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Alcohol and Drug Research Newsletter

Updated Cochrane review of heroin maintenance treatment

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New HRB trends paper on alcohol-related deaths

On 12 July the third publication from the National Drug-Related Deaths Index (NDRDI) was launched.[1] HRB Trends Series 10 describes, for the first time, trends in alcohol-related deaths and deaths among people who were alcohol dependent in Ireland for the years 2004–2008.

Four of the authors of the report: (l to r) Simone Walsh, Marie Sutton, Suzi Lyons and Ena Lynn

The NDRDI was established in September 2005 as a system for recording drug-related deaths and deaths among drug users;[2] its remit was expanded in January 2006 to include alcohol-related poisonings and deaths among people who were alcohol dependent.

The NDRDI retrospectively recorded from 2004 onwards:

- deaths in which alcohol was implicated (regardless of history of alcohol dependence); and
- deaths of individuals reported in any of the data sources as having been 'an alcoholic' or 'alcohol dependent' or suffering from 'chronic alcohol use' or having had a diagnosis of 'alcohol dependence syndrome' (exact terms only) and/or one or more of the relevant International Classification of Diseases (ICD) codes (F10.2 to F10.9).

According to the World Health Organization (WHO), alcohol is the eighth leading cause of death in the world.[3] Most alcohol-attributable deaths are due to injury, cancer, liver cirrhosis or cardiovascular disease.

Poisoning deaths

Alcohol-related poisonings

Between 2004 and 2008, 672 poisoning deaths in which alcohol was implicated (alone or in conjunction with other drugs) were recorded (Table 1). This makes alcohol the drug most frequently implicated in *all* fatal poisonings in Ireland in the five-year period. Most of those who died were male. The highest number of deaths was recorded in 2007 (170). The median age of those who died of alcohol-only poisoning was 48 years, that of those who died of alcohol polysubstance (alcohol plus other substance/s) poisoning was 41 years.

contents

Alcohol-related deaths *(continued)*

Table 1 Alcohol-related poisoning deaths (NDRDI 2004–2008) (N = 671)

	2004	2005	2006	2007	2008
Total	**125**	**116**	**111**	**170**	**150**
Alcohol only (n = 331)	61	51	54	85	80
Alcohol polysubstance (n = 341)	64	65	57	85	70

Just over half (50.7%) of all alcohol-related poisonings involved another substance. Most commonly implicated along with alcohol were benzodiazepines (61.3%) and opiates (including heroin and methadone) (55.7%) (Table 2).

Table 2 Additional drugs involved in alcohol polysubstance poisoning deaths (NDRDI 2004–2008) (N = 341)

	%
All alcohol polysubstance poisonings*	**100.0**
Benzodiazepines	61.3
Antidepressants	23.5
Heroin	22.9
Other opiates	21.4
Other prescription medication	15.5
Methadone	11.4
Cocaine	9.1
Other‡	8.8

* Percentages in columns do not add up to totals shown in this row because individual deaths may be attributable to more than one drug or substance.

† Excludes heroin and methadone.

‡ Includes other illicit and licit drugs such as amphetamines, hallucinogens, volatile inhalants, cannabis or non-opiate analgesia.

All NDRDI-recorded poisoning deaths

Table 3 presents data on alcohol poisonings alongside data on poisonings from all other substances in order to compare the contribution of alcohol to fatal poisonings nationally. Alcohol was implicated in 40.7% of all poisonings, making it the drug most frequently implicated in fatal poisonings in Ireland for the period 2004–2008.

Table 3 Drugs involved in all poisoning deaths in Ireland (NDRDI 2004–2008) (N=1,650)

	%
All poisoning deaths*	**100.0**
Alcohol	40.7
Benzodiazepines	31.1
Heroin	18.7
Methadone	16.7
Antidepressants	16.7
Other prescription drugs	14.5
Cocaine	14.0
Other opiates†	17.3
Non-opiate analgesic	5.0
MDMA	3.3
Other‡	3.1

* Percentages in column do not add up to total shown in this row because individual deaths may be attributable to more than one drug or substance.

† Excludes heroin and methadone.

‡ Includes other illicit and licit drugs such as amphetamines, hallucinogens, volatile inhalants or cannabis.

Alcohol-related deaths *(continued)*

Non-poisoning deaths in those who were alcohol dependent

There were 3,336 non-poisoning deaths of people who were alcohol dependent, increasing from 508 in 2004 to 799 in 2008 (Table 4). Almost all (89.2%) were due to medical causes, the remainder (10.8%) were due to traumatic causes.

Table 4 Causes of death in people who were alcohol dependent (NDRDI 2004–2008) (N = 3,336)

	2004	2005	2006	2007	2008
Total	508	564	720	745	799
Medical (n = 2,975)	459	499	617	680	720
Trauma (n = 361)	49	65	103	65	79

The NDRDI assigns medical and traumatic causes of death to a limited number of broad categories to allow for data to be presented in a meaningful way.

Examples of medical-cause categories:

- **Haemorrhage** includes deaths due to ruptured oesophageal varices, gastrointestinal bleed (but not cerebral haemorrhage);
- **Cerebra**l includes deaths as a result of a stroke, cerebral haemorrhage (non-traumatic);
- **Other respiratory disease** includes emphysema, chronic obstructive airways disease;
- **Other infection** includes sepsis or peritonitis.

Examples of traumatic-cause categories:

- **Fall** includes deaths as a result of a fall from a height (from a building or down a stairs) or fall on same level (trip over step or from footpath)
- **Choking** includes deaths as a result of asphyxia due to foreign body (for example food or vomit);
- **Violence** includes fatal injuries as a result of an assault, shooting or stabbing;
- **Road traffic collision** (RTC) includes drivers (of any vehicle), passengers or pedestrians.

Deaths from medical causes

The number of deaths from medical causes in people who were alcohol dependent rose from 459 in 2004 to 720 in 2008. Half were aged 59 years or under and the highest number of cases was in the 55–59-year age group (15.7%). Seventy-four per cent were male. The most frequent causes of death in this group were: alcoholic liver disease (23.6%); cardiac conditions (17.2%); and respiratory infections (11.4%).

Deaths from traumatic causes

The number of deaths as a result of a traumatic event was highest in 2006 (103 deaths). Half were aged 49 years or under. The most frequent causes of death in this group were: falls (39.9%); hanging (19.4%); and choking (12.2%).

Deaths from medical or traumatic causes that also involved alcohol, of people who were not alcohol dependent

A further 215 non-poisoning deaths in which alcohol was implicated were recorded among people who did not have a recorded history of alcohol dependence. The number of these deaths increased from 14 in 2004 to 84 in 2008.

The majority (66.0%) died as a result of traumatic events, most commonly drowning (21.1%) and choking (18.3%).

Conclusion

The increase in the number of deaths recorded may be explained by a number of factors. It could indicate a true increase in the number of deaths, or an effect of improved recording practices, as the NDRDI is a relatively new system. However, given that the per capita consumption of alcohol in Ireland is among the highest in Europe,[4] and that 56% of Irish people drink in a harmful manner,[5] a combination of these factors is the most likely explanation.

Alcohol was the drug most frequently implicated in all fatal poisonings in Ireland in the five-year period. The findings of this analysis in relation to the types of non-poisoning death in which alcohol was implicated are similar to those of other international research on alcohol-attributable mortality. However, the NDRDI data will need to be further analysed in detail to better understand the relationship between alcohol use and specific diseases, for example breast or oesophageal cancer.

The analysis showed clearly the extent of premature mortality as many of those who died were still in their prime, aged between 40 and 59 years. The NDRDI will be able to measure the effects of any changes in public health policy on alcohol-related mortality in the Irish population.

(Suzi Lyons)

1. Lyons S, Lynn E, Walsh S, Sutton M and Long J (2011) *Alcohol-related deaths and deaths among people who were alcohol dependent in Ireland, 2004 to 2008.* HRB Trends Series 10. Dublin: Health Research Board. www.drugsandalcohol.ie/15370
2. 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. www.drugsandalcohol.ie/11513
3. World Health Organization (2011) *Global status report on alcohol and health.* Geneva: World Health Organization. www.who.int/substance_abuse/en
4. OECD (2010) *OECD health data 2010 - frequently requested data.* Accessed May 2011 at www.oecd.org/dataoecd/52/42/48304068.xls
5. Morgan K, McGee H, Watson D, Perry I, Barry M, Shelley E *et al.* (2008) *SLÁN 2007: survey of lifestyle, attitudes and nutrition in Ireland.* Main report. Dublin: Department of Health and Children. www.dohc.ie/publications/slan07_report.html

Standardising drinking survey methodologies

Although population surveys which focus on alcohol consumption and alcohol-related harm are regularly conducted in most European countries, comparison of results across countries is difficult due to the lack of standardised methodologies. The SMART (Standardising Measurement of Alcohol-Related Troubles) project team was established to develop a standardised comparative survey methodology on alcohol consumption, alcohol-related problems and public support for policy measures. Ten European countries, including Ireland, were involved in developing these guidelines.[1]

Following a literature review on methodologies of alcohol surveys and a number of expert meetings, a survey protocol for a comparative drinking survey was designed, which was then piloted in the participating countries. The proposed questionnaire had a number of core sections, each with guidelines for its implementation. It is estimated that an interview based on these core questions should not last longer than 10–15 minutes, especially if CAPI (Computer Assisted Personal Interview) is used.

1. Alcohol consumption: frequency, beverage-specific quantity and frequency, and context of drinking;
2. Risky single-occasion drinking and drunkenness;
3. Adverse consequences of own alcohol use;
4. Rapid alcohol problem screen;
5. Unrecorded alcohol supply;
6. Harm from others; and
7. Attitudes towards alcohol policy.

The results of the pilot study demonstrated that comparative alcohol surveys are feasible across Europe despite the existence of different drinking cultures, various political traditions and economic inequalities. While there is a need to confirm the results of the pilot test in larger, random samples of inhabitants of different European countries, 'it is expected that better use of standardized approaches across Europe will lead to more informed and evidence based policy making to reduce alcohol's health and economic burden'.

(Deirdre Mongan)

1. Moskalewicz J and Sieroslawski J (2010) *Drinking population surveys: guidance document for standardized approach.* Warsaw: Institute of Psychiatry and Neurology. http://www.drugsandalcohol.ie/15682/

Report on incidence of alcohol-related brain injury

Alcohol-related brain injury (ARBI) is a term used to describe physical impairment to the brain sustained as a result of alcohol consumption. The two most common conditions associated with ARBI are: Wernicke's encephalopathy, an acute condition caused by a lack of thiamine and which causes confusion, ataxia and disturbance of the muscles controlling eye movement; and Korsakoff's amnesic syndrome, a chronic condition that leads to difficulty in learning new information, memory loss and confabulation. Other associated conditions include cerebellar atrophy, peripheral neuropathy, hepatic encephalopathy and frontal lobe dysfunction.

The North West Alcohol Forum (NWAF) recently published the results of research they commissioned in relation to ARBI in three counties in the Health Service Executive (HSE) West Region (Donegal, Sligo and Leitrim) and the Western Health and Social Care Trust (WHSCT) area in Northern Ireland.[1]

Data from all acute hospitals in both areas for 2005–2009 were obtained to determine the incidence of ARBI.

There were 163 ARBI admissions to acute hospitals in the three HSE West counties and 151 in the WHSCT area in that period. The report does not give population rates. In both areas the majority of admissions were male (68% in the HSE West and 62% in the WHSCT area) and were aged over 55 years.

A number of interviews were conducted with health professionals who highlighted the difficulties in obtaining accurate data on the incidence of ARBI and the potential for under-reporting. They also stated that there are currently no defined care pathways for people with ARBI in either area. As a result, 'people with a high level of care needs may be placed in inappropriate care settings such as older people's homes or dementia care settings'.

The authors conclude that there is anecdotal evidence that the prevalence of ARBI is growing but that there is no systematic way of capturing data conclusively; that there is no co-ordinated approach to treating patients with ARBI due to the absence of a clear pathway of care; and that 'the lack of agreement as to whether ARBI is considered a mental health condition or a brain injury results in a dilemma as to which pathway of care the patient should follow'.

(Deirdre Mongan)

1. North West Alcohol Forum (2011) *Assessment of incidences of alcohol-related brain injury (ARBI) in the HSE West (Donegal, Sligo, Leitrim) and Western Health and Social Care Trust areas.* Donegal: North West Alcohol Forum. http://www.drugsandalcohol.ie/15440/

Cost of alcohol-attributable hospitalisations in Ireland

Harmful use of alcohol is a considerable burden on Irish hospitals. A recent Irish study calculated the number and costs of hospital bed days due wholly or partially to alcohol use over the five-year period 2000 to 2004.[1] Research by the Health Research Board has established that conditions wholly attributable to alcohol accounted for 3.6% of all bed days in Ireland in 2008.[2] However, this analysis did not reflect the hospitalisations due to alcohol across all injury and disease categories known to be causally related to alcohol.

Age- and sex-specific alcohol-attributable-fractions (AAFs) for Ireland were developed by combining international risk estimates with Irish consumption data where available; where Irish AAFs were not available, international AAFs were used. These were applied to two national datasets – the Hospital In-Patient Enquiry Scheme (HIPE) and the National Psychiatric In-patient Reporting System (NPIRS) – to calculate the number and costs of bed days wholly caused and prevented by alcohol, and that proportion of bed days that were partially caused and prevented by alcohol.

