.0	28.6
Last year (recent use)	5.0	6.3	7.2	8.5	2.9	3.9	8.6	10.4
Last month (current use)	2.6	2.6	3.4	4.0	1.7	1.1	4.3	4.2

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (Bulletin 3, 2005 & 2008)

Practices among users – 2006/7 survey

Those who had ever used: Half of all cannabis users had first used the drug before they were 18 years old. The lifetime prevalence rate was higher for men (27%) than for women (17%).

Regular users: Over one-quarter (26%) of respondents who had ever taken cannabis reported using (or having used) it regularly. The lag time between first use and regular use was two years. Of those who were or had been regular users, two-thirds (66%) said that they had stopped taking cannabis, 10% said that they had tried to stop but failed and almost one-quarter (24%) had never tried to stop. Of those who had stopped, approximately one-third (32%) said they had done so because they no longer wanted to take the drug, 19% said they had health concerns and 17% said it was no longer part of their social life.

Recent users: The majority (62%) of recent cannabis users considered it 'very easy' or 'fairly easy' to obtain the drug within a 24-hour period. Over half (57%) reported obtaining the cannabis they had last used at the house of friends, 12% obtained it in the street/park, 8% in a disco/bar/club and 5% ordered it by phone. The majority (44%) got the cannabis they had last used from a family member or friend, 28% had shared it among friends and 22% had bought it.

Current users: The majority (60%) of current cannabis users reported using a form of cannabis resin. Almost two-in-five (38%) reported using a form of herbal cannabis. Approximately 24% used the drug daily in the month prior to the survey, a further 10% used it several times a week, 28% used it at least once a week and 37% used it less than once a week. Men were more frequent users than women. Almost all (99%) smoked it as a joint (93%), in a pipe (4%) or in a bong (3%): less than 1% ate the drug.

NDTRS data

Analysis from the NDTRS indicates that the number of treated cases reporting cannabis as a main problem drug decreased from 1,384 in 2003 to 958 in 2007 (Table 2), of whom 74% used one or more additional drugs. The number of cases reporting cannabis as an additional problem drug increased from 1,383 in 2001 to 1,630 in 2007 (Table 3). The drugs associated with cannabis use were alcohol, ecstasy, amphetamines and cocaine (Table 4). These data indicate that only a small proportion of cannabis users are seen at treatment services, and that the majority of those use more than one drug. Of the 958 cases treated in 2007 who reported cannabis as their main problem drug, 99% smoked it, and 1% ate it. Use by these cases in the month prior to treatment was reported as follows: 49% used it daily, 22% used it between two and six days per week, 8% used it once per week or less and 19% had not used it. As expected, the frequency of cannabis use among treated cases was considerably higher than that among the general survey population.

Of these 958 cases, half had commenced cannabis use before they were 14 years old, and 86% were men. Of the total number, 109 (11%) lived in Dublin and 849 (89%) lived elsewhere in Ireland. The numbers reflect the greater availability of treatment for cannabis, cocaine and other non-opiate drugs in Dublin, rather than use among the general population.

Cannabis use in Ireland *(continued)*

Table 2 Cases entering treatment for cannabis 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 cannabis as main problem drug	1136 (23.7)	1336 (27.0)	1384 (27.0)	991 (22.0)	1039 (21.3)	1096 (21.1)	958 (16.9)
Of whom:							
New cases	781	924	955	736	794	809	694
Previously treated cases	299	349	401	224	219	260	255
Treatment status not known	56	63	28	31	26	27	9

Source: Unpublished data from the NDTRS

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

	2001	2002	2003	2004	2005	2006	2007
	Number (%)						
All cases reporting an additional problem drug	**3459**	**3582**	**3760**	**3157**	**3401**	**3692**	**3816**
Cases reporting cannabis as main problem drug	1383 (40.0)	1362 (38.0)	1445 (38.4)	1239 (39.2)	1417 (41.7)	1579 (42.8)	1630 (45.5)
Of whom:							
New cases	540	511	556	449	527	583	681
Previously treated cases	797	797	842	757	844	925	904
Treatment status not known	46	54	47	33	46	71	45

Source: Unpublished data from the NDTRS

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

New cases	**4708**	**769**	**1064**	**99**	**228**	**160**	**4999**
	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)	1897 (37.9)
Cocaine	1029 (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	1029 (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	1866 (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)	2389 (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

Cannabis use in Ireland *(continued)*

NDRDI data

According to data from the NDRDI, the number of poisoning deaths in which cannabis was implicated, alone or with another drug, was extremely small.[3]

Garda data

Cannabis accounts for the majority of all drugs seized in Ireland. Of the 8,417 reported drug seizures in 2006, 4,243 (50.4%) were of cannabis.[4] The cannabis seizure data is in line with the use of cannabis among the general population prevalence data indicating that it is the most common illegal drug used in Ireland.

(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: cannabis results.* Bulletin 3. Dublin: National Advisory Committee on Drugs.
2. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005) *Drug use in Ireland and Northern Ireland. 2002/2003 drug prevalence survey: cannabis results.* Bulletin 3. 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.
4. Alcohol and Drug Research Unit (2008) *2008 National Report (2007 data) to the EMCDDA by the Reitox National Focal Point. Ireland: new developments, trends and in-depth information on selected issues.* Dublin: Health Research Board.

Cannabis again reclassified in the UK

In January 2004, on foot of a modification order to the UK Misuse of Drugs Act 1971 cannabis was reclassified from a Class B to a Class C drug. The changes came about following a recommendation by the Advisory Council on the Misuse of Drugs (ACMD) in March 2002.

In January 2009, despite the opposition of the ACMD on this occasion, cannabis was again reclassified as a Class B drug. Substances controlled under the Act are grouped on the basis of their harmfulness into three classes:

- **Class A** (the most harmful) includes cocaine, heroin, ecstasy, LSD and methamphetamine
- **Class B** (an intermediate category) includes amphetamine, barbiturates and, now, cannabis
- **Class C** (less harmful) includes benzodiazepines and anabolic steroids.

This system of classification helps determine the penalties for the possession and supply of controlled substances.

In July 2007 the Home Secretary requested, in the light of 'real public concern about the potential mental health affects of cannabis use, in particular the use of stronger forms of the drug, commonly known as skunk', that the ACMD re-assess the classification of cannabis.[1] The ACMD reviewed the literature, particularly material published since 2005, and considered oral and written evidence. In its published report, the Council concluded that 'there are clear and obvious harms associated with the use of cannabis by people with psychotic disorders' and that this was confirmed by recent studies (p. 15). It also concluded that the evidence supports a 'causal association between the use of cannabis, in adolescence, and the later development of schizophrenia' (p. 18). The report refers to a recent study where 'the authors concluded that the shift in cannabis consumption to more prolonged use, initiated at an earlier age, is relatively recent; and that its full impact may not yet be apparent' (p. 18). The ACMD remarked that while the causal link between cannabis use and psychotic illness was weak, 'whether such a causal link will become stronger with the wider use of higher potency cannabis products remains uncertain' (p. 30).

The ACMD reviewed the evidence on cannabis availability and purity and concluded that sinsemilla now dominates the UK cannabis market and that it appears to have a substantially higher tetrahydrocannabinol (THC) content than cannabis resin or traditional herbal cannabis. THC is the active ingredient which produces the sensation or 'high' being sought by users. Sinsemilla is composed of the flowering tops of unfertilised female cannabis plants produced by intensive indoor cultivation methods. Because of its greater potency, the ACMD expressed concern about the 'substantial increase' in the market share of sinsemilla.

As part of its deliberations, the Council commissioned an opinion poll to investigate the views of the wider public on the classification of cannabis. A majority of the 1,003 respondents wanted cannabis to be classified as a Class A or Class B substance. However, most did not favour the introduction of harsher penalties for cannabis possession, although this was the logical consequence of reclassification.

The ACMD made 21 recommendations to government, including that cannabis remain a Class C drug. In making this recommendation the Council stated: 'Although the majority of members recognise the harms caused by the use of cannabis to individuals and society, they do not consider these to be as serious as those of drugs in Class B.' However, the report also noted that: 'A minority of members…remain very concerned about the effects of cannabis on the mental health of users, especially in the light of the (now) wide availability and use of sinsemilla. In their view the balance of harms more closely equates to substances in Class B than Class C' (p. 34). The ACMD agreed to conduct a further review of the evidence in 2010.

The government accepted 20 of the 21 recommendations of the ACMD. These covered areas such as primary and secondary prevention, supply reduction, measures to protect particular at-risk groups, and further research. In rejecting the ACMD's recommendation on the classification of cannabis and in justifying its decision to reclassify cannabis as a Class B drug, the government stated: 'Government is expected to take an overview…we have to maintain a

Cannabis reclassified in the UK *(continued)*

classification for cannabis that takes account of its known risks to health as well as the potential long-term impacts on health where the evidence is not conclusive. The significant increase in both the market share of higher than average potency cannabis and its actual potency in the last few years in the UK are compelling factors.'[2]

As a Class B drug, the maximum penalty for supplying or producing cannabis is 14 years' imprisonment and/or an unlimited fine. This remains unchanged from when the drug was Class C. However, with reclassification, the maximum penalty for possession increases from two to five years' imprisonment. The government also intends to introduce an 'escalation' penalty system for cannabis possession by those aged over 18. The system for under-18s caught in possession will remain unchanged as it already provides an escalation mechanism, according to the government's response.

(Johnny Connolly)

1. Advisory Council on the Misuse of Drugs (2008) *Cannabis: classification and public health*. London: United Kingdom Home Office. Available at: http://drugs.homeoffice.gov.uk/publication-search/acmd/acmd-cannabis-report-2008?view=Binary
2. Central Office of Information (2008) *Government response to the recommendations made by the Advisory Council on the Misuse of Drugs in its report* Cannabis: classification and public health. London: Central Office of Information (COI) on behalf of HM Government, p. 2. Available at: http://drugs.homeoffice.gov.uk

HSE outlines plans for drug and alcohol services in 2009

The Health Service Executive's *National Service Plan 2009* (NSP) contains the agency's plans in the drugs and alcohol area during 2009.[1] HSE Addiction Services, including both illicit drugs and alcohol, are delivered as part of Social Inclusion Services, which, in turn, are part of the Primary, Community and Continuing Care (PCCC) directorate. The table below summarises the key result areas for 2009 together with the outputs delivered in 2008 and the deliverables for 2009.

'Key result areas' are a new element in the HSE's annual service plan. They have resulted in a rationalisation and reduction in the number of action lines in the addiction services area. Just three key result areas are identified: enhancement of addiction services, development of the National Drugs Strategy, and the mainstreaming of health-related drugs task force projects.[2]

Addiction Services in 2009 (after HSE *NSP* 2009: 49)

Key result area	Output 2008	Deliverable 2009
Enhancement of addiction services (Progress implementation of the recommendations of the 2007 report of the Working Group on Drugs Rehabilitation.)	Regional addiction plans developed Recruitment of Rehabilitation Co-ordinator under way Development of National Rehabilitation Implementation Committee under way	Further development of multi-disciplinary teams for provision of services to under-18 year-olds. This will facilitate the further development of harm reduction services, including needle exchange and methadone services. Implementation of the Rehabilitation Strategy (to include appointment of co-ordinator)
Development of new National Drugs Strategy (NDS)	HSE / Department of Health and Children submission to NDS review.	Planning undertaken for implementation of HSE components of the new National Drugs Strategy 2009 – 2013
National Drugs Task Force	Mainstreaming process agreed with the Departments of Community, Rural and Gaeltacht Affairs and Health and Children	Progression of mainstreaming of 169 local drugs task forces (LDTFs) as appropriate, starting from April onwards.

The performance information framework used in the HSE has also been refined. In the addiction services area, one measure of 'activity' and two indicators of 'performance' have been identified. The figures indicate that, nationally, the level of activity in the addiction services area increased in 2008 and this new level is due to be maintained in 2009, but the level of performance is expected to remain static at 2007 levels. The 2009 performance target for treatment of substance misusers aged under 18 is based on baseline data collected in 2008.

HSE plans for drug and alcohol services *(continued)*

- *Activity – the average number of clients in methadone treatment per month per area:* In 2008 the national target was to maintain throughput at the 2007 level of 7,000 clients. In the event, throughput in 2008 reached 7,636 and the HSE expects to reach this level of activity again in 2009.
- *Performance – the number and percentage of substance misusers for whom treatment, as deemed appropriate, commenced within one calendar month:* In 2008 the national target was to exceed the 84% (n=1,406) performance level achieved in 2007. In the event, the 2007 level was attained but not exceeded, and this same level of 84% has been set as the target for 2009.
- *Performance – the number of substance misusers under 18 years of age for whom treatment, as deemed appropriate, commenced within one calendar month:* No target was set for this indicator in 2008 as the staff to develop services for under-18s were only appointed during 2008. However, data collected in 2008 showed that 88% (n=106) of substance misusers under the age of 18 commenced suitable treatment within a calendar month. This performance level has been set as the target for 2009.

The breakdown of performance by HSE region, also published in the plan, reveals variations, with the regions around Dublin performing below par. Regarding commencement of treatment for substance misusers in 2008, the Southern Region exceeded the national target by over 10% at 96% (n=547), while the combined Dublin/North East and Dublin/Mid-Leinster regions only achieved a performance level of 64% (n=510). Regarding commencement of treatment for under-18s, the target timeframe of one calendar month was achieved 100% by both the Southern (n=53) and Western (n=30) regions, but the combined Dublin/North East and Dublin/Mid-Leinster regions only achieved a level of 62% (n=23). These regional performance targets have been rolled over for 2009.

Under the heading of 'Improving our infrastructure', the service plan lists two capital works in the Dublin/Mid-Leinster Region, which, it states, are to be commissioned and in place before the end of 2009 and which can be funded within the HSE's 2009 allocation:

- *Clondalkin:* new purpose-built addiction centre providing psychiatry, GP, counselling, pharmacy, nursing, psychology and family therapy services; and
- *Pearse Street:* refurbishment and upgrade of the Drug Treatment Centre.

(Brigid Pike)

1. Health Service Executive (2008) *National Service Plan 2009*. Available at www.hse.ie
2. For accounts of previous HSE Service Plans, see B Pike (2007) HSE outlines plans for drug-related services in 2007. *Drugnet Ireland*. (22): 5–7; B Pike (2008) HSE outlines plans for drug and alcohol services in 2008. *Drugnet Ireland*. (25): 9–10.
3. According to the discussion on the measurement and monitoring of performance contained in the National Service Plan 2009, the performance indicators contained in the plan will be reported in the HSE Performance Monitoring Reports (PMRs), which are due to be produced monthly, quarterly, bi-annually and annually.

British–Irish Council meeting on drug misuse

On 20 November 2008 the British–Irish Council's Misuse of Drugs Sectoral Group held a Ministerial meeting.[1] Chaired by Ireland's Minister of State with responsibility for drugs strategy, John Curran TD, the meeting focused on how to engage effectively with communities regarding drug use. The ministers agreed that engaging communities and developing community-based responses can make a significant contribution in dealing with the issue of problem drug use in society. Although different administrations are developing their own approaches, the ministers were of the view that sharing experiences provides a good opportunity for learning from each other. They resolved to continue to co-operate and exchange experiences, with particular emphasis on initiatives that have led to successful outcomes and that may lend themselves to broader application in other administrations.

The ministers reviewed the work carried out by the Sectoral Group during 2008:

- Ireland hosted the tenth BIC Summit when the topic of 'Families and drugs misuse – challenges and opportunities' was discussed;
- Northern Ireland hosted an expert seminar presented by Professor J David Hawkins (Seattle) on the topic 'Using advances in prevention science to guide substance misuse prevention in communities'; and
- Jersey hosted a meeting on 'Engagement of young people with substance misuse'.

The ministers agreed that work in 2009 will focus on the following areas:

- Guernsey will host a meeting on substance issues in prisons;
- Ireland will host a meeting on drug deaths indices;
- Scotland will host a meeting on a topic for discussion yet to be finalised: and
- Isle of Man will host the next Ministerial meeting in late 2009.

These meetings will also seek to strengthen and consolidate the ongoing co-operation and the exchange of information, experience and best practice between members.

(Brigid Pike)

1. For further information on the British–Irish Council and the work of its Misuse of Drugs Sectoral Group, visit www.britishirishcouncil.org

Review of the evidence base in drug prevention

This article summarises the main conclusions drawn in a recent review of the evidence base in substance abuse prevention published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).[1] It will focus in particular on family- and school-based prevention as these are important areas of intervention in Ireland's National Drugs Strategy.

The review included 49 studies, including eight meta-analyses, 22 systematic reviews, 13 unsystematic reviews, four best-practice surveys and two other publications. These studies were systematically identified from searches of established databases, e.g. the Cochrane Library, PubMed and PsychInfo. Two assessors independently rated the studies by content and method using a coding system. They then jointly formulated their conclusions and rated them for strength of evidence from A to F, according to whether they were based on:

A – a meta-analysis involving high-quality studies
B – a systematic review involving high-quality studies
C – a meta-analysis or systematic review covering all relevant studies
D – an unsystematic review
E – a discussion or an individual study or conclusion on the basis of empirical results
F – a contradictory body of evidence from reviews in different categories.

Family-based prevention: conclusions from the evidence base

What works
Comprehensive family-orientated approaches (training for parents, children and families) have preventive effects on consumption behaviour in relation to alcohol. The studies included did not focus on preventing illicit drug use.

Family-orientated measures are particularly effective with non-consumers (of alcohol), particularly the parents.

Parental training alone can influence risk factors (increasing pro-social behaviour) but not consumption of substances.

How it works
Parental training includes a focus on developing basic educational behaviour (use of discipline, supervision and problem-solving techniques) and on fostering parent–child relationships, as well as on parental commitment to the child's schooling.

Training involving children teaches ways to resist peer offers of substances for consumption, social problem-solving abilities, conflict management and learning skills.

Engaging hard-to-reach families
Measures to involve hard-to-reach families appear successful (Strategic Structural Systems Engagement approach)

Strength of evidence for family-based prevention
Rated C and D. While there were numerous random controlled trials included in the reviews, there were no reviews of high-quality studies and no meta-analyses.

School-based prevention: conclusions from the evidence base

What works
Interactive school-based programmes have preventive effects on consumption behaviour for tobacco, alcohol, cannabis and other illicit drugs.

School-based programmes that implement the concepts of social influence and life skills are effective, and equally so for all substances.

Effects with regard to alcohol and tobacco can be long term (2–3 years)

School-based prevention programmes have less effect on consumption behaviour than they do on risk factors such as dropping out of school, truancy and other problem behaviour.

Short-term effects are a good pointer to long-term effectiveness.

What does not work
Non-interactive programmes are not effective; such programmes include information provision alone, emotional education alone, transmission of values and decision-making alone and DARE-type programmes (delivered didactically by police officers in the United States).

Strength of evidence for school-based prevention
Rated A to C. The report reviewed numerous meta-analyses including high-quality studies.

Disseminating information on what works in drug prevention is an important field of interest for the EMCDDA. Currently this work is done through the best practice portal of the EMCDDA[2] where a number of reviews are stored. The Alcohol and Drug Research Unit of the Health Research Board (HRB), as the Focal Point for the EMCDDA in Ireland, is committed to summarising these reviews for the benefit of our stakeholders in Ireland and disseminating this information. Commentary on a review of the evidence base for selective prevention targeting high-risk groups will be covered in a future issue of *Drugnet Ireland*.

(Martin Keane)

1. Bühler A and Kröger C (2008) *EMCDDA Insights: Prevention of substance abuse.* Luxembourg: Office for Official Publications of the European Communities. First published in German in 2006 as *Expertise zur Prävention des Substanzmißbrauchs* by the Federal Centre for Health Education and subsequently translated into English by the EMCDDA.
2. http://www.emcdda.europa.eu/themes/best-practice

Tony Gregory 1947–2009 – an appreciation

Tony Gregory TD passed away on 2 January of this year, after a short battle with stomach cancer. Tony was first elected to Dublin City Council in 1979 and he won his Dáil seat in 1982. His name immediately became recognised nationally as the so-called 'Gregory deal' brought Charles Haughey and Fianna Fáil to power. The fall of Haughey's government within the year meant that the deal never fully bore fruit, with its promise of 500 local houses and 3,000 jobs, as well as the nationalisation of a 27-acre site in Dublin's docklands. However, Tony's tireless advocacy over the next 20 years on behalf of his constituents in Dublin North Central would see him returned to the Dáil in every subsequent election until his untimely death, a feat never before achieved in the history of the state by an independent politician.

Tony Gregory 1947–2009 (Photo: JJ Berkeley)

In a constituency with a very low electoral turnout and one of the highest levels of socio-economic deprivation in the state, Tony's focus was on the issues of poverty, unemployment, education and housing. The added scourge of drug dealing and the attendant misery it brought to the community of which he was a part would ensure that, over the next three decades of public life, his name would become synonymous with confronting this issue. On one occasion he bravely named a number of local drug dealers in Dáil Éireann. On another, as he questioned why more of these dealers were not being jailed, he went to prison himself in defence of the treatment of street traders who were bringing one of the few sources of legitimate income into his constituency.

Tony was an extremely private person and he did not welcome intrusion into his personal affairs. In one of his last political battles he won a Press Council ruling against the Evening Herald for breach of privacy, after a reporter and photographer visited his Ballybough home in search of a story about his illness.

I began working with Tony in a professional capacity in the late 1990s as an advisor on the setting up of the North Inner City Community Policing Forum. To say he was a joy to work with would perhaps be a poor choice of words. He had a healthy scepticism about so-called 'advisors' and his standards were exacting. Whatever about his 'bite', his 'bark' was generally enough to ensure that few mistakes were made and that none were repeated. Working with him on other issues since that time, I came to realise that this was how he delivered on the mandate he received at the polls and I respected him immensely for it. He applied an incredible intensity to the work at hand, whether it was reading a mundane report or preparing a parliamentary question. His work rate was phenomenal and, although he had loyal comrades who worked with him throughout his Dáil career, he never took his position for granted, always highlighting the extra challenge facing an independent against the party machines come election time.

I heard of Tony's untimely passing during a holiday on Inis Meáin, one of the Aran Islands. As we all watched the news of his death on RTÉ, the esteem in which he was held even in that remote part of the country was palpable. As his legacy was discussed through the medium of the Connemara gaeltacht, I wondered how many were aware of his background as a teacher in Coláiste Eoin in south Dublin and his grá for the language, reflected in his request that his funeral mass be delivered primarily through Irish.

Having worked in recent years with Tony and others in relation to community policing, the final impression left after his funeral was the huge Garda presence and the effort that was put by An Garda Síochána into ensuring that the occasion attended by thousands passed off smoothly. It was clear to me and others that the gardaí had pulled out all the stops as a mark of respect for him, never one of their biggest cheerleaders. Tony was above all a servant of his community, and he saw it as their entitlement that his constituents received nothing less than the service to which they are entitled. Ní bheidh a leithéad arís ann.

(Johnny Connolly)

Substance use among Ireland's children

On 9 December 2008 the Minister for Children and Youth Affairs, Chris Andrews TD, launched *State of the nation's children: Ireland 2008* (SONC 2008).[1] As with the first report, published in 2006, the 2008 report presents key indicators on aspects of children's lives, including outcomes on their education, health and social, emotional and behavioural well-being; their relationships with their parents and their friends; and the services available to and accessed by them.

(Brigid Pike)

1. Office of the Minister for Children and Youth Affairs (2008) *State of the nation's children: Ireland 2008*. Dublin: Stationery Office. Retrieved on 21 January 2009 at www.omc.gov.ie

Alcohol Implementation Group report 2008

Ms Mary Wallace TD, Minister for Health Promotion and Food Safety at the Department of Health and Children, published the Social Partnership Alcohol Implementation Group (AIG) report in December 2008.[1] This group was formed to monitor and report on progress on the implementation of the actions contained in its report, Working together to reduce the harms caused by alcohol misuse.[2] The group comprised social partners and relevant government departments and agencies, and agreed a programme of 29 actions to deliver targeted results in relation to underage drinking, binge drinking and drink driving.