Between 2000 and 2004, alcohol was estimated to have caused 3,428,973 (10.3%) and prevented 529,239 (1.6%) of hospital bed days, giving a net number of bed days due to alcohol of 2,899,734 (8.7%). Bed days wholly attributable to alcohol accounted for only 33% of all alcohol-attributable bed days. The impact of alcohol on hospital bed days was greater in men than in women and greater in young to middle aged people than older people, which supports previous Irish and international findings. The effect of low levels of alcohol consumption, which can protect against cardiovascular disease, on hospitalisations was seen only in the older age groups of both sexes. Alcohol did not prevent bed days among the younger age groups.

Ninety-five per cent (n=3,262,408) of bed days attributed to the harmful effects of alcohol were due to chronic conditions associated with alcohol, and 5% were due to acute conditions. Cardiovascular and cerebrovascular diseases accounted for 48% of bed days due to alcohol and neuropsychiatric diseases accounted for 36%. Conditions not wholly due to alcohol accounted for two thirds (2,297,412) of hospital bed days due to the harmful effects of alcohol. The hospital inpatient cost attributed to the negative effects of alcohol was €953,126,381 and the cost saved from prevented hospitalisations was €147,968,164, giving a net cost of €805,158,217.

The negative impacts of alcohol were greater than previously thought and spread across the whole population. As this analysis does not include the costs associated with patients attending GPs, outpatient services, emergency departments and private hospitals, the costs presented here represent only a portion of total hospital costs and a small portion of total healthcare costs. However, even this conservative estimate of cost is considerable and indicates a significant preventable burden on our health care system.

(Deirdre Mongan)

1. Martin J, Barry J and Skally M (2011) Alcohol attributable hospitalisations and costs in Ireland, 2000–2004. *Irish Medical Journa*l, 104(6): 140–4. www.drugsandalcohol.ie/15284
2. Mongan D (2010) The burden of alcohol-related morbidity on hospital services. *Drugnet Ireland*, (35): 9–12. www.drugsandalcohol.ie/13967

Harmful use of alcohol can result in substantial economic costs

A report by Byrne[1] aimed to calculate the quantifiable costs imposed on Irish society in 2007 by harmful use of alcohol. These cost estimates can assist policy makers in justifying and evaluating policies, such as taxation measures, that are aimed at reducing alcohol-related harm, and can help to identify research needs and gaps in national statistical reporting systems. Cross-national comparisons of cost estimates are useful in assessing the negative consequences of alcohol use in different countries and the different policy approaches to dealing with these consequences.

The costs associated with harmful use of alcohol include both the private cost incurred by the drinker, such as medical expenses, and external costs which are borne by third parties. The taxpayer bears significant external costs in the form of increased healthcare costs and the cost to the justice system of dealing with alcohol-related crime. The methodology used by the author of this study to estimate the cost of harmful use of alcohol was based on the methods used in similar reports from other developed countries, including the UK, and used data from surveys and surveillance systems.

In 2007 the overall cost of harmful use of alcohol in Ireland was estimated to be €3.7 billion, representing 1.9% of GNP that year. The overall economic cost as a percentage of GNP was broadly in line with estimates calculated for other EU countries. A breakdown of these costs is presented in Table 1. Health system costs accounted for 32% of the overall cost, and included the costs of general practitioner and community care (€574 million), hospital inpatient care (€500 million), and mental health services (€104 million). Alcohol-related crime also accounted for 32% of the overall cost, and included the costs of property, health and victim services (€435 million), the criminal justice system (€319 million), security systems (€264 million) and loss of productive output (€171 million).

Costs of harmful use of alcohol *(continued)*

Table 1 Overall cost of harmful use of alcohol in Ireland in 2007

Alcohol-related events	€ million	% of total cost
Illness	1,200	32
Crime	1,189	32
Road accidents	526	14
Absence from work	330	9
Accidents at work	197	5
Suicides	167	5
Premature mortality	110	3
Total	**3,710**	**100**

Source: After Byrne (2011), p. 32

These estimates include only the *tangible* costs of harmful use of alcohol and are an underestimate of the total costs insofar as sufficient data are not available in Ireland to calculate some of the intangible costs included in estimates from other countries. Intangible costs include the pain and suffering caused to both the drinker and those affected by his/her behaviour. No attempt is made in this report to calculate these human or emotional costs. When the unquantified human costs are considered, estimates of the tangible costs greatly understate the true cost to society of harmful use of alcohol.

(Deirdre Mongan)

1. Byrne S (2011) *Costs to society of problem alcohol use in Ireland.* Dublin: Health Service Executive. www.drugsandalcohol.ie/15781

Cochrane review of interventions for problem alcohol use in illicit drug users

The Health Research Board (HRB) has awarded a fellowship to complete a Cochrane review entitled 'Psychosocial interventions for problem alcohol use in illicit drug users' to a team based in the University of Limerick. The review aims to find out whether interventions that are based on behavioural, motivational or social theories of change for treating alcohol problems could also be effective for people with coexisting addiction issues.

The findings of the review will inform the development of clinical guidelines for screening and treatment for problem alcohol use among methadone users attending Irish primary care services.[1]

Cochrane fellowships aim to build capacity in conducting systematic reviews in the health and social care field in Ireland by freeing up protected time for applicants to conduct a review.[2] The Cochrane Collaboration is a not-for-profit independent organisation dedicated to providing readily available, up-to-date, accurate information on the effects of healthcare interventions. It produces and disseminates systematic reviews of healthcare interventions in over fifty topic areas through The Cochrane Library (www.thecochranelibrary.com). In 2002 Ireland became the first country in the world to provide free national access to the Cochrane Library, an initiative co-funded by the HRB and the Research and Development Office in Northern Ireland.

The co-reviewers are Dr Jan Klimas, Prof Walter Cullen, Prof Clodagh O'Gorman, Dr Jean Saunders and Prof Colum Dunne (all Graduate Entry Medical School, UL); Ms Catherine-Anne Field and Prof Gerard Bury (UCD School of Medicine and Medical Science); Dr Eamon Keenan (HSE Addiction Services, Dublin) and Dr Liam Glynn (NUIG School of Medicine) who is acting as a local mentor on this review. More information about the project is available from Jan Klimas (01– 473 0893) or from the Cochrane Library, where the protocol for this review was published in August.[3]

(Jan Klimas)

1. Lyons S (2011) Problematic alcohol use among methadone users: update on a HRB-funded study. *Drugnet Ireland* (37): 18–19. www.drugsandalcohol.ie/14999
2. For more information about the Cochrane Fellowships visit: http://www.hrb.ie/research-strategy-funding
3. Klimas J, Field CA, Cullen W, O'Gorman CSM, Glynn LG, Keenan E *et al.* (2011) *Psychosocial interventions for problem alcohol use in illicit drug users.* Cochrane Database of Systematic Reviews 2011, Issue 8. Art. No.: CD009269. www.mrw.interscience.wiley.com/cochrane.

Drugnet digest

This section contains short summaries of recent reports and other developments of interest.

Coolmine Therapeutic Community (CTC) longitudinal study

In August 2010 CTC started a longitudinal research study in collaboration with Paula Mayock of Trinity College Dublin and the National Health Information Systems Unit of the Health Research Board.

The aims of the study are to:

- collect baseline data on drug use, health and behavioural status of participants as they enter and progress through primary treatment and aftercare in CTC;
- follow up participants over time including after leaving the CTC programme; and
- compare CTC client outcomes with outcomes recorded in other national studies, e.g. ROSIE.

The study will use both quantitative and qualitative methodologies and it is estimated that up to 30 people will participate. Participant's progress will be followed up every six months during their treatment (i.e. three times) and then 18 months after discharge. The quantitative data will be obtained using the Treatment Outcomes Profile tool and routine data collected through the National Drug Treatment Reporting System. The qualitative data, collected through one-to-one interviews with participants, will help reveal their reasons for choosing treatment in a therapeutic community and their perceived progress over time. The experiences of those who drop out of the programme will also be recorded and analysed.

Prevalence of adult ADHD in psychiatric clinic in north Dublin

Syed and colleagues[1] estimated the prevalence of attention-deficit hyperactivity disorder (ADHD) in adults attending outpatient psychiatric services. A total of 265 adults (aged 18–65) attending six out-patient clinics in north Dublin were asked to complete the World Health Organization Adult ADHD Self-Report Scale VI.I questionnaire; 243 (92%) did so. Respondents rated themselves against six criteria (a symptom checklist) on a five-point scale. Demographic and clinical data were also recorded using a self-completed questionnaire and the medical record.

The average age of the respondents was 42.5 years and 56% were women. Using the WHO scale, 24% were diagnosed as having ADHD. Of the ADHD cases, 69% were men and the average age was 42.1 years. Almost 11% had a diagnosis of substance misuse (alcohol and other drugs). When compared to patients without ADHD, those diagnosed with ADHD were significantly more likely not to have completed second-level education, to have had an ADHD diagnosis or ADHD symptoms in childhood, to have a forensic history, a current personality disorder diagnosis and a higher rate of prescribed benzodiazepine use. The data indicate that ADHD is common among adults treated for mental illness. None of the patients had a recorded diagnosis of adult ADHD, indicating significant under-diagnosis of this manageable condition.

DAA launches information guide and new website

On June 15, Irish AIDS Day, the Minister of State at the Department of Health, Róisín Shortall TD, launched the Dublin Aids Alliance (DAA) information booklet, *Living with HIV in Ireland*: a self-help guide, and the new DAA website www.dublinaidsalliance.ie. The guide was developed in response to needs identified in the course of many years of community support work and through focus groups involving HIV positive people and various stakeholders. The new website provides a lot of relevant information, including where to access services. DAA hopes that it will increase sexual health awareness among the general public.

DAA Executive Director Anna Quigley acknowledged the positive impact the work of its partners in the statutory, community and voluntary sectors was having in reducing the number of newly reported infections. However, she cautioned that more needed to be done to raise awareness as HIV is a preventable disease. The DAA recommends that a national strategy on sexual health be developed to provide a co-ordinated approach to this problem.

Evaluation of self-harm awareness training programme

The National Suicide Research Foundation evaluated the self-harm awareness training programme currently delivered throughout HSE South and HSE West.[2]

The study aimed to identify whether the training changed participants' knowledge, attitudes and confidence in relation to people who self-harm. The objective was then to identify the resources required and the indicators of, and barriers to, the successful implementation of the training. Of 532 participants who completed the programme, 120 returned a completed self-report questionnaire. The study revealed significant positive changes post training in terms of increased knowledge, enhanced positive attitudes towards and confidence in dealing with people who engage in self-harm.

Drug Treatment Court

In late July 2011 the Courts Service and the Health Service Executive agreed to extend the catchment area of the DTC to all areas of Dublin county north of the river Liffey, and to make the Court accessible to those receiving treatment in the Castle Street Drug Treatment Centre, which provides services to people in Dublin 2,4,6 and 8. The extension of the catchment area will be piloted for a period of six months, after which the capacity of the court to manage a further extension will be considered. Courts Service press release: www.drugsandalcohol.ie/15689

White Paper on crime

The Department of Justice and Law Reform has published the fourth and final document as part of a consultation process to develop a White Paper on crime. The White Paper, due to be completed in 2011, will provide a high-level statement of government policy, its rationale and the strategies to give effect to that policy. The four thematic discussion documents are available at www.justice.ie/en/JELR/Pages/White_Paper_on_Crime

(Contributors Suzi Lyons, Jean Long, Vivion McGuire, Fiona Bannon and Johnny Connolly)

1. Syed H, Masaud TM, Nkire N, Iro C and Garland MR (2010) Estimating the prevalence of adult ADHD in the psychiatric clinic: a cross-sectional study using the adult ADHD self-report scale (ASRS). *Irish Journal of Psychological Medicine*, 27(4): 195-197.
2. Arensman E and Coffey C (2010) *The efficacy of a self-harm awareness training programme: report of an independent evaluation.* Cork: National Suicide Research Foundation. www.nosp.ie/html/reports.html

Merging policies on psychoactive substances

In 2007 the Council of Europe's Pompidou Group (PG), whose core mission is to contribute to the development of effective and evidence-based drug policies in member states, started an enquiry into how policy on different psychoactive drugs is organised in different countries. The PG has now published two reports on its investigation and is embarking on a third phase. Ireland is one of seven countries that the Pompidou Group is studying in depth.

The first phase of the investigation revealed that policies on psychoactive substances in 17 Council of Europe member states lay along a continuum between an integrated substance-use policy at one end and separate policies for different substances at the other end.[1] Ireland was found to lie near the midway point, with three separate policies for illicit drugs, alcohol and tobacco, but a tendency to combine elements of illicit drugs and alcohol policy and practice.[2]

This preliminary investigation led to two recommendations – (1) develop a global policy framework for psychoactive substances within the context of health, and (2) improve the use of research evidence in policy making.[2] These conclusions influenced the direction and shape of the second phase of the PG's enquiry, the results of which were published in November 2010 and are briefly outlined below.[3]

Evidence from 'social cognitive neural science'

In the first part of the new report, Richard Muscat, professor of behavioural neuroscience at the University of Malta, reviews the contribution of scientific evidence to policy making. Having outlined how epidemiological research over several decades has helped to determine the size of the problem associated with the use of psychoactive substances and its impact on society, he describes how biomedical research, including the emerging discipline of social cognitive neural science,[4] is now improving our understanding of why people use psychoactive substances, why some users go on to become addicted/dependent, and how this new research evidence could help to improve the efficacy of policy making in the area of psychoactive substances.