The main actions and progress to date are outlined below.

Actions	Progress to date
Local community responses	
■ Establish 4–6 community mobilisation projects (CMPs)	Nineteen grants totalling €1,061,955 were awarded to community-based projects to tackle alcohol misuse. The AIG is disappointed that the envisaged number of multi-agency CMPs have not been established.
Treatment intervention services	
■ Establish pilot screening and brief intervention (SBI) programmes and protocols in healthcare settings	The HSE is introducing systems whereby alcohol-related data collection and SBI can be put in place in all acute hospitals, and is developing protocols for the roll-out of SBI programmes on a pilot basis in some acute hospitals.
Awareness and education	
■ Continue roll-out of the Social, Personal and Health Education (SPHE) programme in schools ■ Develop education initiatives in out of school settings ■ Increase training on alcohol issues for community/youth workers ■ Increase public awareness through local media campaigns	The SPHE is a compulsory part of the junior cycle programme and a SPHE curriculum for senior cycle students has been finalised. The Department of Education and Science intends to establish a working group to develop guidelines for implementing programmes in non-school settings. The HSE ran a public information campaign on underage drinking in 2008 and the drinks industry has committed to providing funding of €20 million to promote responsible alcohol use.
Alternative facilities	
■ Promote and develop alcohol-free recreational facilities ■ Promote responsible approaches to alcohol by sporting organisations	In 2007, €1.12 million was allocated to provide recreational and personal development opportunities for disadvantaged young people. The national recreation policy,Teenspace, was launched in 2007 and provides a strategic framework for the promotion of positive recreational opportunities. The HSE has developed partnerships with the GAA and the FAI to address alcohol-related harm though policy and action.
Compliance and enforcement	
■ Promote responsible serving of alcohol (RSA) and trading programmes ■ Improve security for National Age Card to prevent forgery ■ Develop early intervention within the justice system	In 2007 a working group was established to review the effectiveness of RSA programmes. The National Age Card regulations are in place and the new card contains security features to prevent forgery. In 2007, 29 new Garda youth diversion projects were announced and 12 new projects are expected in 2008; €11.909 million has been allocated for these projects in 2008.
Workplace	
■ Develop guidelines for workplace alcohol policy	The HSE is working with IBEC and ICTU to develop and publish these guidelines.
Below-cost selling	
■ Prohibit below-cost selling	The AIG is hopeful that the report of the Alcohol Advisory Group will lead to progress on this issue.

AIG report *(continued)*

Off-trade	
■ Develop a code of practice with the off-trade sector	This process is being led by the Minister for Justice, Equality and Law Reform following enactment of the Intoxicating Liquor Act 2008.
Alcohol advertising	
■ Consider further representation from social partners on alcohol monitoring body ■ Introduce a 9pm watershed for alcohol advertising	Strengthened codes of practice have been accepted and came into effect in 2008. Some social partners expressed the view, however, that legislation was preferable to voluntary codes as a means of protecting young people.
Drink driving	
■ Introduce random breath testing ■ Reduce blood alcohol concentration (BAC) limit for drivers to 0.05% (50mg per 100ml) ■ Review lowering of BAC limit for provisional drivers	Random breath testing was introduced in 2006 and led to a decrease in road fatalities in 2007. The current road safety strategy identifies the need to reduce the legal BAC level and the government has accepted this recommendation.
Labelling	
■ Establish group to consider what information to include on non-draft alcohol products	The AIG recommends that mandatory information be shown on labels, including the amount of alcohol in the container and the dangers of alcohol consumption in pregnancy.

The AIG had mixed views on the progress achieved in implementing the actions, and some partners expressed concern that the present group had a narrow focus and did not encompass the broad range of recommendations contained in the Strategic Task Force on Alcohol report. However, it was agreed that a remit to monitor and seek implementation of a smaller number of actions would improve the possibility of progress in the area, and establishing a small number of broadly based community mobilisation projects was considered a very worthwhile initiative by the group.

(Deirdre Mongan)

1. Department of Health and Children (2008) *Report of the implementation group on alcohol misuse.* Dublin: DOHC.
2. Department of Health and Children (2006) *Sustaining Progress special initiative: working together to reduce the harms caused by alcohol misuse.* Dublin: DOHC.

Alcohol pricing and promotion

A recent report commissioned by the Department of Health in the UK has analysed the effects of alcohol pricing and promotion polices on alcohol-related consumption and, by extension, on health, crime, workplace absenteeism and unemployment to help government decide future alcohol policy.[1] The research team at the University of Sheffield analysed over 40 separate policy scenarios to examine how policies affect alcohol purchasing and consumption by different population groups, including moderate, hazardous, harmful and underage drinkers, both in the on-trade and off-trade sector.

The main effects of different policy measures are summarised below.

The effects of introducing across-the-board price increases

Across-the-board price increases covering all products in the on-trade and off-trade can have a substantial impact on reducing consumption and harm. Such price increases mean that there is less incentive for consumers merely to switch between different types of alcohol or drinking venues, unlike price increases targeting certain products or market sectors. Across-the-board price increases tend to lead to relatively larger reductions in mean consumption than other pricing options. Policies that specifically target low-priced products or certain product categories lead to smaller changes in consumption, as they only cover a part of the market.

The effects of introducing minimum pricing

Harmful drinkers tend to buy alcohol that is cheaper than that bought by moderate drinkers. Cheap alcohol is also attractive to young people. A minimum price policy might be considered beneficial in that it targets the drinkers causing the most harm to both themselves and society while having little effect on the spending of adult moderate drinkers. Increasing levels of minimum pricing show a very steep increase in effectiveness; for example, a 20p minimum unit price would lead to a 0.1% reduction in consumption, while a 70p minimum unit price would lead to an 18.6% reduction. Minimum prices targeted at particular types of drink are less effective than all-product minimum prices.

Alcohol pricing and promotion *(continued)*

The effects of banning off-trade price promotions

Just over 50% of all alcohol purchased from supermarkets in the UK is sold on promotion. Only quite tight restrictions on the level of discount offered would have noticeable policy effects. Banning only buy-one-get-one-free offers has very little effect on alcohol consumption and harm. A total ban on off-trade discounting is estimated to reduce consumption by 2.8%, although this may prove effective only if retailers are prevented from reacting to the ban by simply lowering their non-promotional prices.

The effects of banning alcohol advertising

There is some uncertainty over the mechanisms linking advertising to consumption, and it is unclear whether advertising restrictions can be expected to have an immediate effect on consumption. The international evidence suggests that the effects of advertising may be cumulative over time, and may work by influencing attitudes and drinking intentions, rather than by directly altering consumption levels.

The effects of these policies on alcohol-related harm

In 2008 the cost of alcohol misuse in England was estimated to range between £17.7 and £25.1 billion, which corresponds to £346–£491 per head of population. The general pattern observed in this report is that the more restrictive the policy, the greater the harm reduction. Higher minimum unit prices lead to greater harm reduction.

As prices increase, alcohol-attributable hospital admissions and deaths are estimated to reduce, the reduction in deaths occurring disproportionately among harmful drinkers. The health harm reductions are mostly related to chronic diseases rather than to acute conditions such as injuries. This is because much of the alcohol-attributable health harm occurs in middle or older age groups at significant risk of developing or dying from chronic disease. In addition, policies resulting in bigger price increases reduce deaths in moderate and hazardous drinkers. In terms of hospital admissions, policy options that increase prices for only a proportion of products and by marginal amounts have very small effects.

Crime harms are estimated to reduce as prices are increased. Reductions take place across the spectrum of violent crime, criminal damage and theft, robbery and other crimes. A minimum unit price of 30p is estimated to reduce total crimes by around 3,800 per year, whereas at 40p the reduction is estimated at 16,000. Crime harms are estimated to reduce particularly among 11–18-year-olds as they are disproportionately involved in alcohol-related crime and are significantly affected by price rises in low-priced products.

In general, all policy options that target harmful and hazardous drinkers are effective in reducing alcohol-related harm in the workplace. The size of the effect is dependent on the extent of the price increase. Unemployment due to alcohol problems occurs mainly in the harmful drinker group and is estimated to reduce as prices increase; for example, 3,800 avoided unemployment cases per annum in response to a minimum unit price of 30p, compared to 12,400 for a 40p minimum.

In conclusion, pricing policies can be effective in reducing health, crime and employment harms and these policies can be targeted so that those who drink within recommended limits are minimally affected and very heavy drinkers, who are responsible for the majority of alcohol-related harms, pay the most.

(Deirdre Mongan)

1. Meier P, Brennan A, Purshore R, Taylor K, Rafia R, Booth A *et al.* (2008) *Independent review of the effects of alcohol pricing and promotion: Part B. Modelling the potential impact of pricing and promotion policies for alcohol in England: Results from the Sheffield alcohol policy model, Version 2008(1-1).* Sheffield: University of Sheffield.

Maggie Bowen – an appreciation

Staff and clientele at Rialto Community Drug Team (RCDT) were given the very sad news of the death of Maggie Bowen on 22 December 2008 after a relatively short period of illness. The RCDT was set up in late 1992 and within three years we were joined on our team by Maggie. It was her first post as an addiction counsellor, being seconded to us by the then Eastern Health Board.

There is much talk these days about 'target indicators' and 'value for money'. Her clientele expressed a profound sense of devastation, sadness and loss. They told about how she touched their lives and helped them to make changes and move forward. These were very eloquent and touching testimony of how her work and input made a huge and incalculable and qualitative difference to so many individuals and families in this part of the city and sadly capture in a dramatic and personal manner the value of building trusting relationships that all the statistics in the world can only hint at.

Maggie played a major part in helping to develop the broad range of services in our drug team. She particularly put a lot of time and effort into building up our community methadone satellite clinics and was to the fore in ensuring that the treatments did not stop with methadone only. She conscientiously developed her counselling skills and knowledge over the years. She built on her Trinity diploma course by doing a psychotherapy degree and a specialised course on cognitive behaviour therapy. Her work in helping others to grow was matched by her commitment to her own personal growth.

Our team is now doing its best to cope with its great loss. We send our love to her son, Russell and to her mother and brothers in Wales.

We held a 'Month's Mind' for Maggie in our Centre at the end of January. Clients, family, friends and colleagues attended the service, which included the dedication of the 'Maggie Bowen Counselling Room'. It can be truly said of Maggie – Ní bheidh a leithéid arís ann (her likes will never be here again).

(Rialto Community Drug Team)

Assessment of early interventions for at-risk youth

This article reports findings from a recent Rapid Evidence Assessment (REA) of effective early interventions for youth at risk of future poor outcomes.[1] The REA is a review of reviews including systematic reviews and meta-analysis. This review had two objectives: (1) to identify the risk factors related to poor outcomes, and (2) to identify the interventions that work to reduce these risk factors and improve outcomes. This article will focus on the review findings in relation to risk factors and effective interventions for alcohol and drug use among 13–19-year-olds.

Review findings on risk factors

The review identified risk factors in four areas, as shown in Table 1 below.

Table 1 Risk factors associated with alcohol and drug use

Family risk factors	School risk factors	Individual and peer risk factors	Community risk factors
Poor parental discipline Weak family cohesion Parental drug and alcohol use Parental attitudes to drugs Poor parental monitoring and supervision Sibling drug use Sibling sources of drug supply Siblings co-drug-users Early-life trauma Family breakdown and mode of family interactions Low income and poor housing Experience of authority care	Low achievement at school Lack of commitment (absences, truancy) School exclusions Non-compliance with school rules Lack of educational attainment Truancy (when experienced during middle childhood, 9–11 years, and adolescence, 12–18 years)	Personal attitudes condoning problem behaviour (malleable) Friends involved in problem behaviour during adolescence (malleable) Poor self-esteem and depression (malleable) Age (fixed) Gender (fixed) (female school truants more likely to abuse than males) Ethnic background (fixed)	Drug availability Exposure to drug-using peer groups Increased chance of being targeted as new consumer

Source: Adapted from Thomas *et al.* 2008

Review findings on effective interventions

- Behaviour therapy, culturally sensitive counselling in residential settings, family therapy, and the 12-step Minnesota programmes were most successful in reducing drug use.
- Family therapy was most successful in reducing psychological problems of young drug users.
- Family therapy, family teaching, non-hospital day programmes, residential care services, and school-based life-skills interventions were most successful in improving family and social outcomes.
- Drug education was associated with lower drug use; however, the interventions had only a small impact and the gains dissipated over time.
- School-based life-skills training programmes had some success in preventing drug use in high-risk subgroups; success rates improved when targeted interventions were nested within the universal programmes.