Muscat describes the research evidence for how individual substances, including alcohol, tobacco, marihuana, cocaine, amphetamines, ecstasy, heroin, methadone and buprenorphine, affect the functioning of the brain and the consequences for the brain's reward system (which influences behaviour), learning and memory, and decision making. He goes on to discuss the evidence for how addiction/dependence develops, looking at recent research on the contribution of neural processes, psychiatric disorders, genetic predisposition, psychological traits and sociological determinants.

Providing clearer insights into what determines our health and well-being, social cognitive neural science can, Muscat suggests, significantly improve policy making in the area of prevention, harm reduction and treatment for problems associated with a wide range of psychoactive substances. For example, a prevention campaign could target youngsters with specific psychological traits such as sensation seeking, which guides their decision making. With regard to harm reduction, Muscat observes that policy interventions are only adopted at national level after the measures have been found to work on the ground; he suggests that this pattern should be reversed 'because policy makers should take cognisance of current scientific evidence earlier on'.

'Integrating' policies on psychoactive substances

In the second part of the report, Dike van de Mheen and Cas Barendregt of the Addiction Research Institute in the Netherlands report on an empirical investigation into (1) what the term 'integrated policy' means in seven countries chosen for study, including Ireland, and (2) how 'integrated policy' has been operationalised in these countries. A 'short open questionnaire' to elicit information on these two research questions was sent to one or two national experts in each country for completion, and was followed up by telephone interviews with the national experts.

A key finding is that the concept of 'integration' is highly nuanced. In order to ensure effective policy structures, it is essential to understand the nuances. To begin with, integration may refer to the combination of a variety of psychoactive substances in the one substance misuse policy. Alternatively, it may refer to the co-ordination of policies and actions in different government departments through a formal co-ordinating mechanism. Ireland is unique among the seven countries investigated as part of the study in having separate policies on drugs, alcohol and tobacco and not having any formal integrated structure for co-ordinating policies on psychoactive substances (Figure 1).

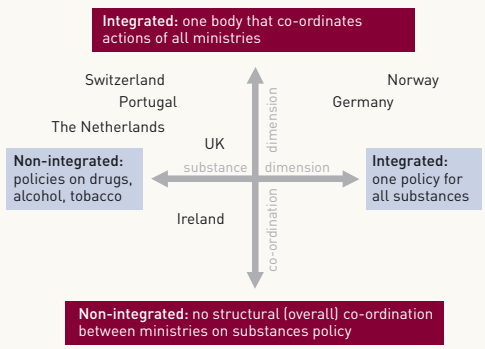


Figure 1 Two dimensions of integration: substances and co-ordination

Source: After Muscat *et al.* (2010), p. 55

Underlying these two structural forms of integration is the possible integration of ideas (politics) and action (policy). The authors explain:

> If the idea is that the consumption of psychoactive substances, other than tobacco or alcohol, is sinful or bad it may lead to prohibition of these substances. If the dominant idea is that legal and illegal substances can be viewed as potentially damaging to health, a health approach to psychoactive substances comes into focus. Co-ordination of health-oriented interventions requires a different policy infrastructure from a merely prohibitionist approach. (p. 57).

Merging policies on psychoactive substances *(continued)*

What are the best structures to ensure 'coherent' drug policies?

The next phase of the PG enquiry will seek to develop a model to test the 'coherence' of policies on substance misuse, in other words the extent to which the different modes of integration are compatible, the extent to which the political and policy approaches are aligned. This approach does not presuppose the superiority of any particular policy framework.

(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. See Pike B (2009) Illicit drugs, alcohol and tobacco – understanding the policy issues. *Drugnet Ireland*, (29): 3–4.
3. Muscat R, van de Mheen D, Barendregt C and members of the Pompidou Group Research Platform (2010) *Towards an integrated policy on psychoactive substances: a theoretical and empirical analysis.* Strasbourg: Council of Europe Publishing.
4. Muscat defines the new discipline as including elements of sociology, cognitive psychology and neuroscience.

Report on new psychoactive substances and the outlets supplying them

The NACD commissioned a study of new psychoactive substances and the outlets supplying them, which was completed by a research team from the Dublin Institute of Technology (DIT) and published in June 2011.[1]

The study comprised several components:

- Chemical analysis of 49 new psychoactive substances sold in head shops or online
- Review of the availability of head shop products in retail outlets and via online sales
- Users' reported use and effects of such substances
- Risks associated with the use of such substances
- Legal responses to control the availability of such substances.

Analyses of the products bought in head shops and online detected the emergence of five new substances following the changes introduced by the Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order of May 2010, namely: dimethylcathinone, naphyrone, fluorotropacocaine, desoxypipradol and dimethylamylamine. 'A comparison of substances identified before and after the May 2010 Order indicates that suppliers moved quickly to replace controlled substances with new uncontrolled substances' (p.74). Five products bought online as part of the study all contained controlled substances, including mephedrone. This led the authors to conclude that 'head shops may respond to local control measures more quickly than international online suppliers' (p.74). The analysis also found a lack of consistency between the advertised content and the actual content of products, and, over time, between products with the same name or packaging. These findings, according to the authors, 'have implications for consumers, including the potential for misuse, adverse reactions and possible overdose' (p.74).

The authors observe that as a consequence of the May 2010 Order and the Criminal Justice (Psychoactive Substances) Act 2010 which came into effect on 23 August 2010, the vast majority of head shops had closed. Ten to twelve remained opened in November 2010, 'selling pipes, bongs and clothing. None are selling psychoactive substances and only one…was observed to have hydroponic equipment on display' (p.75).

The authors did an anonymous online survey, using a self-completed questionnaire, to identify what new psychoactive substances were used, how and in what contexts they were used and what effects were experienced. The questionnaire had 51 items covering demographics, alcohol and tobacco use, use of powders, party pills, liquid highs, smoking blends and ethnobotanicals. Participants were recruited over a two-week period through print and online media, personal contacts and DIT staff and student listings. Of the 333 survey entries completed, four were excluded as invalid. The authors stress that the sample was not representative of the general population and that findings could not be extrapolated beyond this survey.

The 329 respondents ranged in age from 16 to 58 years, with an average age of 25 years. Sixty-seven per cent were men, 59% lived in Dublin, 38% lived elsewhere in Ireland and 3% lived outside of Ireland. Just over half (51%) lived with their parents, 18% lived with a spouse or partner, 14% lived with friends and 10% lived alone. The majority (65%) were students, 26% were working or self-employed and 6% were receiving a state benefit. Almost all (98%) were educated to leaving certificate or above. Among the 261 (79%) respondents who had obtained a new psychoactive substance, the main sources were: head shops (78%), friends (66%), acquaintances (23%), online (17%) and/or dealers (15%). Seven had obtained new psychoactive substances through a home delivery service. Sixty-five per cent had access to a head shop within five kilometres of their home.

Fifty-seven per cent (186/329) of the sample had used one or more psychoactive powders at some time, 21% (68/329) in the month prior to the survey. Mephedrone was the most common powder used; 66% of respondents had tried it. Methylone was used by 10% of respondents. The most common methods of consumption were snorting (86%), and rubbing it on gums or the inside of the mouth (40%). Fifty-eight per cent consumed between 0.1 gram and 1 gram of powder in a typical session. Respondents reported a high frequency of undesirable (though not always unexpected) effects, including palpitations (68%), chest pain (17%), breathing difficulties (20%), anxiety (40%), paranoia (38%), aggression (19%), memory blackout (43%) and fainting or collapse (5%). Users also experienced come-down effects, including insomnia (74%) and low mood or depression (72%).

Report on new psychoactive substances *(continued)*

Forty-eight per cent (159/329) of the sample had used one or more psychoactive party pills or liquid highs at some time, 12% (38/329) in the month prior to the survey. BZP was the most common party pill used; 37% of respondents had tried it. The most common methods of consuming a party pill were swallowing it whole (74%), snorting its contents (15%) and bombing it (13%). Two pills was the most common number taken in a typical session (night). Respondents reported a high number of undesirable effects, including palpitations (61%), chest pain (16%), breathing difficulties (11%), anxiety (39%), paranoia (36%), aggression (13%), memory blackout (28%) and fainting or collapse (6%). Users also experienced come-down effects, including insomnia (82%) and depression (70%).

Only a small number of respondents who used powders, party pills or liquid highs sought formal medical assistance; for example, four attended a general practitioner, three attended an emergency department and seven attended a mental health professional.

Powders, pills and liquid highs were most commonly consumed with friends (96%) and acquaintances (30%) and rarely with family (9%). They were consumed most often on Friday and Saturday nights and most often at parties (83%), but also at friends' homes, festivals and clubs.

Sixty per cent (197/329) of the sample had used one or more psychoactive smoking blends at some time, 15% (49/329) in the month prior to the survey. Smoke XXX (74%) was the most common blend used, followed closely by Spice (66%).

Thirty-eight per cent (126/329) of the sample had used one or more psychoactive ethnobotanicals at some point in their life. Salvia divinorum (61%) was by far the most common plant used.

The authors report a rapid and marked decrease in the number of head shops nationwide as a result of the Criminal Justice (Psychoactive Substances) Act 2010, and speculate on future effects of the Act:

- It is likely that there will be a concomitant decrease in the use of psychoactive substances by casual, young and first-time users, and an associated decrease in presentations to hospital emergency departments.
- Habitual users who were attracted by the legality and easy availability of head shop products are likely to return to 'traditional' illegal substances.
- A proportion of head shops' customer base will take their business online, where chat rooms and blogs will keep them updated with new products, perceived effects, and recommended sources and avenues of delivery. (p.79)

Among the recommendations made in various sections of this report are those summarised below.

- Existing models of online monitoring to curtail online trading are examined, such as the model of co-operation between the Irish Medicines Board and the Customs authorities to monitor the sale of counterfeit medicines and other psychoactive substances.
- The Department of Health monitors the emergence of new head shop products and moves speedily to control their use.
- A centralised national database to collect data from emergency departments on alcohol and other drug use is developed and managed by an appropriate agency. This would facilitate the verification of the harm being caused by existing and newly emerging drugs.
- The HSE National Drugs Awareness Campaign takes account of users' experiences of new psychoactive drugs. Also, online campaigns such as drugs.ie should highlight the dangers of new psychoactive drugs as identified in this report.
- Ireland should review the proposed legislation in the UK which would allow the temporary banning of new psychoactive substances while they are being fully assessed for their harmful effects.

(Jean Long and Johnny Connolly)

1. Kelleher C, Christie R, Lalor K, Fox J, Bowden M and O'Donnell C (2011) *An overview of psychoactive substances and outlets supplying them.* Dublin: National Advisory Committee on Drugs. www.drugsandalcohol.ie/15390

Acute liver failure following recreational use of psychotropic 'head shop' compounds

Fröhlich and colleagues[1] report the case of a young man who presented with acute psychosis and subsequently developed hepatic failure following ingestion of butylone and MDPV (methylenedioxypyrovalerone). These substances were banned in Ireland under legislation that came into effect on 23 August 2010.

The patient was a 28-year-old male suffering from bipolar affective disorder but otherwise healthy. Following ingestion of 12 tablets he had a seizure. On arrival to hospital his neurological assessment (GCS) was 5 out of a possible 15, his heart rate was 190 beats per minute, systolic blood pressure 230 mmHg, temperature 39.5°C and he was sweating profusely. He was treated in the intensive care unit, with cooling (to reduce his temperature), mechanical ventilation (to assist his breathing), labetalol (to reduce his blood pressure) and phenytoin (to manage his seizures). His urine and blood were tested for standard drugs did not reveal any evidence of MDMA, cocaine, paracetamol, or salicylates. The tablets taken were examined and contained butylone and MDPV which are stimulant type drugs. After ten hours his neurological and respiratory status was normal. On day 2, he **developed rhabdomyolysis, a condition which can be associated with stimulant use, in which** damaged skeletal muscle tissue breaks down rapidly.

Unexpectedly, between day 2 and day 3, the patient developed acute liver failure. Following treatment for three days with N-acetylcysteine infusion (normally used as a treatment for paracetamol overdose), his liver functions

Acute liver failure following use of 'head shop' compounds *(continued)*

tests slowly returned to normal. Following treatment to manage liver failure, the patient was discharged from the intensive care to psychiatric care where he received treatment for a relapse of his psychosis thought to be triggered by consumption of butylone and MDPV. According to the authors, this is the first case report associating these compounds with acute liver failure. There is no record in the literature of these compounds being associated with liver injury. However, MDMA, which is structurally similar to MDPV, is known to be toxic to the liver.

(Jean Long)

1. Fröhlich S, Lambe E and O'Dea J (2011) Acute liver failure following recreational use of psychotropic 'head shop' compounds. *Irish Journal of Medical Science*, 180(1): 263–264.