Strengths and weaknesses of this review

This is a wide-ranging review of the literature, covering many topic areas and, because its conclusions are based on systematic reviews, the evidence behind its findings can, on the whole, be considered to be high quality and robust. However, the authors advise caution in interpreting the findings for two reasons. First, while the vast majority of studies reviewed show correlations between risk factors and poor outcomes, the results do not usually justify the inference of a causal link between a given risk factor and an outcome. Second, an intervention which works for one group of clients may have no comparable effect on another group because of moderating variables that may be present, e.g. genetic factors.

Discussion

Eleven reviews were identified which targeted alcohol and drug use. Many of these reviews included multi-component interventions delivered in a range of settings, including school, community, and family. The vast majority of interventions operate at the individual or family level. According to the authors, this may reflect the greater importance of these levels in determining behaviour. Equally, this may reflect the greater emphasis placed on individualism and personal responsibility by policymakers and scientists alike. The findings suggest that multidimensional family therapy and cognitive-behavioral group treatment are effective in reducing risk factors among at-risk youth. This is an interesting finding as it suggests that group-based interventions may be more effective in responding to the needs of at-risk youth than interventions targeted at the individual.

(Martin Keane)

1. Thomas J, Vigurs C, Oliver K, Suarez B, Newman M, Dickson K and Sinclair J (2008) Targeted youth support: Rapid Evidence Assessment of effective early interventions for youth at risk of future poor outcomes. In *Research Evidence in Education Library*. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

The process of youth homelessness

A report on Phase II of a qualitative longitudinal study on homelessness among young people in Dublin city was published in 2008.[1] The research adopted a pathways approach that aimed to generate in-depth understanding of the process of youth homelessness, with particular focus on movement into, through and out of homelessness.

Research methods

Phase II data were collected between September 2005 and August 2006. Information was successfully obtained about the living situations of 37 of the 40 young people (23 males and 17 females) recruited in Phase 1,[2] and follow-up interviews were conducted with 30 (16 males and 14 females). The life history interview was the main method of data collection and young people were asked to 'update' their life history narrative by detailing significant events since the time of their initial interview.

Findings

In analysing the narratives of the 30 young people re-interviewed at Phase II, the researchers were able to categorise three pathways:

- Independent exits from homelessness
- Dependent exits from homelessness
- Continued homelessness

Independent exits

Six of the young people had moved home and one had moved to private rented accommodation. Those who had continued contact with and support from their families throughout the homeless experience made a smoother transition home and were more likely to view their move home in positive terms. Among those for whom drug use was an issue, continued family and parental support was almost always contingent on the young person seeking drug treatment and quitting use. This often involved breaking ties with past friends and associates within both street and drug scenes and establishing new social networks.

Dependent exits

Ten of the young people had either moved to transitional/supported housing (n=7) or to a residential care setting (n=3). They were helped to make this move by support from family members and professional sources, and by participation in education or training. For those who reported drug problems, seeking treatment was a critical enabler in the transition to supported housing. Most felt that it was important to distance themselves from former peer networks and attempted to establish and maintain positive and enabling social relationships. Some experienced financial difficulties as well as problems with everyday household chores and responsibilities. A number reported feelings of loneliness and depression.

Continued homelessness

Thirteen of the young people (11 males and two females) remained homeless, that is, they continued to access emergency hostel accommodation, sleep rough or live in other temporary or unstable living situations. Nine were aged 19 years or under. Most had left school early, reported short-lived attempts at a return to education/training, had limited participation in the labour market and weak family ties. All had a history of drug misuse and two also reported heavy alcohol use; nine reported heroin use.

Housing instability had a discernible impact on these young people's drug-using behaviour. Moving between temporary living places brought them into contact with other drug users and also cultivated an acceptance of 'hard' drug use. Their entry to adult hostels was a point of particular vulnerability due, in large part, to the sense of despair many experienced at this juncture. Escalating drug consumption impacted on their physical and mental health, and negatively influenced their ability to maintain meaningful ties with society. A number had tried to address the matter of their drug consumption and several had sought treatment at some time.

Young people's efforts to address their substance use were constantly hampered by the absence of a stable place to live, rendering abstinence a constant struggle, as described by Eoin (22):

> I've been going round in circles for a long time probably since back then [time of initial interview] but it's just hard. Like, I was doing well for a while, I'd be doing well for a few weeks but then something would happen. I get setbacks, you know. Having nowhere to stay is the main thing. Staying here, I'm trying to get clean urine but as you know it's, this hostel is for people who's on drugs and I'm sharing a room with a fella and like… I'm trying to stay away from everything and he's doing it in me face. It's just there in me face. It's just so, it's just so hard. (p. 131)

This research shows that there are pathways out of homelessness for young people whose contact with their families has remained strong; they receive support in accessing treatment for their substance use and in making the transition to supported living conditions. The research also shows that there are young people who remain trapped in homelessness and substance use. They tend to have weak ties with family, poor education skills and problems related to drug and alcohol use. Despite many making efforts to 'get clean' their experience of housing instability and exposure to adult hostels and the street drug scene can place them at an elevated risk of escalating their use of substances and their experience of homelessness.

(Martin Keane)

1. Mayock P, Corr ML and O'Sullivan E (2008) *Young people's homeless pathways*. Dublin: Homeless Agency.
2. Mayock P and VekičK (2006) *Understanding youth homelessness in Dublin city: key findings from the first phase of a longitudinal cohort study*. Dublin: Stationery Office.

An assessment of treatment needs in the North Eastern RDTF

The North Eastern Regional Drugs Task Force (NERDTF) commissioned a needs assessment study in order to:

- assess the number and profile of drug-users;
- assess in-patient and out-patient drug treatment services;
- explore needs of drug treatment service users and their families;
- identify gaps in service provision; and
- make recommendations for future service development and resources required.

The study examined available quantitative data sources and also carried out qualitative interviews with a wide range of stakeholders, including staff working in addiction services, community and voluntary groups, drug users and family support groups.[1] The NERDTF covers the counties of Louth, Meath, Cavan and Monaghan. The main results are summarised below.

The study found that drug use in the region had increased in recent years. National prevalence data show that almost one in four people in the region reported using an illicit drug at some point in their life, and one in three in the 15–34-year age group.

The report did not include all data available at the time from the National Drug Treatment Reporting System (NDTRS); Table 1 presents the complete figures for 2001 to 2006, showing a 27% increase in the total number of cases over the six years.[2] This was mainly due to the increase in new cases seeking treatment.

Table 1 Number (%) of cases entering treatment in the former North Eastern Health Board area, 2001 to 2006

	2001	2002	2003	2004	2005	2006
All cases	370	306	387	374	365	471
Previously treated cases	125 (33.8)	99 (32.4)	146 (37.7)	130 (34.8)	125 (34.2)	149 (31.6)
New cases	221 (59.7)	186 (60.1)	229 (59.2)	236 (63.1)	224 (61.4)	303 (64.3)
Treatment status unknown	24 (6.5)	21 (6.9)	12 (3.1)	8 (2.1)	16 (4.4)	19 (4.0)

According to the NDTRS, the incidence of treated drug use in the region for 2001–2006 was to 91.3 per 100,000, an increase on the 1998–2002 rate of 50.1 per 100,000.

The main problem drugs identified by the study were cocaine, cannabis, alcohol, heroin and prescription drugs. The main problem drugs for those entering treatment between 2001 and 2006 were cannabis (54%), opiates (27%) and cocaine (10%).[2]

Most of the respondents interviewed felt that drug use was a growing problem in the region. Other issues raised included the normalisation of cannabis use to the point where it was considered equivalent to consuming alcohol. Heroin use was associated with social deprivation and rural areas, while cocaine was perceived as being used by all social classes, with use starting in the late teens. Increased polydrug use was also commented on. Increased consumption of alcohol by teenagers was reported.

The report noted that services varied in type, quality and availability throughout the region. There was a range of outpatient services, but no dedicated inpatient facility for drug treatment and detoxification. Underdevelopment of the services was suggested as a factor in some of the weaknesses in service provision. Other issues raised included insufficient staff resources in HSE addiction services, limited collaboration between statutory and voluntary services, lack of a clear focus on polydrug use and lengthy waiting lists.

Recommendations of the report are summarised below.

- Provide services for residential detoxification, out-of-hours treatment, crisis and early intervention, and treatment for under-18s.
- Provide clear access pathways and accessible information on the types of service and treatment available.
- Move to a continuity of care model, with a case management approach, and systems to monitor progress and outcomes.
- Widen the scope of treatment services to cover holistic care for the client and their family, and improve the support services
- Develop a set of standards/guidelines to improve the appropriateness/location of services.
- Adjust treatment approaches to respond to polydrug use including alcohol, and increase harm reduction approaches, including needle exchange, health education and easy access to low-threshold treatment.
- Improve collaboration and communication between statutory and community services.

(Suzi Lyons)

1. Watters N (2008) *Drug treatment: an assessment of needs in the North East Region.* Navan: North Eastern Regional Drugs Task Force.
2. Reynolds S, Fanagan S, Bellerose D and Long J (2008) *Trends in treated problem drug use in Ireland, 2001 to 2006.* HRB Trends Series 2. Dublin: HRB.

Directory of courses 2009

The National Documentation Centre on Drug Use has published a new edition of the Directory of courses and training programmes on drug misuse in Ireland. Thirty-six providers sent us information about 88 courses for this fourth edition. We would like to thank all of those who made contributions.

Most courses refer directly to drugs or addiction, though others aim to develop broad skills, such as supervision, facilitation and counselling techniques, which may be of interest to those working in this area. A wide variety of training standards, methods and approaches are represented. We do not assess the quality of courses listed; we present information as supplied by the course co-ordinators on course length, assessment, qualifications and accreditation.

Course providers are based in Dublin (66%), Cork, Donegal, Kildare, Galway, Leitrim, Mayo, Meath, Tipperary and Waterford. Although many cater specifically for people in their locality, some also offer courses on a regional or national basis.

This year we asked local and regional drugs task forces to provide information about their educational bursaries. A small number of task forces offer financial assistance for those living or working in their area to attend specified courses. We provide information on their application criteria.

(Mary Dunne)

Course co-ordinators who wish to revise an existing entry or include a new course in the 2010 edition of the Directory may request an application form from mdunne@hrb.ie

Study on drug use in Clondalkin

This timely report[1] commissioned by the Clondalkin Local Drugs Task Force (CLDTF) was launched on 7 December 2008 by John Curran TD, Minister of State with responsibility for drugs strategy, at Áras Chrónáin in Clondalkin. The research team was led by Dr Marianne Greene of Merchants Quay Ireland with assistance from the Clondalkin Drug Users Forum. The CLDTF, entering its third strategic review, commissioned the research to 'define the current nature and extent of drug use in Clondalkin ... in order to inform drug strategy, policy and services' (p. 6).

Both qualitative and quantitative research methods were used, including a survey of 150 drug users by nine peer research assistants, and focus groups with problematic drug users, family members and community members. Available relevant statistics were also collated, such as Garda crime statistics and drug treatment figures.

The report covers a wide range of drug-related issues, including information relating to availability, prevalence, profile and patterns of use, drug-related health issues and risk behaviours, drug treatment and drug-related crime.