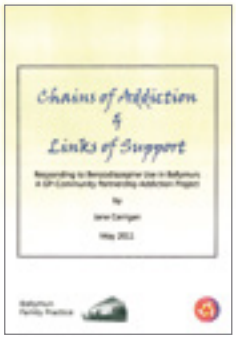
Report on innovative project in response to benzodiazepine use

The GP–Community Partnership Addiction Project was set up in Ballymun in 2006 in response to concerns about the acceptance and normalisation of benzodiazepine use in the area, as highlighted in a study published by the Ballymun Youth Action Project (BYAP) in 2004.[1] Benzodiazepines are among the most commonly prescribed drugs; they are used to treat conditions such as anxiety, depression or insomnia. While they are safe for short-term use, the risk of abuse and dependence as a result of inappropriate long-term use has been well documented. The Ballymun Family Practice took part in this project funded by the Ballymun Local Drugs Task Force in search of a non-pharmaceutical alternative to benzodiazepine prescribing. A report outlining the project and analysing the outcomes of its first three years was published in June 2011.[2] The project includes:

- providing general practitioners (GPs) with training in motivational interviewing;
- providing a free counselling service within the GP practices;
- inviting long-term users of benzodiazepines to review and discuss their need for prescribed medication and, to some users, also offering onsite counselling service;
- assessing, through quantitative and qualitative research, the impact of the letter and of the counselling service on reducing benzodiazepine use.

GPs in the four general practices that make up the Ballymun Family Practice identified 134 long-term benzodiazepine users among their patients. This sample was then divided into two groups: people in Group 1 (n=54) were sent a letter advising them to consider their current benzodiazepine use; people in Group 2 (n=80) were sent the same letter *with an added paragraph* offering the services of a counsellor. Prescriptions were monitored for the year before the letters were sent and for six months afterwards. In the six month, post-letter period, just over 29% of patients in Group 1 and over 38% in Group 2 reduced their benzodiazepine use. The letter resulted in lower prescription rates, and the offer of onsite counselling reinforced the positive impact of the letter.

Looking in more depth at the patients' profiles, it appears that the initiative was more effective among younger benzodiazepine users who were on a methadone maintenance programme. There was a clear positive outcome for patients who used or had used multiple substances, including opiates, and who may have been more willing to address their benzodiazepine use as part of their overall addiction problem.



The project had less impact among older patients who had been on low doses of benzodiazepine for many years and were not receiving medical treatment for problem use of other substances. Reducing benzodiazepine use for this cohort involves tackling long-term health beliefs or a so-called 'culture of benzodiazepine use', a more complex undertaking that can only achieve results over a longer period.

The quantitative data on benzodiazepine prescription rates was complemented by qualitative research. Feedback from focus groups with GPs and in-depth interviews with two addiction counsellors emphasised the fact that having the addiction counsellors on site was a key element of the project. The nature and extent of integration of the counselling service within the GP practice was reported as very positive and complementary to both services. Counsellors were part of the team, while GPs felt more empowered and welcomed the much-needed support in treating addictions in general. In addition to the practical benefits to patients and practitioners, the service integration contributed to the effectiveness of the project, through early identification and intervention, and made referrals easier. The additional training provided to GPs was reported to be very helpful in the selection of referrals, and improvements in the referral process had in turn a positive impact on attendance levels.

Benzodiazepine use and its reduction is a complex issue. The project demonstrated positive outcomes for long-term benzodiazepine patients and it was particularly successful for patients who were battling other addictions.

While focusing on benzodiazepine use in Ballymun, this project provides relevant evidence-based information that can help communities respond to the issue of drug use. It is clear that the integration of addiction counselling in a primary care setting is beneficial, and that simple cost-effective interventions, such as the letter in this case, can make a difference. As said in the report (p. 40), 'the project provided a tangible way of developing and fostering links in the community and promoted a multidisciplinary approach to the issue of drug use'.

Project in response to benzodiazepine use *(continued)*

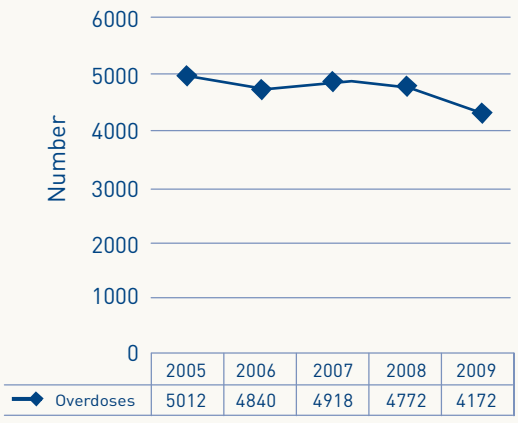
Jane Carrigan, researcher and author of the report, described the project as a very challenging and interesting experience for researchers, GPs, and counsellors alike. The patients' perspective was not included in this analysis, an element that may be included in future research. At the launch of the report by Minister of State Róisín Shortall, Andrew Montague, chair of Ballymun Local Drugs Task Force, Jacintha Harte, addiction counsellor, and Dermot King, interim director of BYAP, all emphasised the positive feedback from all practitioners and expressed hopes that such initiatives might lead the way in informing and influencing the work of primary health care teams. Minister Shortall also reiterated the importance of data reporting and research in the area of drug treatment as a stepping stone for improving policies and service planning.

(Delphine Bellerose)

1. Ballymun Youth Action Project (2004) Benzodiazepines – whose little helper? The role of benzodiazepines in the development of substance misuse problems in Ballymun. Dublin: National Advisory Committee on Drugs. www.drugsandalcohol.ie/5898
2. Carrigan J (2011) *Chains of addiction & links of support: responding to benzodiazepine use in Ballymun. A GP–Community Partnership Addiction Project.* Dublin: Ballymun Local Drugs Task Force and Ballymun Family Practice. www.drugsandalcohol.ie/15361

Non-fatal overdoses and drug-related emergencies

Data extracted from the Hospital In-Patient Enquiry (HIPE) scheme were analysed to determine trends in non-fatal overdoses discharged from Irish hospitals in 2009. There were 4,202 overdose cases in that year, of which 30 died in hospital. The 4,172 discharged cases are included in this analysis. The number of overdose cases decreased by 13% between 2008 and 2009 (Figure 1).



	2005	2006	2007	2008	2009
Overdoses	5012	4840	4918	4772	4172

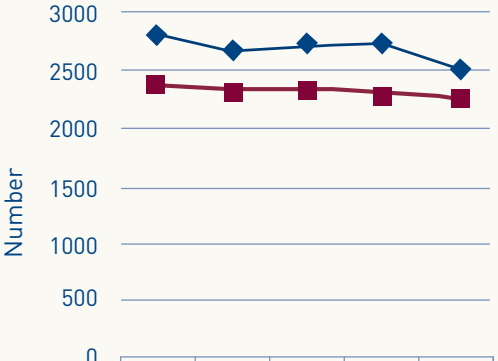
Figure 1 Overdose cases by year, 2005–2009 (N=23,714)

Source: Unpublished HIPE data

Characteristics of cases

Gender

In the years 2005–2009 there were more overdose cases among females than among males (Figure 2), with females accounting for 54% of all overdose cases in 2009.



	2005	2006	2007	2008	2009
Female	2794	2605	2691	2640	2258
Male	2218	2235	2227	2132	1914

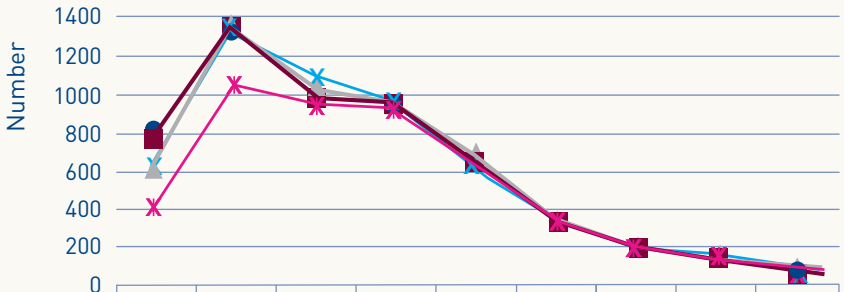
Figure 2 Overdose cases by gender, 2005–2009 (N=23,714)

Source: Unpublished HIPE data

Age group

In the four-year period 2005–2008, one quarter of overdoses occurred in those aged 15–24 years, with the incidence of overdose decreasing with age (Figure 3). The number of under-25s fell in 2009, accounting for 32% (n=1,328) of overdose cases, compared to 40% (n=2,015) in 2005.

Non-fatal overdoses and drug-related emergencies *(continued)*



	0–14	15–24	25–34	35–44	45–54	55–64	65–74	75–84	85+
2005	740	1275	1017	882	581	282	140	70	25
2006	701	1269	942	835	575	273	126	98	21
2007	550	1287	995	893	624	312	136	99	22
2008	560	1233	1026	867	543	274	148	90	31
2009	353	975	887	845	576	281	140	85	30

Figure 3 Overdose cases by age group, 2005–2009 (N=24,314)

Source: Unpublished HIPE data

Drugs involved

Table 1 presents the positive findings per category of drugs and other substances involved in **all cases of overdose** in 2009. Non-opioid analgesics were present in 36% (1,518) of cases. Paracetamol is included in this drug category and was present in 27% (1,129) of cases. Psychotropic agents were taken in 22% (903) and benzodiazepines in 25% (1,053) of cases. There was evidence of alcohol consumption in 13% (534) of cases. Cases involving alcohol are included in this analysis only when the alcohol was used in conjunction with another substance.

Table 1 Category of drugs involved in overdose cases, 2009 (N=4,172)

Drug category	Positive findings per drug category*	
	n	%
Non-opioid analgesics	1518	36.4
Benzodiazepines	1053	25.2
Psychotropic agents	903	21.6
Anti-epileptic / Sedative / Anti-Parkinson agents	556	13.3
Narcotics and hallucinogens	539	12.9
Alcohol	534	12.8
Systemic and haematological agents	201	4.8
Cardiovascular agents	158	3.8
Autonomic nervous system agents	128	3.1
Anaesthetics	116	2.8
Hormones	100	2.4
Systemic antibiotics	94	2.3
Gastrointestinal agents	74	1.8
Other chemicals and noxious substance	58	1.4
Diuretics	51	1.2
Muscle and respiratory agents	45	1.1
Topical agents	25	0.6
Anti-infectives / Anti-parasitics	23	0.6
Other gases and vapours	7	0.2
Other and unspecified drugs	981	23.5

* The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.

Source: Unpublished data from HIPE

Non-fatal overdoses and drug-related emergencies *(continued)*

Overdoses involving narcotics or hallucinogens
Narcotic or hallucinogenic drugs were involved in 13% (539) of overdose cases in 2009. Figure 4 shows the number of positive findings of drugs in this category among the 539 cases. The sum of positive findings is greater than the total number of cases because some cases involved more than one drug from this category. Opiates were used in 82% of the cases, cocaine in 17% and cannabis in 9%.

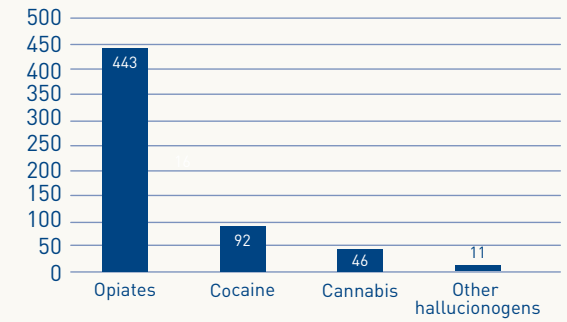


Figure 4 Narcotics and hallucinogens involved in overdose cases, 2009 (N=539)

Source: Unpublished data from HIPE

Overdoses classified by intent
In 70.3% of cases the overdose was classified as intentional (Figure 5).

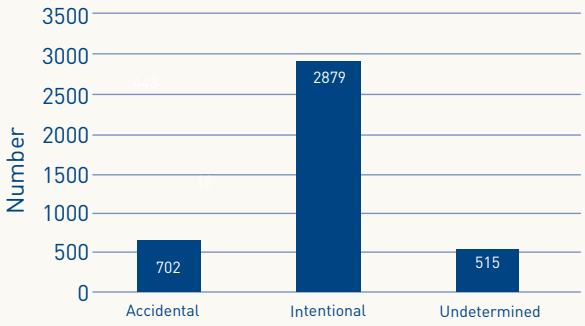


Figure 5 Overdose cases by classification, 2009 (N= 4,096)

Source: Unpublished data from HIPE

Table 2 presents the positive findings per category of drugs and other substances involved **in cases of intentional overdose** in 2009. Non-opioid analgesics were involved in 43% (1,236) of cases, benzodiazepines in 28% (816) and psychotropic agents in 25% (728).

Table 2 Category of drugs involved in intentional overdose cases, 2009 (N=2,879)

Drug category	Positive findings per drug category*	
	n	%
Non-opioid analgesics	1236	42.9
Benzodiazepines	816	28.3
Psychotropic agents	728	25.3
Anti-epileptic / Sedative / Anti-Parkinson agents	451	15.7
Alcohol	402	14.0
Narcotics and hallucinogens	293	10.2
Cardiovascular agents	99	3.4
Systemic and haematological agents	97	3.4
Autonomic nervous system agents	87	3.0
Systemic antibiotics	74	2.6
Hormones	71	2.5
Gastrointestinal agents	58	2.0
Anaesthetics	52	1.8
Other chemicals and noxious substances	41	1.4
Anti-infectives / Anti-parasitics	29	1.0
Other gases and vapours	23	0.8
Muscle and respiratory agents	16	0.6
Topical agents	9	0.3
Diuretics	5	0.2
Other and unspecified drugs	606	21.0

*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.

Source: Unpublished data from HIPE

(Deirdre Mongan)

Substance use among third-level students in Limerick

Houghton and colleagues[1] examined students' health and lifestyles in a quota sample survey[2] that included questions on recent (within the last year) drug use. One thousand students attending lectures were asked to participate in the survey and 76% (742) did so. Participants ranged in age from 17 to 63 years and half were aged 20 or under. Fifty-two per cent (386) were men. Five (0.7%) reported that they had taken 'Revelin' (the name of a dummy drug) and these were excluded from the analysis.

Cannabis was the most common illegal drug taken; one-third of students reported having taken it at least once in the year prior to the survey (Table 1). Cocaine was also commonly used, with 13% taking it during the same time period. Ecstasy was taken by 12% of respondents. Similar proportions took magic mushrooms (7%) and amphetamines (7%). Five per cent were prescribed tranquillisers and 3% took tranquillisers that were not prescribed for them. Similar proportions took LSD and solvents. Only 0.9% took heroin, and 0.5% injected an illicit drug, in the last year. Almost 18% of respondents took more than one drug concurrently (polydrug use).
Men were marginally more likely to take drugs than women. The authors state that the high rates of drug use have implications for physical and mental health.

(Jean Long)

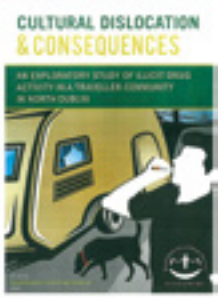
1. Houghton F, Keane N, Murphy N, Houghton S and Dunne C (2011) 12 month prevalence of drug use among third-level students in Limerick City. *Irish Medical Journal*, 104 (5). www.drugsandalcohol.ie/15300
2. See also two short papers by Houghton *et al.* (2010) on alcohol use and smoking among the same sample of students in *National Institute of Health Sciences Research Bulletin*, 5(4):104–107. www.nihs.ie/researchbulletin/index/cfm

Table 1 Drug type and frequency of use in the last year by third-level students surveyed

	All			Male			Female		
Drug type	Never	1 or 2 times	3 or more times	Never	1 or 2 times	3 or more times	Never	1 or 2 times	3 or more times
	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)	% (n)
Cannabis	66.8 (412)	11.2 (69)	22.1(136)	67.9(226)	9.9 (33)	22.2 (74)	65.6(177)	13.0(35)	21.5 (58)
Cocaine	87.0 (562)	7.3 (47)	5.7 (37)	87.1(311)	5.6 (20)	7.3 (26)	87.0(240)	9.8(27)	3.3 (9)
Ecstasy	87.6 (567)	6.3 (41)	6.0 (39)	85.7(306)	7.3 (26)	7.0 (25)	90.3(250)	5.4(15)	4.3 (12)
Magic mushrooms	92.9 (598)	5.1 (33)	2.0 (13)	91.9(327)	5.6 (20)	2.5 (9)	94.2(268)	4.7(13)	1.1 (3)
Amphetamine	93.0 (599)	4.2 (27)	2.8 (18)	91.6(327)	5.0 (18)	3.4 (12)	94.9(261)	3.3 (9)	1.8 (5)
Tranquillisers with prescription	94.9 (610)	3.6 (23)	1.4 (9)	95.2(338)	3.7 (13)	1.1 (4)	94.5(260)	3.6(10)	1.5 (4)
Tranquillisers without prescription	96.9 (622)	2.3 (15)	0.8 (5)	96.6(344)	2.2 (8)	1.1 (4)	97.4(267)	2.2 (6)	0.4 (1)
LSD	96.3 (620)	2.0 (13)	1.7 (11)	95.5(341)	2.5 (9)	2.0 (7)	97.5(268)	1.5 (4)	1.1 (3)
Solvents	96.3 (619)	2.5 (16)	1.1 (7)	95.5(340)	2.8 (10)	1.4 (5)	97.1 (268)	2.2 (6)	0.7 (2)
Heroin	99.1 (638)	0.6 (4)	0.3 (2)	98.6(352)	1.1 (4)	0.3 (1)	99.6(274)	0.4 (1)	0 (0)
Drugs by injection	99.5 (642)	0.3 (2)	0.2 (1)	99.4(355)	0.3 (1)	0.3 (1)	99.6(275)	0.4 (1)	0 (0)

Source: Adapted from Houghton *et al.* (2011)

Exploring illicit drug use in a Traveller community



Walsh[1] set out to explore the nature of illicit drug use within one Traveller community in the greater Dublin area and assess the relative merits of mainstream drug services and Traveller-specific drug services.

Data were collected through semi-structured interviews with seven female and seven male Travellers. Four of the men were using a local drug service. The remaining three men and the seven women were not using drug services and did not report any form of illicit drug use. In addition, seven service providers were interviewed.

Perceptions of illicit drug use in the community and the implications for research

There was a perception among interviewees, particularly among service providers, that illicit drug use within the Traveller community was closely associated with the marginal status accorded to members of the community by sections of mainstream society.

Among the four male drug-using Travellers interviewed, cocaine was perceived as the drug most used in their community, followed by cannabis, ecstasy and prescription tablets, with a few using heroin. They said that these drugs were primarily used as part of the social and recreational night-out scene, but expressed fears about the likely impact of heroin use if it became more prevalent. Smoking cannabis was perceived to be part of normal activity in the community.

All but one of the interviewees believed that illicit drug use within the local Traveller community was confined to men. The one dissenting male agreed that illicit drug use was predominantly a male activity; however, he mentioned being aware of plenty of Traveller women who used illicit drugs. The Traveller women interviewed were of the view that it would be highly unusual for women to get involved in illicit drug use. The perception that illicit drug use among Traveller women is not a common activity was also reported by Fountain[2] and Van Hout[3] However; all three studies have an over-reliance on the perceptions of service providers and non-drug-using members of the Traveller community, with only minimal data provided by drug-using Travellers.

All three studies reported difficulties in securing access to drug-using Travellers. Both Fountain and Walsh relied almost exclusively on Traveller advocacy organisations, service providers and non-drug-using Travellers as 'gatekeepers' to secure access to drug-using Travellers. Perhaps drug-using Travellers, both male and female, are reluctant to disclose their use of illicit drugs to such organisations and to non-drug-using members of their own communities because of the stigma that surrounds such activity. If this is the case, then perhaps the use of research techniques that are closer to the ethnographic position or 'snowball sampling' where a sample of drug-using Travellers is built up over time using one contact to secure access to others, would be more appropriate. An over-reliance on the perceptions of service providers and non-drug-using Travellers, rather than on the experiences of drug-using Travellers, has implications for both the quality and usability of the research being undertaken. Such reliance could mean that the nature of illicit drug use could remain under-reported and poorly understood; indeed Fountain (2006) mentions that service providers were often unable to differentiate between problematic and non-problematic illicit drug use.

Perceptions of the supply of illicit drugs

Interviewees had mixed views about how illicit drugs were being supplied within the local community. Some Travellers believed that other Travellers were dealing drugs in the community; other interviewees felt that drugs were being purchased from the settled community. The four male drug-using Travellers recalled their experiences of being introduced to illicit drug use (often ecstasy or cocaine) through contacts with members of the settled community.

Perceptions of the potential impact of illicit drug use

The negative image of Traveller men using illicit drugs and the potential impact of this image on young children was cited as a key concern by the Traveller women; fears were also expressed that an escalation in illicit drug use could contribute to an increase in conflict and criminal activity within the community.

Service provision for illicit drug use in the community

Service providers not working directly with drug-using Travellers were in favour of Traveller-specific drug services, whereas two service providers working directly with drug-using Travellers favoured mainstream drug services as they could offer more privacy and confidentiality, a view endorsed by all the Travellers interviewed. Three of the four male drug-using Travellers were using a mainstream drug service on the recommendation of other Travellers.

Traveller culture and identity as potential protective factors

Retaining traditional religious values and practices, a close-knit style of family life and the strong role of women in preserving the family were mentioned as distinct cultural aspects of the Traveller community. There was a perception that families that adhered to religious practices and had fewer interactions with the settled community also protected themselves from the use of illicit drugs. There was a degree of consensus that the influence of Traveller women, both as mothers and as wives, can deter the men from using illicit drugs. For example, the fear of the wife leaving the husband was cited as an example of this protective capacity. It was acknowledged by some that despite the advantages of familial closeness, drawbacks included a lack of personal privacy and individuality.

Because of the methodological limitations of this study, it can be argued that it is more of a snapshot of untested perceptions than an exploratory analysis of the nature of illicit drug use within this community.

(Martin Keane)

Exploring illicit drug use in a Traveller community *(continued)*

1. Walsh B (2010) *Cultural dislocation and consequences: an exploratory study of illicit drug activity among a Traveller community in North Dublin.* Dublin: Blanchardstown Local Drugs Task Force. www.drugsandalcohol.ie/15530
2. Fountain J (2006) *An overview of the nature and extent of illicit drug use amongst the Traveller community: an exploratory study.* Dublin: Stationery Office. www.drugsandalcohol.ie/3958
3. Van Hout MC (2009) Irish Travellers and drug use – an exploratory study. *Ethnicity and Inequalities in Health and Social Care*, 2(1): 42–49.

UK expert group reports on recovery-oriented treatment

The UK National Treatment Agency (NTA) has published an interim report by Professor John Strang,[1] chair of an expert group set up in 2010 'to provide guidance to the drug treatment field on the proper use of medications to aid recovery and on how the care for those in need of effective and evidence-based drug treatments is more fully orientated to optimise recovery' (p.2). The author makes 'some early observations' under three key headings: consensus reached on a number of issues, how services can improve the quality of treatment offered in the short term, and a vision of what recovery-orientated services can become. These observations are summarised below.

Consensus on a number of issues

The group acknowledged the strong body of evidence that supports the effectiveness of opiod substitution treatment (OST) and seeks to build on this evidence to develop a recovery platform which will achieve even greater outcomes. It recognised the expansion in treatment services in the UK and the benefits to patients through a concerted drive to reduce waiting lists and improve retention in treatment. It also acknowledged, that, in some instances, there has been an over reliance by clinicians on prescribing medication, and 'patients being allowed to drift into long-term maintenance' (p.3). The group shared the view that 'the prescribing of any medication (and perhaps especially of OST) must not be allowed to become detached and delivered in isolation from other crucial components of effective treatment. Other elements of overall care need also to be considered, including individual recovery care planning, psychosocial interventions and integration with mutual help-groups and peer- support' (p.3).

Key elements of effective drug treatment

A comprehensive individual needs assessment that is undertaken early and is ongoing throughout treatment is a key part of the treatment process. The group is agreed that 'assessment should not be a process that happens to someone but one in which they are actively involved' (p.4).

A recovery plan tailored to the patient's needs must be developed collaboratively between the clinician and the patient and should be reviewed regularly and revised when appropriate. This report repeatedly stresses the importance of regular reviews of the recovery plan: 'if an individual is deriving little or no benefit from an intervention, then it should be modified and tailored in partnership with the patient so that the provision of treatment delivers identified and valued benefit' (p.4).

The group recognised that the eventual package of recovery-orientated treatment services was likely to appear complex to service providers, and that services will need time to adjust and will require training to reorient themselves towards a balance between harm reduction (reduction of negatives) and recovery (accrual of positives). The report lists some immediate steps services can take to begin to strike this balance. These are summarised below.

1. Undertake an audit of your service to assess the current balance between overcoming dependence (recovery) and reducing harm to ensure that both objectives co-exist.
2. Review all your patients to ensure they have achieved abstinence from their main problem drug(s) or are actively working to achieve abstinence.
3. Consider changing the current balance between recovery and harm reduction to encourage more patients to pursue recovery.
4. Let your patients see other patients who have successfully exited from treatment by linking your service to a recovery community, or employing ex-service users or using them as volunteers or as recovery mentors and coaches.
5. Ensure adequate support is in place for patients who wish to reduce and/or stop using their medication and that rapid response mechanisms are in place in the event of relapse.
6. Audit the availability of key psycho-social interventions using as a benchmark the interventions recommended by the National Institute of Clinical Excellence (NICE)[2] and the audit tool recommended by the NTA and the British Psychological Society.[3]
7. Strengthen and develop the social networks around patients including families and access to mutual-help groups.
8. Establish opportunities for patients to accrue social capital via employment placements, vocational training and volunteering.
9. Ensure all key workers are trained and supervised to deliver psychosocial interventions to a competent standard. Effective key working should also involve building collaborative interventions to develop the insight of patients and help them build a more integrated lifestyle by attending to their employment and housing needs.