Patterns of drug use and emerging trends

Heroin remains the primary drug of use among those attending drug treatment facilities but crack cocaine is regarded as an emerging problem drug in the Clondalkin area. Polydrug use is common and generally involves heroin combined with cannabis, cocaine, crack or benzodiazepines. The injection of cocaine by injecting heroin users was another emerging trend.

Drug dealing and drug related crime

As drug consumption has become less visible in public areas, concerns of the wider community have centred upon drug-related crime and the normalisation of such crime. A greater amount and variety of illegal drugs has become available in recent years. Dealing has become more open, frequently being conducted in public places, and is seen as an attractive and lucrative career option for a proportion of young people living in Clondalkin. The report highlighted a belief that law enforcement focused too much on breaking up high-level drug distribution networks rather than on disrupting the activities of local dealers. Lenient sentencing of drug offenders was also of concern to participants.

Drug treatment and harm reduction

On the basis of data from statutory and community agencies in the CLDTF area, there appeared to be a small decrease in the numbers attending drug treatment services in the last three years. Of the 150 drug users surveyed, nearly two-thirds were not accessing drug services at the time of the study, while 42% had never accessed drug services other than needle exchanges. Over half (59.3%) of the 81 injecting drug users surveyed reported using needle exchanges weekly or monthly.

Just over one-third of the sample (37.3%) were currently on methadone maintenance programmes. Typical waiting times for methadone maintenance were less than three months (33.3%), and over twelve months (29.8%). While there was general satisfaction with the methadone programme as a stabilising influence, some participants were frustrated at the lack of a moving-on mechanism for those on the programme. The lack of inpatient detox facilities was also highlighted in the report.

(Anne Marie Donovan and Anne Marie Carew)

The report is available from Clondalkin Drugs Task Force, telephone (01) 457 9445.

1. Breen M (2008) *Nature and extent of drug use in Clondalkin.* Dublin: Clondalkin Local Drugs Task Force.

Kerry Life Education evaluation report

The Kerry Life Education (KLE) project is delivered from a fleet of mobile buses called 'Life Education' classrooms that visit primary schools in Co Kerry. The project includes a mix of health promotion and information and covers diet, self-esteem, peer dynamics, bullying and alcohol and substance use. It has been visiting schools since 2004 and is estimated to reach between 5,000 and 7,000 students per year. An evaluation of the KLE project has recently been published.[1]

Methods of evaluation

This was a process evaluation aimed at uncovering the perspective of schools, parents and professionals on the operation and relevance of the KLE project. A survey questionnaire was sent to 68 schools that had participated in the project; the response rate was 84%. The principal of each school was asked to complete the questionnaire using a consensus view between principals, teachers and parent representatives. A different survey questionnaire was sent to eight key professionals in the fields of health promotion and education; six responded. In addition, data from the Health Behaviour in School-aged Children (HBSC) dataset for 2006 were analysed and comparisons on a number of variables were made between students in KLE schools and students from comparison schools in Kerry.

The perspective of schools

The majority of schools (89%) reported the teaching, content and presentation of KLE to be excellent and appropriate for children, and 95% wanted the project to continue. Ninety per cent reported that KLE was good or excellent at supporting individual components of the Social, Personal and Health Education (SPHE) programme,[2] such as learning about the body, making decisions and relating to others. Ninety-three per cent reported having a substance use policy, with 94% reporting that KLE provided either good or excellent support to the development of substance use policy. Only 46% reported that parents had received input from the KLE project. Ninety-six per cent perceived the impact of the project on students to be good or excellent, with the same figure anticipating the potential impact over time to be good or excellent.

The perspective of key professionals

Three of the six professionals who responded were not familiar with the work of KLE prior to being surveyed. When they did learn of the project, respondents reported mixed views. Public health professionals expressed cautious optimism that KLE could provide consistent information on substance use, contribute to a holistic approach to health promotion and increase the number of health promotion sites available to young people. In contrast to the view of the majority of schools, the two education professionals expressed concern that KLE was short-term and did not reinforce the consistent approach taken in SPHE that seeks to develop life skills during school-going years.

Comparison of KLE student data with HBSC data

The evaluators compared data for Fifth and Sixth Class students who participated in the KLE project with HBSC 2006 data from comparison schools in Kerry. Lifetime consumption of alcohol was lower among Fifth Class KLE students than among students in comparison schools. Differences favouring KLE students were noted on a number of other variables, including being satisfied with life, taking more frequent exercise, consuming less soft drinks, snacks and chips and being less likely to be involved in incidents of bullying.

When interpreting these favourable results for KLE students it is important to note that the sample was small and was 75% female. In addition, the differences observed between KLE students and students not receiving the intervention cannot be attributed solely to the intervention of KLE as any number of factors may explain these changes. Further research under more controlled conditions is needed before any substantive conclusion can be reached. Nonetheless, the KLE project is popular among school personnel and parents in Kerry and it would be interesting if further research investigated the perception of young people regarding the project.

Evidence shows that short-term interventions delivered on a once-off basis are not very useful in making drug education effective in young people's lives. However, when used in conjunction with a comprehensive programme such as SPHE, they can enhance understanding of the issues being addressed and contribute to a perception in the community that potential substance use among young people is being tackled. Such a perception can undermine the belief among young people that substance use is 'normalised' and tolerated by the community. However, it is important that short-term projects are premised on the same theoretical basis as the more comprehensive programme that they are supporting, otherwise different perceptions can arise among stakeholders regarding how interventions operate. Such differences are noted in this evaluation – between public health professionals and educational experts – and it would be helpful to address such differing views if the KLE project is to support the delivery of SPHE in Kerry in the future.

(Martin Keane)

1. Jackson T, Kelly I and Dee A (2008) *Kerry Life Education project: an evaluation*. Cork: Department of Public Health HSE South.
2. SPHE stands for Social, Personal and Health Education and is the main life-skills programme delivered in primary and secondary schools in Ireland. The programme uses the Walk Tall component in primary schools to support the implementation of substance use education.
3. McGrath Y, Sumnall H, McVeigh J and Bellis M (2006) *Drug use prevention among young people: a review of reviews*. Evidence briefing update. London: National Institute for Health and Clinical Excellence.

Trends in alcohol and drug admissions to psychiatric facilities

Activities of Irish psychiatric units and hospitals 2007, the annual report published by the Mental Health Research Unit of the Health Research Board in December 2008, shows that the total number of admissions to inpatient care has continued to fall.[1]

In 2007, 2,699 cases were admitted to psychiatric facilities with an alcohol disorder, of whom 808 were treated for the first time.[1] Figure 1 presents the rates of first admission between 1990 and 2007 of cases with a diagnosis of alcohol disorder, per 100,000 of the population.[1-6] It is notable that the rate decreased steadily between 1991 and 2004 and more than halved during the reporting period. The rate stabilised in 2004 and 2005, but decreased again in 2006 and 2007. The trend since the early nineties reflects changes in alcohol treatment policy and practice, and the resultant increase in community-based and special residential alcohol treatment services. Of the 2,743 discharges with an alcohol disorder, just under 44% spent less than one week in hospital and 17% spent more than one month in hospital. Whether or not these admissions were appropriate, and in line with the recommendations of the mental health policy, *A vision for change*, could not be discerned from the report as the numbers with co-morbid illness were not reported.

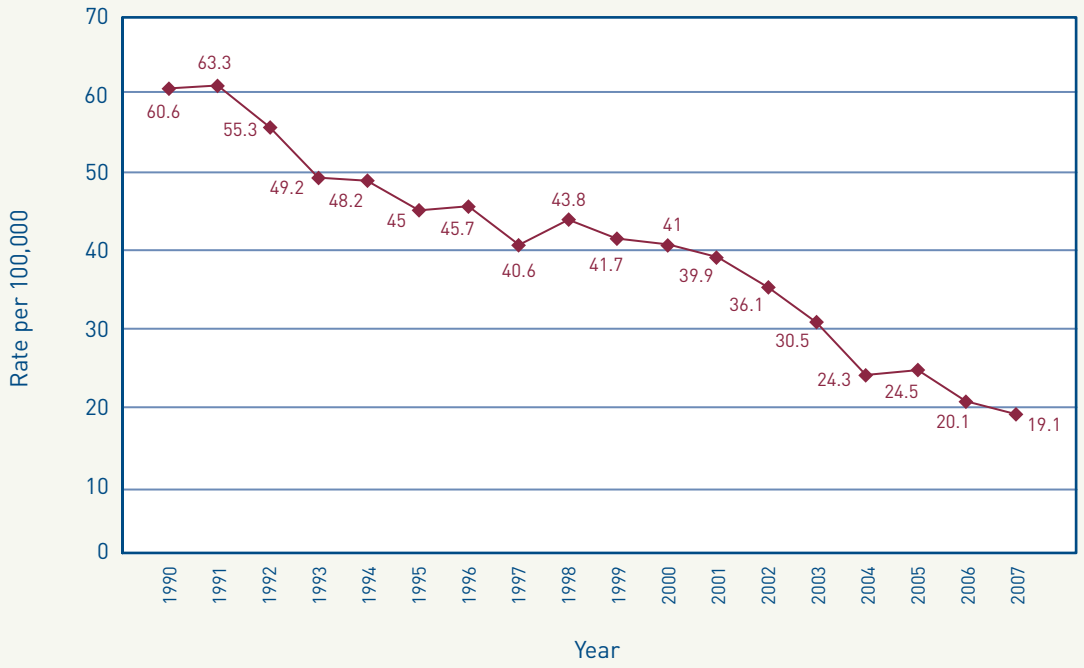


Figure 1 **Rates of psychiatric first admission of cases with a diagnosis of alcohol disorder (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the National Psychiatric Inpatient Reporting System, 1990 to 2007**

In 2006, 724 cases were admitted to psychiatric facilities with a drug disorder, of whom 265 were treated for the first time.[1] The report does not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate. Figure 2 presents the rates of first admission between 1990 and 2007 of cases with a diagnosis of drug disorder, per 100,000 of the population.[1-6] The rate increased steadily between 1990 and 1995, with a dip in 1996, and further annual increases between 1997 and 2001. The rate was almost three times higher in 2001 than it was in 1990. Notable dips in the rate occur in the census years 1996 and 2002, and can be partly explained by the increased population figure used as the denominator in calculating the rate for those years.

The overall increase in the rate of drug-related first admissions between 1990 and 2001 reflects the increase in problem drug use in Ireland and its burden on the psychiatric services. The overall decrease in the rate since 2001 possibly reflects an increase in community-based specialised addiction services during this period. The increased rate in 2005 may be accounted for by the use of the 2002 census figure in calculating the rate. The decrease to 5.9 in 2006 reflects the new census figure used as denominator. The rate increased marginally to 6.3 in 2007. Of the 776 discharges with a drug disorder, 51% spent less than one week in hospital and just under 13% spent more than one month in hospital.

Alcohol and drug psychiatric admissions *(continued)*

Figure 2 **Rates of psychiatric first admission of cases with a diagnosis of drug disorder (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the National Psychiatric Inpatient Reporting System, 1990 to 2007**

(Jean Long)

1. Daly A, Walsh D and Moran R (2008) *Activities of Irish psychiatric units and hospitals 2007*. Dublin: Health Research Board.
2. Daly A, Walsh D and Moran R (2007) *Activities of Irish psychiatric units and hospitals 2006*. Dublin: Health Research Board.
3. Daly A, Walsh D, Ward M and Moran R (2006) *Activities of Irish psychiatric units and hospitals 2005*. Dublin: Health Research Board.
4. Daly A, Walsh D, Comish J, Kartalova-O'Doherty Y, Moran R and O'Reilly A (2005) *Activities of Irish psychiatric units and hospitals 2004*. Dublin: Health Research Board.
5. Daly A, Walsh D, Moran R and Kartalova-O'Doherty Y (2004) *Activities of Irish psychiatric services 2003*. Dublin: Health Research Board.
6. Walsh D and Daly A (2004) *Mental illness in Ireland 1750–2002: reflections on the rise and fall of institutional care*. Dublin: Health Research Board.