Report on recovery-oriented treatment *(continued)*

A vision of what recovery-orientated services can become
The report outlines an eight-point vision for the future in which services will:

- continue to recognise the role of prescribing medication, but not as an end in itself, rather as one component part in an integrated treatment package that minimises risk and promotes each patient's recovery;
- develop and support staff to adopt and promote recovery among patients and train staff to deliver evidence-base psycho-social interventions alongside prescribed medication;
- make visible to all patients entering treatment the range of treatment and recovery options available and the likely trajectories through options and possible destinations;
- maximise what individual can achieve with a clear emphasis on movement and progress for patients;
- recognise the achievement of preventing further deterioration in the most severely damaged patients;
- involve the families and carers of patients in their recovery planning;
- develop close links with the community to promote reintegration of all patients; and
- Work with clearly defined guidelines that will allocate clearly defined roles for medication in stabilising, maintaining, detoxing and preventing relapse among patients.

The report identifies four key issues which require further intensive consideration: (i) distinguishing between the proportion of patients who might be expected to recover rapidly with no or modest substitute prescribing and the proportion which may need long-term care, including substitute prescribing (this issue is being addressed by a sub-group of the main group), (ii) how can treatment help patients to build 'recovery capital', the social, physical, human and cultural resources seen as necessary to initiate and sustain recovery from addiction? (iii) how can recovery capital and its accumulation be measured? and (iv) how can treatment services decide who receives what intervention, when they receive it and how is it best delivered? The last three issues will continue to be addressed by the main body of the expert group.

Recovery capital is mentioned as a key conceptual driver of their vision of recovery and further work on assessing how treatment services can help patients to develop recovery capital is underway through a sub-committee of the group. Drawing on the work of the French Sociologist Pierre Bourdieu and the concept of social capital, Cloud and Granfield (2008) [4] conceptualise recovery capital as the sum of resources necessary to initiate and sustain recovery from substance addiction. Recovery capital includes the social, physical, human and cultural resources needed to advance the recovery of drug users. Such resources include networks of non-drug using friends and supports (social capital), tangible assets such as secure accommodation and regular income through employment (physical capital), social and personal skills, education, mental and physical health and career goals and ambitions (human capital) and values, beliefs and attitudes that promotes social reintegration and the ability to live within socially prescribed norms (cultural capital). The full report on the work of the group is expected to be available towards the end of 2011 and will be covered in a later issue of *Drugnet Ireland*.

(Martin Keane)

1. Strang J (2011) *Recovery-oriented drug treatment: an interim report.* London: National Treatment Agency for Substance Misuse. www.drugsandalcohol.ie/15524
2. NICE (2007) *Drug misuse: psychosocial interventions.* Nice clinical guidelines 51. London: National Institute for Health and Clinical Excellence. www.nice.org.uk/CG51
3. Pilling S, Hesketh K and Mitcheson L (2010) *Psychosocial interventions in drug misuse: a framework and toolkit for implementing NICE-recommended treatment interventions.* London: National Treatment Agency for Substance Misuse and British Psychological Society. www.drugsandalcohol.ie/13622
4. Cloud W and Granfield R (2008) Conceptualising recovery capital: expansion of a theoretical construct. *Substance Use and Misuse*, 43(12–13): 1971–1986.

Updated Cochrane review of heroin maintenance treatment

Heroin was first prescribed for chronic opiate dependence in the UK back in 1926. By the 1960s the number of problem opiate users had increased, fuelling a black market in heroin which subsequently led to the introduction of restrictions. Thirty years later, clinical trials conducted in Switzerland and the UK re-opened the debate on the effectiveness of prescribed heroin for the treatment of problem opiate use.

The original Cochrane review on this topic was published in 2003; this update (published June 2011) integrates results from European and Canadian clinical trials.[1] The objective was 'to compare heroin maintenance to methadone or other substitution treatments for opioid dependence regarding: efficacy and acceptability, retaining patients in treatment, reducing the use of illicit substances, and improving health and social functioning'.

In all, 3,346 article titles and abstracts were screened, of which 22 were eligible for the review but only eight met the inclusion criteria.[2] The methodology used followed the accepted Cochrane Review guidelines on search strategies, selection of studies, data extraction and management.[3]

While most of the studies compared heroin (plus flexible doses of methadone) against oral methadone only, there were some variations.[2] One study compared injectable heroin to a control group on a drug treatment waiting list, and one study compared supervised inhaled heroin and another injectable methadone to oral methadone. Depending on the outcome of interest, the relevant studies were included in the various pooled analyses carried out to investigate the effect of heroin maintenance treatment.

Cochrane review of heroin maintenance *(continued)*

1. Retention in treatment
Analysis of the relevant studies (1,388 patients) found that clients on supervised injectable heroin plus flexible dose of methadone were retained in treatment longer compared to patients in oral methadone maintenance (RR 1.44 [95% CI 1.19, 1.75]).[4] Compared to any other drug treatment, heroin (supervised or not) (1,535 patients) improved retention in treatment (RR 1.44 [95% CI 1.16, 1.79]).

2. Relapse to illicit drug use
This was measured as self-reported illicit drug use (including illicit heroin). The authors decided that meta-analysis was not suitable to carry out on the pooled data for this outcome and therefore reported the results of each individual study. They found a statistically significant reduced use of illicit drug use in all the relevant studies in the groups on heroin maintenance compared to the groups on methadone maintenance. The different types of other illicit substances used were not identified in almost all of the studies.

3. Mortality
In four relevant studies (1,477 patients) six deaths were recorded in the group on supervised injectable heroin maintenance, compared to 10 in the group on oral methadone maintenance. There was no statistically significant difference in mortality found between the injecting heroin group and the groups on oral methadone (RR 0.65 [95% CI 0.25, 1.69]) or on any other drug treatment (RR 0.78 [95% CI 0.32, 1.89]).

4. Adverse medical events related to the study medication
For this outcome measurement (type of adverse event not specified), only data from four studies could be pooled for meta-analysis, with the results from the other studies presented separately. The results from that analysis were that those in the supervised injectable group had a higher risk of adverse medical events than those in the oral methadone maintenance group (RR 14.42 [95% CI 2.74, 75.97]).

5. Secondary outcomes
Although the results could not be combined, the results of the appropriate studies indicated a reduction in criminal offences. The only other secondary outcome where prescribed heroin appeared to have a protect effect was for imprisonment, compared to other treatments.

Discussion

In relation to overall completeness and applicability of the evidence, the authors concluded that the studies included were able to answer the main review questions. The risk of bias was reduced because of the acceptable sample sizes of and the consistency of results across the included studies. One area that was lacking was a clearer description of the characteristics of clients who would most benefit from this intervention.

The authors concluded that there were statistically significant results which showed supervised injectable heroin plus flexible doses of methadone improved retention in treatment, and led to a reduction in rates of illicit drug use, criminal offending and imprisonment. This intervention would be of benefit to clients who have failed to remain in methadone treatment.

Some limitations to this mode of treatment were identified by the authors. The review showed the increased risk of adverse medical events, indicating that prescribed heroin should only be given in treatment centres that were equipped to deal with emergencies. Clients' attempts to re-integrate into society could be restricted by having to attend a treatment centre two or three times a day for injections. There are many factors related to non-compliance with drug treatment, including poverty, lack of family support and psychiatric co-morbidity. The authors considered that in the current climate of limited and diminishing resources, the appropriateness of providing a more expensive medical treatment rather than attempting to address the known social predicators of non-compliance and relapse. Other studies are anticipated on this topic.

Implications for practice

- Prescribed heroin provides added value to methadone treatment;
- Risk-benefit of prescription heroin must be evaluated fully before implementation in clinical practice due to the higher rate of serious adverse events;
- Prescribed heroin should be considered for clients who are have failed to remain in methadone substitution treatment programmes;
- It should only be provided in treatment centres if proper follow-up is available;
- The capacity of treatment services and the cost of the programme must be assessed before provided prescribed heroin.

(Suzi Lyons)

1. Ferri M, Davoli M and Perucci CA (2011) Heroin maintenance for chronic heroin-dependent individuals. *Cochrane Database of Systematic Reviews* 2010, Issue 8. Art. No.: CD003410. http://onlinelibrary.wiley.com
2. The studies included were: RIOTT (2010), NAOMI (2009), Haasen (2007), PEPSA (2006), CCBH (A) (2002), CCBH (B) (2002), Perneger (1998) and Hartnoll (1980). Once pooled, a total of 2007 participants were available for analysis. Further details and references of each study included can be found on pp. 25–41 of the review.
3. Higgins JPT and Green S (eds) (2008) *Cochrane handbook for systematic reviews of interventions*. Version 5.1.0 [updated September 2009]. The Cochrane Collaboration. www.cochrane-handbook.org
4. Risk Ratio (RR) and 95% Confidence Interval (95% CI).

Keltoi residential rehabilitation programme: outcome study

Keltoi offers a residential therapeutic rehabilitation programme for problem opiate users, emphasising occupational work and with a strong focus on after-care and living drug-free. This study[1] reports on follow-up interviews with clients who attended the programme between September 2002 and July 2004. It was done as part of a wider evaluation of the programme, which has already been published.[2]

The study aim was to evaluate how effective the Keltoi programme had been in helping participants to remain drug free. During the evaluation period, 149 clients had entered Keltoi, 94 had participated in the original evaluation, and 80 of these participated in the follow-up interview, which was based on the Maudsley addiction profile (MAP). The interviews started in May 2004 and finished in July 2009. The average time between discharge and follow-up interview was 1.9 years (range 1.2 to 3.0 years). Two participants in the original evaluation had died before the follow-up interview took place, giving a mortality rate of 2.1% for the 94 participants. There was no control group.

Half (51.3%) of the interviewees self-reported as fully abstinent (defined as abstinence from all substances including alcohol and prescription substitution drugs) in the 30 days before the interview. Most (88.1%) were still in contact with some type of drug treatment service. Those who were abstinent reported higher levels of well-being than those who reported that they were not abstinent.

In the 30 days before the interview;

- five (6.3%) interviewees reported injecting;
- a lower proportion of those who were abstinent (3.8%) reported suicidal thoughts compared to the proportion who were not abstinent (18.8%);
- over two thirds (77.5%) of those interviewed reported no criminal activities; and
- half (50.0%) reported having undertaken paid employment.

Self-reported abstinence was recognised to be a limitation by the authors, but was felt to be reasonably reliable among this population as there were no negative consequences for the interviewees. Because of the methodology used it was not appropriate to undertake statistical analysis of the data looking for factors which might be associated with abstinence. The authors stated that, for the same reason, they were 'wary of direct comparisons with the majority of current international literature' (p. 358) in this area. This lack of comparability is an issue in many studies.

Compared to the completion rate among the abstinence cohort in the ROSIE study (66%),[3] the rate of completion in Keltoi was higher (77%). The outcomes of the Keltoi also compare favourably with another Irish study, with Keltoi participants reporting abstinence rates of 51% at follow-up, compared to 23% in a study by Smyth *et al.*[4]

The authors found large gaps in outcome-based evaluations for treatment programmes in Ireland and recommended the introduction of a health outcomes monitoring system. They also concluded that the evidence from their studies and others done in this area showed that many of those who enter residential treatment do not have successful outcomes. It is important to find out what works and what does not work for different people.

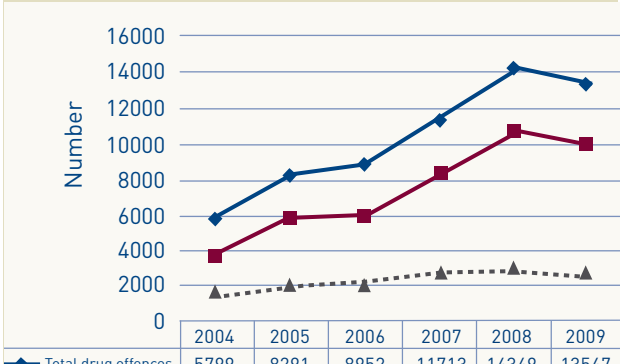
(Suzi Lyons)

1. White E, Browne C, McKiernan B and Sweeney B (2011) Keltoi rehabilitation programme: post-discharge outcome study. *Drugs: education, prevention and policy*, Early online: 1–8. http://www.drugsandalcohol.ie/14766
2. Sweeney B, Browne C, McKiernan B and White E (2007) *Keltoi client evaluation study*. Dublin: Health Service Executive. http://lenus.ie/hse/handle/10147/92643
3. Cox G, Comiskey C and Kelly P (2007) *ROSIE Findings 3: summary of 1-year outcomes: abstinence modality*. Dublin: National Advisory Committee on Drugs. www.drugsandalcohol.ie/11516
4. Smyth BP, Barry J, Lane A, Cotter M, O'Neill M, Quinn C *et al.* (2005) In-patient treatment of opiate dependence: medium-term follow-up outcomes. *British Journal of Psychiatry*, 187: 360–365. www.drugsandalcohol.ie/6777
2. Skinner R, and Conlon L, Gibbons D and McDonald C (2011) Cannabis use and non-clinical dimensions of psychosis in university students presenting to primary care. *Acta Psychiatrica Scandinavica*, 123(1): 21–27.

Drugs and crime data

This article looks at trends in reported drug offences and drug seizures for various periods between 2003 and 2010. It should be noted that drug offence and seizure data are primarily a reflection of law enforcement activity. Consequently, they are affected in any given period by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of drug users and drug traffickers to law enforcement activities. Having said that, drug seizures are seen as indirect indicators of the supply and availability of drugs.

Figures 1 and 2 show trends in proceedings for drug offences from 2004 to 2009. As can be seen from Figure 1, criminal proceedings for the possession of drugs for personal use (simple possession) decreased in 2009 for the first time since 2004. Proceedings for drug supply also decreased marginally, from 2,964 in 2008 to 2,721 in 2009, when they returned to the 2007 level. Possession offences accounted for 74.5% of total drug offences in 2009.



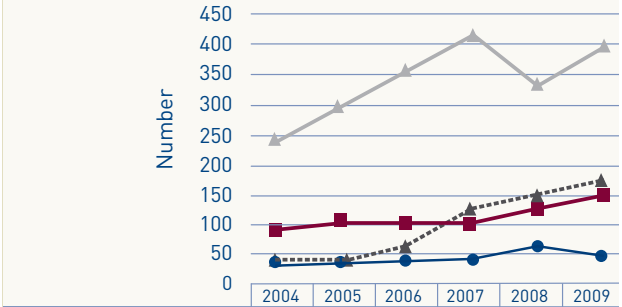
	2004	2005	2006	2007	2008	2009
Total drug offences	5799	8291	8952	11713	14349	13547
Drug possesion for personal use	3762	5861	6103	8346	10746	10093
Drug possesion for supply	1654	1987	2323	2725	2964	2721

Figure 1 Trends in relevant legal proceedings for total drug offences and for possession and supply offences, 2004–2009

Source: CSO (2008, 2009, 2010, 2011) www.cso.ie

Figure 2 shows trends in legal proceedings for a selection of other drug offences between 2004 and 2009.

The offence of obstructing the lawful exercise of a power conferred by the Misuse of Drugs Act 1977 (s.21) continues to account for a large majority of offences each year. Obstruction offences often involve an alleged offender resisting a drug search or an arrest or attempting to dispose of drugs to evade detection. Following a decline in 2008, proceedings for such offences increased in 2009, as they did for cultivation offences and forged prescription offences.



	2004	2005	2006	2007	2008	2009
Obstruction	239	290	349	406	328	390
Forged/altered perscriptions	85	95	91	91	119	139
Cultivation or manufacture	32	29	54	110	136	163
Importation	27	29	32	35	56	41

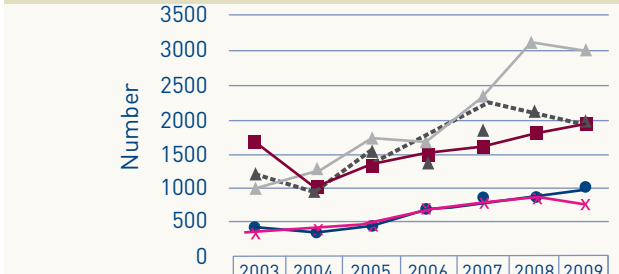
Figure 2 Trends in relevant legal proceedings for selected drug offences, 2004–2009

Source: CSO (2008, 2009, 2010, 2011) www.cso.ie

Importation offences decreased marginally in 2009. Proceedings for the cultivation or manufacture of drugs have continued to increase, rising from 29 in 2005 to 163 in 2009. It is unclear whether this increase reflects a genuine growth in the commission of such offences or a sustained concentration of law enforcement on detecting them.

Drug offence data can assist in understanding aspects of the operation of the illicit drug market in Ireland.[1] Data on drug offence prosecutions by Garda division are a possible indicator of national drug distribution patterns. While these data primarily reflect law enforcement activities and the relative ease of detection of different drugs, when compared with other sources such as drug treatment data, for example, they can show us trends in market developments throughout the State. Such data can also indicate trafficking patterns by showing whether there is a concentration of prosecutions along specific routes. Figures 3 and 4 show trends in relevant legal proceedings for possession of drugs by Garda region. It should be noted that possession includes possession for personal use and possession for the purpose of supply. It is not possible to distinguish these two offences in the data reported by Garda region. However, as shown in Figure 1 above, it is generally the case that in 70-75% of all possession cases the drugs are deemed to be for personal use.

Drugs and crime data *(continued)*

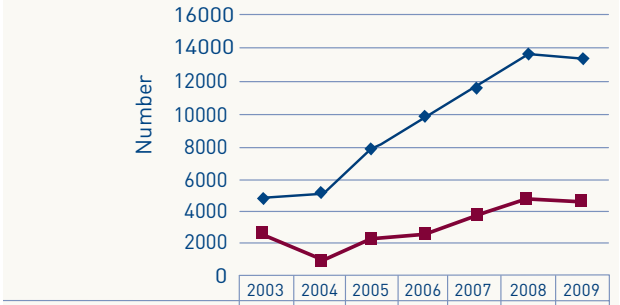


	2003	2004	2005	2006	2007	2008	2009
Southern region	1026	1214	1628	1560	2208	2996	2815
South eastern region	1624	977	1287	1405	1540	1733	1787
Eastern region	1201	929	1517	1274	1715	2126	1854
Northern region	442	351	450	629	782	873	955
Western region	390	429	464	609	747	848	708

Figure 3 Trends in relevant legal proceedings for possession of drugs, by Garda region excluding the Dublin Metropolitan Region, 2003–2009

Source: Central Statistics Office

It can be seen from Figures 3 and 4 that prosecutions for possession decreased in all but two Garda regions (the Northern and the South Eastern) in 2009, after a steady increase since 2006.



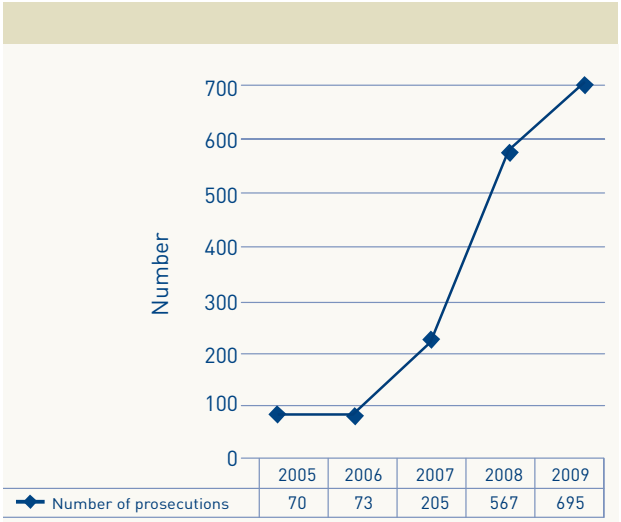
	2003	2004	2005	2006	2007	2008	2009
Stat (total)	4987	5414	7846	8422	11074	13855	12814
Dublin Metropolitan region	2810	1514	2500	2945	4082	5279	4695

Figure 4 Trends in relevant legal proceedings for possession of drugs in the Dublin Metropolitan Region and nationally, 2003–2009

Source: Central Statistics Office

The Dublin Metropolitan Region still accounts for the majority of prosecutions for possession in the state. However, the proportion of prosecutions taking place outside the capital has increased significantly, from 43.6% in 2003 to 63.3% in 2009. These data show that the drug phenomenon is now more widely distributed throughout the state than previously.

Drug driving offences



	2005	2006	2007	2008	2009
Number of prosecutions	70	73	205	567	695

Figure 5 Trends in relevant legal proceedings for driving in charge of a vehicle under the influence of drugs 2005–2009

Source: CSO (2011)

Figure 5 shows the trend in prosecutions for driving under the influence of drugs (DUID) between 2005 and 2009, when the number rose from 70 to 695, an increase of more than 900%. It is unclear why this increase has occurred. It could be due either to an increase in the incidence of DUID or, the more likely possibility, an increase in targeted police activity in this area.

The new programme for government, *Government for National Recovery 2011–2016*, contains a number of actions related to criminal justice and drugs policy.[2] The following is included as an action:

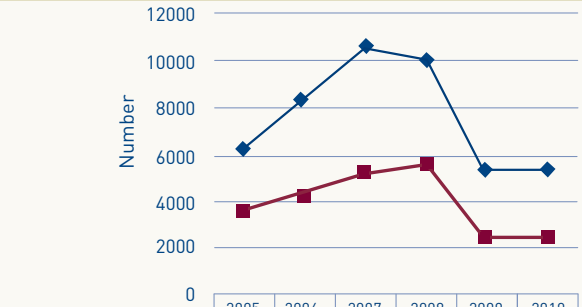
We will introduce roadside drug testing programmes to combat the problem of driving under the influence of drugs.

The development of reliable roadside testing procedure has been a challenging issue for many countries. At present the Garda Síochána, the Department of Transport and the Medical Bureau of Road Safety are collaborating in the development of a scheme to introduce US-style roadside testing of suspected drug drivers to accompany roadside alcohol tests.

Drug seizures

Cannabis seizures account for the largest proportion of all drugs seized. Figure 6 shows trends in cannabis-related seizures and total seizures between 2003 and 2010. The decrease and levelling out in total seizures between 2008 and 2010 can partly be explained by the parallel trend in cannabis seizures during the same period. It is not clear if the reduction in cannabis-related seizures reflects a decline in cannabis use or a reduction in law enforcement activity targeted at the cannabis market. However, it should be noted that drug offence prosecutions reported above, most of which are cannabis-related, also decreased slightly in 2009, with figures for 2010 not currently available.

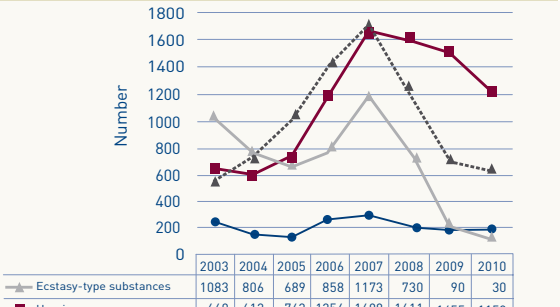
Drugs and crime data *(continued)*



	2005	2006	2007	2008	2009	2010
All seizures	6362	8417	10444	9991	5494	5477
Cannabis type substances	3555	4243	5176	5652	2314	2268

Figure 6 Trends in the total number of drug seizures and cannabis seizures, 2005–2010

Source: Central Statistics Office (2008, 2009, 2010); An Garda Síochána (2011)



	2003	2004	2005	2006	2007	2008	2009	2010
Ecstasy-type substances	1083	806	689	858	1173	730	90	30
Heroin	660	612	763	1254	1698	1611	1455	1150
Cocaine	566	753	1045	1500	1749	1010	635	588
Amphetamines	211	145	125	277	235	126	72	89

Figure 7 Trends in the number of seizures of selected drugs, excluding cannabis, 2003–2010

Source: Central Statistics Office (2008, 2009, 2010); An Garda Síochána (2011)

The reduction in the total number of reported seizures in 2009 and its levelling off in 2010 may also be explained by a reduction in the number of seizures of other drugs since 2008. Figure 7 shows trends in seizures for a selection of drugs, excluding cannabis, between 2003 and 2010. There has been a significant decline in seizures of cocaine, heroin and ecstasy-type substances since 2007. It appears that the significant reduction in total drug seizures reported in 2009 can be explained primarily as the result of a reduction in seizures of cannabis and cocaine. However, in 2010 we have seen the continued decline in heroin seizures. It is unclear whether this reflects a decline in heroin use or a change in law enforcement activities or some other factor.

(Johnny Connolly)

1. Connolly J (2005) *The illicit drug market in Ireland.* HRB Overview Series 2. Dublin: Health Research Board. www.drugsandalcohol.ie/6018

2. Fine Gael and the Labour Party (2011) *Towards recovery: programme for a national government 2011–2016.* www.drugsandalcohol.ie/14795

Courts Service annual report 2010

The Courts Service annual report for 2010 provides statistics on the outcomes of prosecutions for drug offences between January and December 2010.[1] Table 1 shows the outcomes of trials in 16,939 drug offence cases prosecuted in the District Court, the lowest court in the criminal justice system where most drug offences are dealt with. The most common outcome for drug offences in the District Court in 2010 were cases being struck out, which made up 22.6% (3834) of case outcomes followed by fines, which accounted for 19.2% (3249) of outcomes. Almost 10% of cases (1,588) led to a sentence of imprisonment.

The Courts Service reports that 1,186 drug offences were tried in the Circuit Court, which has a higher jurisdiction than the District Court and can thus impose more severe sentences. Of those prosecutions, 767 led to guilty pleas. Of the 46 cases which went to trial, 14 were convicted, 14 acquitted and 18 led to a *nolle prosequi*, where the prosecution enters a stay on criminal proceedings. It is unclear from the data provided what sentence was imposed in relation to the 14 convictions.

(Johnny Connolly)

1. Courts Service (2011) *Courts Service annual report 2010.* Dublin: Courts Service. www.courts.ie

Table 1 Sentences for drug offences in the District Court, 2010

Sentence	Imprisonment	Fine	Community service/ probation	Struck out	Dismissed	Taken into consideration*	Other	Peace bond	Total
Number of offences	1588	3249	2107	3834	310	2460	2997	394	16939

* Taken into consideration: Section 8 of the Criminal Justice Act 1951 provides that where a person, on being convicted of an offence, admits himself guilty of any other offence and asks to have it taken into consideration in awarding punishment, the Court may take it into consideration accordingly. If the Court takes an offence into consideration, a note of that fact is made and filed with the record of the sentence, and the accused cannot be prosecuted for that offence, unless his conviction is reversed on appeal.