Four cases of botulism among drug users

Botulism is a rare but serious illness caused by *botulin toxin*. The toxin is produced by the bacteria *Clostridium botulinum*. The HPSC was informed of four cases of wound botulism – all affecting injecting drug users – in late November 2008. Wound botulism is a rare condition. The condition is caused by bacteria that are commonly found as spores in soil or gravel and can be acquired if a wound is contaminated by such material. The bacteria grow in skin abscesses as a result of injecting heroin but the bacteria can also reproduce in the nasal passages as a result of snorting cocaine. Symptoms of botulism usually develop about 12–36 hours after exposure to the toxin and normally begin with blurred vision, difficulty swallowing, difficulty speaking and occasionally breathing problems. Diarrhoea and vomiting can also occur and the disease can progress to paralysis. In recent years this type of botulism has been most commonly reported among chronic drug users, in Ireland and elsewhere. Most people (90–95%) with botulism will recover with treatment.

(Jean Long)

The State Laboratory annual report 2007

'The State Laboratory provides an analytical and advisory service to Government departments and offices to support their policies, regulatory programmes and strategic objectives'.[1] The agency's 2007 annual report focuses on five strategic themes: agriculture and food, revenue, the Coroner Service and other departments, organisational review, modernisation agenda and optional capabilities.

The Human Toxicology section of the laboratory provides an analytical service to the Coroner Service and other bodies, including the Irish Medicines Board. Between 2000 and 2007 the laboratory saw a 75% increase in samples analysed for the Coroner Service. Despite the increase in samples, the laboratory has been able to maintain and even improve agreed turn-around times. In 2007 personnel at the laboratory attended 2,950 coroners' inquests to assist the coroner in the interpretation of the toxicology report.

Advances have been made in the analytical capacity of the laboratory. An automated extraction method for analysing cocaine and cannabis samples has been introduced, replacing the labour-intensive manual extraction method. Work is ongoing on streamlining confirmatory analysis methods which are used for detection and identification of substances such as 6-mono acetyl morphine (heroin metabolite), methadone, cocaine and dihydrocodeine. Other advances include new instrumentation, instrumental connectivity and validation methods.

The reported increase in cocaine use in Ireland is mirrored in the rise in the number of post-mortem samples sent to the laboratory for analysis for cocaine. The results of tests of human biological samples support the view that much of the cocaine used in Ireland is adulterated with other substances, most frequently lidocaine (brand name Lignocaine), diltiazem (a benzodiazepine) and phenacetin (a type of analgesic). The toxic effect of cocaine is increased when it is mixed with such substances, particularly lidocaine.

The goal of the State Laboratory in relation to the Coroner Service and other departments is to provide a timely high-quality service and to meet present and future demands in areas such as forensic toxicology, health and safety compliance and environment and heritage protection.

(Simone Walsh)

The State Laboratory website is at www.statelab.ie

1. The State Laboratory (2008) *Annual report 2007*. Kildare: The State Laboratory.

EU Drugs Action Plan evaluated

The EU places great store on evaluation. The European Commission has published guidelines on evaluating both programmes and policies,[1] and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has made a special study of the evaluation of national drugs strategies.[2] In December 2008 the final evaluation of the EU Drugs Action Plan 2005–2008 was published.[3] This report provides an interesting case study of how to conduct an evaluation.

Designing the evaluative framework

The objectives of the evaluation of the EU Drugs Action Plan were defined by reference to the plan's underlying purpose, which is to act as a co-ordination instrument. Three evaluative objectives were identified: (1) to establish the extent to which the *outputs* specified in the plan were delivered, (2) to gauge the *outcomes*, i.e. the impact of the actions on the drugs situation, and (3) to assess the *process*, i.e. the value added of the Action Plan as a policy instrument *per se*. Each objective was supported by two questions which explored different aspects of the objective. Probing the nature of the relationship between actions and their impacts, these questions resulted in comprehensive answers (see table).

Summary of the evaluative framework applied to, and key findings of the evaluation of, the EU Drugs Action Plan 2005–2008

Objectives	Questions	Answers
To establish to what extent the objectives and actions of the Action Plan have been achieved.	To what extent have the operational objectives and actions in the current EU Action Plan on Drugs been implemented and what are the main outputs?	The EU Drugs Action Plan is mainly a co-ordination instrument, pulling together the main strands of drug policy. It is a non-binding co-ordination document for member states, which are autonomous in implementing its aims and objectives. Have the specific priorities in the Strategy and the operational objectives in the Action Plan been adopted by member states?
	Have the specific priorities in the Strategy and the operational objectives in the Action Plan been adopted by member states?	The EU Drugs Strategy and Action Plan are suitably reflected in national policies. The evaluation shows that member states have translated the objectives of the Action Plan into national policy, and/or that these objectives were already reflected in existing documents. (1) Member states report that the Action Plan reflects the main policy fields at national level. Some national priorities are not covered, mostly owing to differences in the drug situations in member states. (2) The evaluation shows that the Action Plan supports a process of convergence between member states' drug policies and helps to achieve policy consistency between countries.

EU Drugs Action Plan *(continued)*

Objectives	Questions	Answers
To understand the relationship between the Action Plan and the actual drug situation.	What are the overall changes in the drug situation in recent years?	Although there has not been a significant reduction in the prevalence of drug use, the use of the most prevalent drugs seems to have stabilised and/or fallen slightly. The use of cocaine is showing an upward trend in some member states.
	To what extent can these changes be linked to the implementation of the EU Action Plan on Drugs?	The stabilisation in prevalence levels of most illicit drugs except for cocaine cannot be linked to specific interventions implemented through the Action Plan.
To estimate the added value that the Action Plan offered to drug policy in the EU as a whole.	What is the overall added value of the EU Drugs Action Plan 2005–2008?	Member states consider that the Action Plan has added value at both EU level and for national policy, where the Action Plan functions as a guiding document.
	What key conclusions and lessons can be drawn from this evaluation for the next plan covering the years 2009 – 2012?	See the article on the EU Drugs Action Plan 2009–2012 below.

Obtaining the necessary information

To obtain the information needed to answer the evaluative questions, five sources of information were used. Objective information on trends in the drug situation in Europe and the responses to it was collected, and the views of member states regarding the Action Plan were surveyed. Various analyses were undertaken, including a reflection on the structure, logic and clarity of the EU Drugs Strategy (2005–2012) and the related EU Drugs Action Plan (2005–2008), a review of the implementation of the actions and achievement of the objectives, and an assessment of intra-institutional co-ordination and co-operation in the implementation of the Action Plan.

Ensuring stakeholder buy-in

To ensure a comprehensive evaluation, the Commission set up a Steering Group comprising representatives of the main stakeholder groups – the member states holding the EU presidency between mid-2006 and the end of 2008, the European Parliament, Europol, the EMCDDA, and Eurostat. This group advised on the choice of evaluation methodology and the interpretation of the evaluation outcomes. The Commission also sought input from the Civil Society Forum on Drugs. In its introductory section, the succeeding EU Drugs Action Plan 209–2012 commented that the evaluation of the 2005–2008 Action Plan was 'the most extensive assessment of EU drug policy to date and shows that the objectives of the present Plan have been partly achieved'.

(Brigid Pike)

1. Commission of the European Communities (2004) *Evaluating EU activities: a practical guide for the Commission services*. Luxembourg: Office for Official Publications of the European Communities.
2. EMCDDA (2004) Evaluation of 'national drugs strategies' in Europe. Selected issue. In *Annual report 2004: the state of the drugs problem in the European Union and Norway*. Luxembourg: Office for Official Publications of the European Communities.
3. Commission of the European Communities (2008) *Report of the final evaluation of the EU Drugs Action Plan (2005–2008)*. Commission staff working document. Accompanying document to the Communication from the Commission to the Council and the European Parliament on an EU Drugs Action Plan 2009–2012. Brussels: European Commission, DG Justice, Freedom and Security.{COM (2008) 567}; {SEC (2008) 2455}; {SEC (2008) 2454}.

EU sets priorities for drug policy 2009–2012

On 8 December 2008 the European Council endorsed the EU drugs action plan for 2009–2012.[1] While using the same five activity areas as the previous action plan (co-ordination, demand reduction, supply reduction, international co-operation, and research, information and evaluation), the new plan reduces the number of objectives from 45 to 24 and increases the number of actions from 61 to 72.[2] As a result, the EU's drug policy priorities for the next four years are more clearly defined than previously. Some key innovations with implications for Ireland's drugs policy are noted below.

Create a European Alliance on Drugs

Having established the European Civil Society Forum on Drugs in 2006,[3] the European Commission will now form a European Alliance on Drugs. This alliance will allow civil society organisations from across the EU, including schools, commercial enterprises, public bodies and non-governmental organisations, to participate in a common framework designed 'to create public commitment about and to take action on drug problems in society'. The action plan also calls on member states to involve civil society at all appropriate levels of drugs policy, 'in accordance with national practices'.

EU priorities for drug policy *(continued)*

Seek an EU consensus on minimum standards for demand reduction activities

The action plan lists 10 actions to be implemented by member states, covering all aspects of demand reduction – prevention, treatment, rehabilitation and reintegration. Harm reduction measures are included to reduce both the spread of blood-borne infectious diseases and the number of drug-related deaths in the general population, and health-related harms associated with drug use in prison. Member states are to pay particular attention to meeting the needs of vulnerable and minority groups and to preventing polydrug use (combined use of illicit and licit substances, including alcohol, volatile substances and tobacco).

At EU level there will be a drive to enhance the quality and effectiveness of these activities. Member states will be requested to survey the availability and effectiveness of prevention, treatment, harm reduction and rehabilitation services, in responding to specific needs, using a methodological framework to be developed by the European Commission. The Commission will then seek to develop an EU consensus on minimum standards and benchmarks.

Achieve a measurable improvement in effectiveness of supply reduction activities

Nineteen actions focus on enhancing co-operation between law enforcement agencies and the judiciary in the member states in tackling the production and trafficking of drugs, including the manufacture and supply of synthetic drugs and the diversion of trafficking of drug precursors.

The need to improve responsiveness to emerging threats, such as new drugs or new trafficking routes, is emphasised. Regional security platforms are to be set up where and when needed. MAOC-N (Maritime Analysis and Operations Centre – Narcotics), of which Ireland, which controls some 16% of the EU's territorial waters, was a founding member in 2007, is cited as an example of this type of mechanism. Moreover, member states and regions with high exposure to 'particular drug production/trafficking phenomena' are to be the focus of co-ordinated and joint efforts at EU level.

Promote the European balanced approach to the drugs problem worldwide

The action plan includes four actions calling for better co-ordination and continuity between EU and member state policy positions in international forums on aspects of drug policy. An agreed EU position, reflecting the fundamental principles of EU drug policy, is to be presented at the high-level segment of the 52nd Session of the UN's Commission on Narcotic Drugs (CND), to be held in Vienna in March 2009. This Session will see the final evaluation of, and agreement on the follow-up to, UNGASS 1998; the EU is seeking to have the EU position included in the new UN Political Declaration on illicit drugs.[4]

Improve understanding of the drugs problem

The action plan asserts that improved understanding will lead to an expanded knowledge base both for public policy and for citizens' awareness of the social and health implications of illicit drug use. The European Commission is to take the lead in (1) establishing research priorities and identifying mechanisms to generate new knowledge and to put a proposal on this matter to the European Council; (2) developing indicators/measures of drug-related crime, illegal cultivation, drug markets and supply reduction interventions, and identifying means of collecting the relevant data; and (3) devising analytical instruments to better assess the effectiveness and impact of drug policy, e.g. model evaluation tools, policy effectiveness indices, and public expenditure analysis.

Member states are charged with evaluating and fine-tuning national drug policies on a regular basis, and with providing the necessary resources to meet the reporting obligations and quality standards established by the EMCDDA for the provision of national data required for monitoring and evaluation purposes.

(Brigid Pike)

1. European Council (8 December 2008) EU drugs action plan 2009–2012. *Official Journal of the European Union* (2008/C 326/09), 20 December 2008.
2. For information on the previous action plan, see B Pike (2005) EU action plan on drugs 2005–2008. *Drugnet Ireland*, (14): 3.
3. For information on the work of the Forum, see B Pike (2008) EU civil society forum discusses new EU action plan on drugs. *Drugnet Ireland*, (27): 23.
4. For background information on UNGASS 1998, see B Pike (2008) UN assesses progress in tackling world drug problem. *Drugnet Ireland*, (26): 25–26.

Irish Prison Service annual report 2007

The Irish Prison Service (IPS) annual report for 2007 details developments in drug supply reduction measures, rehabilitation and treatment services to prisoners during 2007.[1]

Sentenced committals for drug offences increased by 34%, from 395 (6.5% of total offences) in 2006 to 530 (8.2% of total offences) in 2007. These figures do not include people who were imprisoned for drug-related offences, such as economic acquisitive crimes committed to support a drug habit. Given the clear link between drug use and economically motivated crime, it can be assumed that many of those imprisoned for property offences were problematic drug users. Of the 530 offenders sentenced for drug offences, 267 received prison sentences of up to one year, 241 received sentences from one to 10 years and 22 received sentences of more than 10 years.

Section 36 of the Prisons Act 2007, which came into operation on 1 May 2007, makes it an offence for prisoners to have unauthorised possession or use of mobile phones. Phones are viewed by the prison authorities and the Garda Síochána as contributing to illegal activity outside the prison. It is reported that by the end of 2007 more than 2,124 mobile phones had been seized in Irish prisons. Other supply reduction measures reported included:

- New prison visiting arrangements whereby only identified and known persons are allowed to visit prisoners, 'reducing the likelihood of visitors attempting to pass drugs, and of prisoners being coerced into receiving visits from persons not known to them to facilitate the passing of drugs' (p. 25);
- Enhanced perimeter security involving improved netting and closer co-operation with the Garda Síochána to arrest and prosecute persons attempting to convey drugs into prisons;
- Improved technology for searching cells and prison property;
- The introduction of drug detection dogs;
- The establishment of an Operational Support Group dedicated to developing expertise in searching and intelligence gathering.

Measures advanced during 2007 to enhance drug rehabilitation included:

- The awarding of a contract for the provision of addiction counsellor services;
- The allocation of additional nurse officers and prison officers to dedicated drug treatment teams;
- The provision of funding to community groups to provide addiction counselling and support to prisoners while in prison and on their release in the community.

The IPS also reports that 'Considerable work was undertaken during the year in consultation with practitioners at local prison level to draft a Drug Treatment Clinical Policy document to provide guidance to practitioners regarding various clinical issues that may arise in treating addiction in a prison context' (p. 26).

As shown in Table 1, nine prisons provided methadone treatment to 1,840 prisoners in 2007, of which 185 were receiving methadone for the first time. It is noteworthy that methadone treatment was not provided in two large prisons, namely Cork and Castlerea.

Table 1 Numbers of individuals receiving methadone treatment* in Irish prisons in 2007

Prison	Total patients during 2007	New patients in 2007	Patients at 31 December 2007
Cloverhill Prison	710	124	176
Dochas Centre	225	26	38
Limerick Prison	10	0	3
Midlands Prison	90	8	30
Mountjoy Main Prison	474	9	112
Mountjoy Prison Medical Unit	120	8	53
Portlaoise Prison	3	1	1
St Patrick's Institution	15	0	6
Wheatfield Prison	193	9	90
Total	**1840**	**185**	**509**

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

Source: IPS (2008)

(Johnny Connolly)

1. Irish Prison Service (2008) *Annual report 2007*. Longford: Irish Prison Service.

From *Drugnet Europe*

Towards the better treatment of addiction

Cited from article by Roland Simon in Drugnet Europe *No. 65, January–March 2009*

Ongoing research can make a valuable contribution to the effective treatment of drug addiction. This is according to high-ranking scientists attending the European Conference of Scientific Experts, held in Paris from 9–10 December. Organised under the French Presidency of the EU by the Interdepartmental mission for the fight against drugs and drug addiction (MILDT), the event was entitled 'How can we better treat drug addiction? New scientific and clinical challenges for Europe'.

… A session dedicated to neurobiology showed how better insight into the mechanisms underlying addiction could improve interventions. Approaches for treating cocaine and crack addictions were also explored, such as the use of central nervous system (CNS) stimulants as a cocaine substitution. Also presented were the first results of a European adaptation of a US family-based behavioural therapy programme for problem cannabis users, as well as lessons to be learnt from cases of self-healing.

The researchers expressed concern over lack of sustainability (e.g. short-term funding) and problems in putting theory into practice. Possible remedies were discussed … [including] longer-term planning and funding; an adequate slot for drug-related research in future EU research framework programmes; better integration of national and EU funding for addiction research; and the creation of research clusters for better collaboration and concentration on specific themes.

For a summary and full report, see http://mildt.systalium.org/article6022.html

Drug use, a growing challenge for EU road safety

Cited from article by Dominique Lopez and Brendan Hughes in Drugnet Europe *No. 65, January–March 2009*

Alcohol remains the number one substance endangering lives on European roads, but more drivers are now found to be using illicit drugs and psychoactive medicines … . The [EMCDDA] report, *Drug use, impaired driving and traffic accidents*, a review of the latest research in this field, explores the potential impact on road safety.[1] …

The report is dedicated to the effects and risks associated with the use of individual substances or with multiple drug use. … "*Preventing driving under the influence of drugs is targeted by the current EU drugs strategy 2005–12 and its action plans"*, said EMCDDA Director Wolfgang Götz, *"and policymakers are increasingly called upon to respond to the problems of road fatalities linked to licit and illicit substances."*

Research covered in the report is broadly split into two types: epidemiological and experimental. Epidemiological studies examine the prevalence of drugs in driving populations, and are conducted through a range of surveys (e.g. roadside, hospitals). Experimental studies, where a drug is administered to volunteers in measured doses, … show that most illicit drugs can affect some aspect of driving performance and increase the risk of being involved in a traffic accident. And chronic (long-term) use of any illicit drug can decrease driving performance, even when the subject is no longer intoxicated.

1. www.emcdda.europa.eu/publications/insights/driving

New thematic paper on indicated prevention

Cited from Drugnet Europe *No. 65, January–March 2009*

The EMCDDA published its latest online thematic paper in February entitled: Preventing later substance use disorders in at-risk children and adolescents: a review of the theory and evidence base of indicated prevention. The study adds to the current knowledge and understanding of risk factors in the development of later drug problems, focusing on the mental health and behavioural problems that develop during childhood. The study also identifies models of best practice for prevention activities targeting vulnerable children in European countries.

Indicated prevention is a relatively new branch of drug prevention and describes a preventive approach targeting individuals at high risk of developing substance abuse or dependence later in life. Drawing on the current scientific literature, the study describes the results of research into psychosocial and individual risk and protective factors. The neurobiology of drug use and how childhood psychiatric disorders can predispose to addiction are described in detail. One chapter of the report is devoted to the ethical issues raised by indicated prevention. The report also contains a wealth of practical information. This includes guidelines for the assessment and treatment of specific psychiatric risk conditions for adolescent substance abuse, and detailed information on the indicated prevention programmes that have been identified in the study.

Downloadable from www.emcdda.europa.eu/publications/thematic-papers

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

In brief

On 30 September 2008 a nationwide **Dial-to-Stop Drug Dealing** initiative was launched by John Curran TD, Minister of State with responsibility for drugs strategy. This non-Garda, confidential Freefone service is being phased in across local and regional drugs task force areas between October 2008 and May 2009. An overall evaluation of the project is due to be available in summer 2009. Freefone 1800 220 220

On 5 November 2008 the closure of the **Harristown Residential Alcohol and Drug Treatment Centre**, which is funded by the Probation Service and located in the grounds of Castlerea Prison, County Roscommon, was debated in Dáil Éireann. Closure had been recommended by the authors of a ***Review of adult probation residential centres***, commissioned by the Probation Service. The evaluators commented: 'There is demand for an addiction treatment service for offenders and the evaluators recommend establishing a new service with a component to address offending behaviour linked to the most suitable addiction treatment model in the Harristown facility with a new strategic partner.'
www.probation.ie / www.oireachtas.ie

From 17 to 18 November 2008 the **European Crime Prevention Network (EUCPN)** held its annual conference in Paris. This year's theme was crime prevention in urban public spaces, focusing on three main areas: planning of public spaces, video protection and daily actions of public space management. The aim of the network is to facilitate the exchange of ideas on crime prevention issues between EU member states, including policies followed by member states, and initiatives taken by local and regional authorities and associations. www.eucpn.eu

On 25 November 2008 **substitution treatment** was the subject of a Parliamentary Question in Dáil Éireann. Reporting on recent figures relating to the provision of methadone treatment in Ireland, Minister for Health Mary Harney TD stated that a feasibility study on the prescribing and dispensing of Subutex and Suboxone in certain specialist addiction clinics and in a selected number of community settings would commence shortly. www.oireachtas.ie

On 26 November 2009 a research report, ***Young people on remand***, was launched by Barry Andrews TD, Minister of State for Children and Youth Affairs. The study found that the most common outcome (80%) of remand hearings at the Dublin Children Court was a decision to remand a young person on bail. However, over one-third of the professionals consulted noted that young people 'rarely' or 'never' understood what it meant to be on bail. The study identified a core group of young people who, according to the authors, 'are deeply entrenched in the youth justice system and are likely to benefit from bail support and alternatives to remand programmes in order to reduce their risk of future detention.' www.omc.ie

On 26 November 2008 the **Irish Defence Forces Compulsory Random Drug Testing (CRDT) programme** was the subject of a Parliamentary Question in Dáil Éireann. Minister for Defence Willie O'Dea TD reported that, since the programme's introduction in October 2002, 8,422 tests had been conducted, with 34 tests yielding a positive result (0.4%). www.oireachtas.ie

On 18 December 2008 the **Spent Convictions Bill 2007** was introduced in Dáil Éireann for its second reading. The Bill is intended to apply where a prison sentence not exceeding six months or a fine or penalty have been imposed, and then only after a certain number of years have elapsed without a further conviction. The purpose of the Bill is to help rehabilitate convicted persons through facilitating their reintegration into the workforce and allowing them to build new careers. Following a debate, the Bill was referred to the Select Committee on Justice, Equality, Defence and Women's Rights. www.oireachtas.ie

On 6 January 2009 the **Czech Presidency of the EU** released its work programme for January–June 2009. It made the following statement with regard to combating drugs: ' … the attention of the Presidency will focus on the implementation of an EU Drugs Action Plan for 2009–2012; issues concerning the production and use of amphetamines; and the coordination of the joint position of the EU for the regular session of the UN Commission on Narcotic Drugs [to be held in Vienna between 11 and 20 March 2009].' www.eu2009.cz

On 12 January 2009 **a campaign of action with regard to the National Drugs Strategy** was agreed by over 150 activists and community representatives meeting in Dublin. Six key demands were identified:

1. A Minister for the Drugs Strategy at the cabinet table (Super Junior) **2.** Immediate mandate to drugs task forces to develop new plans to meet local needs, and statutory agencies to be instructed to engage **3.** Guarantee YPFSF to remain targeted on drugs prevention **4.** Resources to be made available to implement the Rehabilitation Strategy **5.** Mandate and resources to task forces to begin developing response to alcohol **6.** Community policing fora to be established without delays www.citywide.ie

On 16 January 2009 the **European Commission** published the 818 submissions it received in its public consultation on future priorities, including illicit drugs, in the area of freedom, security and justice for 2010–2014, together with the results of a Eurobarometer survey on awareness of key policy issues in the same area. The Commission will use these inputs to inform its proposal for the next multi-annual programme in the area of freedom, security and justice to follow the Hague Programme in 2010. The Commission has posted all the public submissions and the results of the opinion survey on its website. http://ec.europa.eu/justice_home/news/consulting_public/news_consulting_0001_en.htm and http://ec.europa.eu/public_opinion/flash/fl_252_en.pdf

On 19 January 2009 the **Children's Rights Alliance**, a coalition of 80 NGOs that work to secure the rights and needs of children in Ireland, published the first in what is expected to be an annual 'report card', ***Is the government keeping its promises to children?*** The report card analyses key commitments in the areas of education, health, material wellbeing, and safeguarding childhood. With regard to the protection of children from the negative consequences of alcohol use, it states that 'a piecemeal approach is being taken, while the real problem is being ignored'. The Alliance calls for the implementation of the recommendations in the Strategic Task Force on Alcohol in relation to 'protecting children' and the introduction of a legislative ban to protect children from unnecessary exposure to alcohol marketing.
www.childrensrights.ie

Meeting on 26–27 January 2009 the **Pompidou Group's Research Platform**[1] agreed to investigate the theoretical underpinnings for an integrated illicit drug and alcohol policy, and to publish later this year a synthesis of recent developments in psychological, biomedical and sociological research relevant to the drug problem.
www.coe.int/T/dg3/pompidou

(Compiled by Brigid Pike)

1. The Pompidou Group is a multidisciplinary co-operation forum to prevent drug abuse and illicit trafficking in drugs, set up in 1971 and incorporated into the Council of Europe in 1980. It comprises six platforms – prevention, treatment, criminal justice, research, ethics and airports. Ireland is one of 35 member states that participate in the Pompidou Group.

Recent publications

Journal articles

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

The role of alcohol in deaths presenting to the Coroner's Service in Cork city and county

Bellis M, Bolster MA and Doyle CT
Irish Medical Journal 2009; 101(1): 13–15

A retrospective study was conducted in order to determine the prevalence and concentration of alcohol in post-mortem blood samples sent for toxicological analysis in Cork city and county in 2003 and 2004.

Post-mortem reports of these deaths were reviewed for the presence or absence of alcohol at the time of autopsy, blood alcohol concentration (BAC) at time of death, age and sex of the decedents. Of samples sent for blood alcohol analysis (BAA), 38.4% were positive for alcohol.

Significant differences were found between the proportions of alcohol-positive cases by cause of death. Alcohol-positive cases were significantly younger (44.3 ± 17.8 years) than alcohol-negative cases (51.9 ± 19.4years) and 52% of drivers were positive for alcohol at the time of death.

Awareness of the harmful and potentially fatal effects of alcohol should continue to be raised within the community, so as to prevent future fatalities.

Drug and solvent misuse in national school children in mid-west Ireland

Houghton F, Cowley H, Meehan F and Kelleher K
Irish Journal of Psychological Medicine 2008; 25(4): 157–160

This study provided a baseline assessment of the level of drug and solvent misuse by national school children in the mid-west region of Ireland. Although the results are encouraging in relation to cannabis and may dispel anecdotal concerns, the level of experimentation with glue/solvents, particularly among males, is an issue given its potential lethality. The authors qualified their results by noting that the survey focused only on children attending national school on the survey date. It is probable that children from more chaotic backgrounds where drug misuse may be an issue were under-represented in this study.

The extent and nature of family alcohol and drug use: findings from the Belfast youth development study

Percy A, Thornton M and McCrystal P
Child Abuse Review 2008; 17(6): 371–386

Using data from an ongoing longitudinal study of adolescent drug use, this study examines the proportion of teenagers living with parents who are problem alcohol or drug users. Around 2% of parents report high levels of problem drinking and 1% report problem drug use.

If a broader definition of hazardous drinking is used, the proportion of teenagers exposed increases to over 15%. When substance use is examined at a family level (taking account of alcohol and drug use among dependent children in addition to that of parents), the proportion of families experiencing some form of substance use is considerable. These findings add further support to the call for increased recognition of the needs of dependent children within adult treatment services when working with parents.

Likewise, the reduction of harm to children as a result of parental substance use should be an increasingly important priority for family support services. This is likely to be achieved through the closer integration of addiction and family services.

Methadone and HCV treatment

McCormick PA, Keavney M, O'Toole S and Moloney J
Irish Medical Journal 2008; 101(10): 316–317

Relatively few patients infected with the hepatitis C virus through intravenous drug abuse receive effective antiviral therapy. The aim of this study was to determine if supervised treatment in a drug treatment centre could improve compliance with antiviral therapy. A pilot study of supervised anti-viral treatment in a community non-residential drug treatment facility was conducted. Thirteen patients infected with hepatitis C virus genotype 2 or 3 were identified in a drug treatment clinic. Six patients agreed to treatment. Full treatment course was administered in all six, with sustained viral response in 5/6. This study demonstrates that effective treatment penetration can be improved for this patient group by shared care with drug treatment services, without the need for significant increases in resources.

A qualitative study of Irish teachers' perspective of student substance use

Van Hout MC and Connor S
Journal of Alcohol & Drug Education 2008; 52(1): 80–91

This research aimed to provide an anecdotal perception of student substance use according to the teachers' personal experience in the Irish secondary level educational setting.

Interviews were conducted with 95 teachers at 10 randomly selected schools in county Carlow. The school type included vocational, secondary in disadvantaged area, secondary in non-disadvantaged area, youth training centre, private school and both mixed/single sex schools.

The interview contained questions regarding experience of substance abuse within the school setting, knowledge and recognition of substance use in students, awareness of school drug and alcohol policy, attitude toward substance misuse and drug education, awareness of drug availability in the area and knowledge of drug-related services in their area. A thematic analysis procedure was used to generate lists of key ideas, words, phrases, and verbatim quotes. These were then formulated into categories and topics.

The authors found that teachers perceived that drug education in schools was 'haphazard, dissimilar and rather hit and miss', with not every class receiving it, others receiving it as part of religious education and Social Personal and Health Education and the remainder being visited by the local drug education officer, a former addict or a juvenile liaison officer. Teachers highlighted the need for information and teacher-specific training in order to recognise the warning signs of adolescent problematic substance use, as many felt this social problem was impacting on their classroom and the academic performance of some students. Some teachers also reported not feeling comfortable with the delivery of drug educational material within their class time due to lack of appropriate training and lack of available time in their curriculum, in addition to feeling that this was not compatible with their role as educators.

Upcoming events

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

April

20–23 April 2009

Harm Reduction 2009: IHRA 20th International Conference
Venue: Imperial Queen's Park Hotel, Bangkok, Thailand
Organised by / Contact: The International Harm Reduction Association and the Conference Consortium
Tel: +44 (0) 20 7554 8533
E-mail: info@ihraconferences.com
www.ihra.net/Thailand/Home

Information: IHRA's harm reduction conferences have been held around the world each year since 1990. The theme for the 2009 event will be 'Harm Reduction and Human Rights'. Over four days, this conference will be the main meeting point for all those interested in harm reduction – with over 60 sessions, 250 speakers and 300 posters as well as a film festival, workshops, a conference party, exhibitions and networking events. It will be an invaluable platform for advocacy, debate, and discussion around harm reduction – the key forum for the dissemination of harm reduction ideas and practice.

23–26 April 2009

Asking the right questions in the right way: re-evaluating alcohol research & treatment for the 21st century
Venue: Stranmillis College, Belfast, Northern Ireland
Organised by / Contact: New Directions in the Study of Alcohol Group
Tel: +44 (0)141 548 4507
Email: carol.driver@actiononaddiction.org.uk
www.newdirections.org.uk

Information: This year's conference incorporates a research symposium from the Alcohol Education Research Council. Following international studies that found no apparent differences between treatments, NDSAG takes up the issue of 'asking the right questions in the right way' challenging traditional research. We will examine the relationship between research design and real world change processes. It is time to take a realistic, long term view on treatment effectiveness and consider service users' views.

The conference is designed for practitioners, managers, researchers, commissioners and anyone else interested in the alcohol field. It will feature the usual mix of erudition, hard work, robust debate and informality: a proven formula that promotes high quality learning and networking. Confirmed presenters include: Jim Orford (Birmingham); Lawrence Kirkpatrick (Belfast); Shane Butler (Dublin); and Gillian Tober (Leeds).

May

5–8 May 2009

31st SALIS Conference. Setting Sail: Best Practices for the Next Decade
Venue: Halifax, Nova Scotia, Canada
Organised by / Contact: Substance Abuse Librarians and Information Specialists / Ruth Hart or Sheila LaCroix
Email: ruth.hart@gov.ns.ca / Sheila_Lacroix@camh.net
http://salis.org/conference/call_for_abstracts.html

Information: The SALIS conference committee invites presentations that focus on identifying or creating best practices in librarianship, knowledge or information management relating to all aspects of addictive behaviours, and especially encourages presentations on the themes of:

- Exploring and defining the future role of librarians, knowledge or information managers;
- How we can use technology, partnerships or other best practices to build the relationships and to develop the skills to get us there; and
- Presentations at a special half-day session, "Web 2.0: SALIS, Let's Get Social". Share and showcase, in a 15 minute presentation, your experiences with Web 2.0.

June

1–5 June 2009

35th Annual Alcohol Epidemiology Symposium of the Kettil Bruun Society
Venue: City Campus, University of Copenhagen
Organised by / Contact: Kim Bloomfield, University of Southern Denmark, and Esbjerg Jakob Demant, Center for Drug and Alcohol Research
Email: Kbs2009@crf.au.dk
www.kbs2009.dk

Information: The primary purpose of the conference is to provide a forum where researchers involved in studies on alcohol can exchange ideas about their ongoing research. The scope of the symposium includes studies of determinants and consequences of drinking, drinking practices and attitudes, and the social and institutional responses to drinking-related harms. Empirical research, theoretical papers and reviews of the literature are welcome. Epidemiology is broadly construed and includes research in a variety of disciplines, such as psychology, sociology, criminology, economics, history and other disciplines.

The Symposium focuses on discussion of papers that are pre-circulated electronically at this website. Papers are presented in 10-minute segments, followed by a discussant's comments and general audience participation. Any person who submits a paper may be asked to be a discussant or chair of a session.

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) (Dutch institutions for addiction care)
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 are 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

Upcoming events *(continued)*

2–5 June 2009

EAHIL Workshop 2009. Working with others: Explore, engage, extend!
Venue: Dublin Castle
Organised by / Contact: Health Sciences Libraries Group, in association with the National Documentation Centre on Drug Use, Health Research Board. Contact Louise Farragher (Chair, Local Organising Committee.)
Email: lfarragher@hrb.ie
www.eahil2009.ie

Information: The European Association for Health Information and Libraries (EAHIL) Workshop will be the largest health library and information event of its kind in Ireland. This workshop offers a packed and varied programme with parallel interactive workshops, paper presentations and plenary sessions that aim to explore the nature of collaborative work among health librarians and health information professionals. Join over 200 health librarians and information professionals from Ireland, Europe and beyond and explore issues including:

- Teaching and research support
- Consumer health issues
- Information literacy
- Health technology assessments
- Reflective practice
- Collaborative work in practice

17–19 June 2009

Hepatitis C 3rd International Conference: The Third Decade and Beyond
Venue: Dublin Castle, Dublin
Organised by / Contact: The Consultative Council on Hepatitis C, in association with the Department of Health and Children and the Health Service Executive
Email: paulenemckeever@conferenceorganisers.ie
www.hepc2009.com/

Information: This three-day conference offers two parallel programmes:

Day 1: a half day dedicated to issues relating to primary and community care management of Hepatitis C.
Days 2 and 3:
Programme 1: Scientific/Clinical
Some of the world's leading experts will share their insights, excitement and commitment to understanding the Hepatitis C virus and to developing more effective ways of preventing and treating the disease. Many of the scientific/clinical speakers will participate in both the academic and the patient-focused programmes.
Programme 2: Living with Hepatitis C

October

29–31 October 2009

2009 International conference and annual meeting for the WHO European Network for Prison and Health. What works in the prevention and control of major communicable diseases in prison?
Venue: Offices of the Ministry of Health, Madrid
Organised by / Contact: WHO European Network for Prison and Health

More information regarding the event, registration procedure, accommodation and submission of abstracts will follow shortly.
www.euro.who.int/prisons/meetings/20090123_1

Information: This international conference will address the health problems related to major communicable diseases in prisons and will examine best practices in implementing prison health services. Prison visits will be organised.

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

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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.