Source: Courts Service (2011)

National Registry of Deliberate Self Harm annual report 2010

The ninth annual report from the National Registry of Deliberate Self Harm was published in July 2011.[1] The report contains information relating to every recorded presentation of deliberate self-harm to acute hospital emergency departments in 2010, giving complete national coverage of cases treated.

In 2010, there were 11,966 recorded presentations of deliberate self-harm, involving 9,630 individuals. The rate of presentations increased from 209/100,000 of the population in 2009 to 217/100,000 in 2010, a 4% increase. Of the 9,630 individuals who presented, 86% were presenting for the first time in their life.

Concordant with previous reports, 47% of self-harm presentations in 2010 were men and the same proportion (47%) were aged under 30 years. Two hundred and seventy five (2.3%) were living in homeless hostels or had no fixed abode. Presentations peaked in the hours around 10pm and were highest on Sundays and Mondays; 32% of episodes occurred on these two days. There was evidence of alcohol consumption in 41% of all presentations and this was more common among men (44%) than women (37%).

Drug overdose was the most common form of deliberate self-harm, occurring in 71% (8,538) of all such episodes reported in 2010. Overdose rates were higher among women (77%) than among men (65%). In 73% of cases the total number of tablets taken was known; an average of 31 tablets was taken in these cases. Forty-two per cent of all drug overdoses involved a minor tranquilliser, 29% involved paracetamol-containing medicines and 21% involved anti-depressants or mood stabilisers. The number of deliberate self-harm presentations involving street drugs increased in 2009 (579) and again in 2010 (645) when compared to 2008 (461). Men are much more likely than women to self-harm using street drugs.

The next step, or referral outcome, was recorded for 90% of deliberate overdose cases: over two fifths (41%) were discharged home; 37% were admitted to an acute general hospital; 7% were admitted to psychiatric in-patient care; a small proportion (0.6%) refused admission to hospital; and 14% discharged themselves before receiving referral advice.

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

- A wide range of evidence-based treatments and aftercare programmes;
- Uniform assessment and aftercare procedures;
- Adequate services to deal with alcohol and depression at peak admission times;
- Information campaigns for the general public on the common symptoms of depression and signs of suicidal behaviour, and places where help is available.
- A national strategy to deal with alcohol supply and illegal alcohol use among children under 18 years.

(Jean Long and Ena Lyn)

1. National Suicide Research Foundation (2011) *National Registry of Deliberate Self Harm annual report 2010*. Cork: National Suicide Research Foundation. www.drugsandalcohol.ie/15674

National Poisons Information Centre (NPIC) 2010 report

According to its annual report,[1] NPIC received 11,589 enquiries in 2010, a decrease of 1.6% from 2009. Of these, 1,904 were dealt with by the UK National Poisons Information Service and are not included in the analysis presented in this report. Of the 9,685 calls answered by NPIC, 9,330 (96.3%) were about human toxicology. The remaining calls concerned poisoning in animals (0.7%) and non-emergency requests for information (2.9%).

The most frequent enquiries were from general practitioners/primary care (38.2%), hospitals (33.2%) and members of the public (22.9%). The other sources of enquiries were community pharmacists, carers, vets, industry/manufacturers, schools, emergency services, media and government agencies.

Half of the enquiries about cases of poisoning in humans concerned children under 10 years of age, and males outnumbered females in this age group. There were 2,744 (29.4%) enquiries relating to adults (aged 20 years or over) with a predominance of females in this age group.

The main agents involved in these cases were drugs (pharmaceuticals and drugs of abuse), industrial chemicals and household products. The majority (93.4%) of all human poisoning incidents occurred in the home or in a domestic setting.

More than half (59.6%) of the human cases were suspected accidental poisonings, 25.1% were intentional poisoning or recreational abuse, 12.2% were therapeutic errors, and 3.2% had another or unknown intent.

National Poisons Information Centre (NPIC) 2010 report *(continued)*

The enquiries about human toxicology involved 15,164 agents, mainly drugs, industrial chemicals and household products. The most common enquiry concerned substances containing paracetamol (1,302). The second most common agent was ibuprofen (454). Only a small proportion of cases (361, 3.9%) were followed up. Although most recovered completely, 24 cases suffered adverse effects, a further 12 cases died, and the outcome of 34 cases could not be determined. One of these fatalities may not have been caused by poisoning (post mortem examination to be carried out); the others were all cases of deliberate self-poisoning or drug/substance misuse.

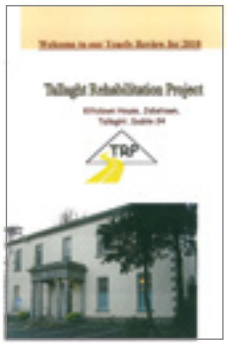
In a section headed 'Toxicovigilance', the report includes the following:

> In June 2010 the NPIC informed the HSE Department of Public Health of significant adverse effects associated with a recreational drug called Whack, which was being sold in head shops. The HSE subsequently issued a warning to the general public about the drug. Between the 30th May and 16th June 2010 the centre was contacted about 49 patients who had suffered adverse effects after taking Whack. They presented with sympathomimetic features of tachycardia and hypertension, as well as agitation and severe psychotic reactions with delusions of parasitosis and hallucinations, persisting for up to 5 days. The Forensic Science Laboratory has since analysed this product and found it to contain two active ingredients. The first, fluorotropacocaine, is a drug of lower potency than the parent compound cocaine. The second compound was tentatively identified as desoxypipradrol (there is no current external reference standard so a best library match was used). This is an analogue of pipradrol, which is a central nervous system stimulant developed in the 1950s. It is likely that the severe, long-acting effects associated with Whack are due to this agent, as pipradrol has been previously associated with psychotic reactions and insomnia. (pp. 5–6)

(Mairea Nelson)

1. National Poisons Information Centre of Ireland (2011) *Annual report 2010*. Dublin: Poisons Information Centre of Ireland. www.drugsandalcohol.ie/15785

Annual review of the Tallaght Rehabilitation Project



The Tallaght Rehabilitation Project (TRP) is a community-based rehabilitation day programme for people with drug or alcohol addiction who are currently drug or alcohol free or who are stable on methadone. The annual review for 2010 is now available on the TRP website.[1]

There are 17 places on the day therapeutic programme, which runs alongside family support activities, aftercare and outreach. During 2010, 57 people were referred to the day programme, of whom 17 were given a place, 20 were referred on to other services and six were awaiting assessment. Some of the main activities of the programme were: key working (433 hours); relapse prevention/addiction awareness (254 hours); therapeutic group process (246 hours); and 'move on' module (95 hours).

Several participants completed the move on module, which provides job-seeking skills alongside relapse prevention. In 2010, the aftercare service, through a service level agreement, was included in the module to further improve the successful transition from TRP.

The Community Employment (CE) scheme in TRP had a very successful year in 2010. Currently all those on the day programme have a ring-fenced position, while a further 10 people are employed on the CE scheme to support the activities of the project. Five of the day programme participants are now in employment (either full-time or CE) and two are in full-time third-level education.

One CE staff member has returned to full-time employment and another is now a third-level student working part time.

In order to provide a holistic service to the people attending, other services are provided, including: family intervention, a play therapist, outreach and a partnership with Dublin Rape Crisis Centre.

The Tallaght Wide Aftercare service (TWA) expanded its services to five evenings a week in 2010 and employed a second project worker. In 2010, 46 people were referred to this service, of whom eight were referred on, 24 accessed the services regularly, and 14 disengaged. Activities undertaken included: social (485 hours); key working (175 hours); peer support group (74 hours); and stress management (70 hours).

The report notes that, despite the 10% reduction in funding, TRP has been able to maintain its standards and level of staff, but warns that any more cuts will inevitably have a negative effect on the project's ability to provide the same level of service.

(Suzi Lyons)

1. Tallaght Rehabilitation Project (2011) *Annual review 2010*. Dublin: Tallaght Rehabilitation Project. http://www.drugsandalcohol.ie/15696

From *Drugnet Europe*

Survey results: youth attitudes to drugs

Cited from article by Maurice Galla, DG Justice, European Commission, in Drugnet Europe, No. 75, July–September 2011

The European Commission published on 11 July the results of its fourth survey exploring *Youth attitudes on drugs.*[1] This 'Flash Eurobarometer' is based on telephone interviews conducted in May 2011 with over 12,000 randomly selected young people (aged 15–24) in all 27 EU Member States. It builds on three earlier Eurobarometer surveys carried out in 2002, 2004 and 2008.

Among the issues covered by the survey are: perceptions on the health risks of drug use; attitudes to banning or regulating substances; views on the availability of drugs; and opinions on the effectiveness of policies. For the first time, questions were included on new psychoactive substances ('legal highs').

On average, around 5 % of the young respondents said that they had used 'legal highs', with Ireland (16%), Latvia (9%), Poland (9 %) and the UK (8%) reporting higher rates and Italy, Malta and Finland (all around 1%) reporting lower rates. These substances were mainly obtained through friends (54%), at parties or in clubs (37%), in specialised shops (33%) or over the Internet (7%).

…[W]hen asked how they had been informed about drugs issues in the past year, the Internet came in third position (39%), behind media campaigns (46%) and school prevention programmes (41%). However, figures show that the Internet has become a more significant drug-related information source than in 2008.

In terms of drug control and regulation, the majority of respondents (59%) still support cannabis prohibition, but this number has declined from 67% since 2008. Regarding new psychoactive substances, respondents indicated that these should be banned only if they pose a risk to health (47%) or be regulated in similar ways to alcohol or tobacco (15%). Around one third of respondents (34%) felt that these substances should be banned under any circumstances.

Released on the same day was a European Commission assessment of the EU's mechanism for addressing new psychoactive substances entering the European market.[2] The EMCDDA contributed to this report.

1. http://ec.europa.eu/public_opinion/flash/fl_330_en.pdf
2. http://ec.europa.eu/justice/anti-drugs/document/index_en.htm

Forum on new drugs — reflections and conclusions

Cited from article by Charlie Lloyd, University of York, and Ana Gallegos, EMCDD, in Drugnet Europe, No. 75, July–September 2011

The first international multidisciplinary forum on new drugs, organised by the EMCDDA in Lisbon from 11–12 May, brought together experts from a wide range of disciplines to discuss what might be described as a paradigm shift in our understanding of 'the drug problem'.

Delegates came from all over the world to discuss how a broad range of new drugs – e.g. mephedrone, BZP and synthetic cannabinoids – had begun to be used in their countries and how policies had been developed in response. … [T]here was a strong impression of commonality. This was a global phenomenon, driven by the Internet, with striking similarities across the world in the names and packaging associated with these substances.

Another overriding impression from participants' accounts was one of dynamism: as one new drug and its use subsided, another unrecognised substance emerged to replace it. While legal controls appeared to work in terms of suppressing production and use, by the time one of these drugs was on the legal schedule, clandestine chemists and producers had already moved on to producing alternative uncontrolled substances. …

Potential solutions discussed at the forum included: public health warnings in response to suspected dangers; working with the media to publicise harms; introducing general legislation that covered whole groups of substances; and using laws relating to medicines or consumer protection to put the legal onus of product safety on the producer. …

Perhaps with better foresight, experts could identify substances likely to become the new drugs of the future. The need to recognise potential problems more quickly was also underlined. Methods to identify new waves of use as they broke, rather than after the event, could include: monitoring Internet chatrooms; testing wastewater; and using information from hospital emergency departments and poison centres.

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:
Health Research Board, Knockmaun House, 42–47 Lower Mount Street, Dublin 2.
Tel: 01 2345 148; Email: drugnet@hrb.ie

In brief

In February of this year In brief reported on the work of the Latin American Commission on Drugs and Democracy and the Inter-American Dialogue on rethinking US drug policy (see *Drugnet Ireland* Issue 37). It also noted that a Global Commission on Drug Policy had been established to review the assumptions, effectiveness and consequences of the 'war on drugs' approach.

In June 2011 the **Global Commission on Drug Policy** published its report. The report sets out the following 'key principles and recommendations':

- End the criminalisation, marginalisation and stigmatisation of people who use drugs but who do not harm others. Challenge rather than reinforce common misconceptions about drug markets, drug use and drug dependence.
- Encourage experimentation by governments with models of legal regulation of drugs to undermine the power of organised crime and safeguard the health and security of their citizens. Apply this recommendation especially to cannabis, but also experiment in the decriminalisation and legal regulation of other substances.
- Offer health and treatment services to those in need. Ensure that a variety of treatment modalities are available, including not just methadone and buprenorphine treatment but also heroin-assisted treatment programmes. Implement syringe access and other harm reduction measures. Respect the human rights of people who use drugs.
- Apply the same principles and policies stated above to people involved in the lower ends of illegal drug markets, such as couriers and petty sellers. The Commission comments, 'Many are themselves victims of violence and intimidation or are drug dependent. Arresting and incarcerating these people in recent decades has filled prisons and destroyed lives and families without reducing the availability of illicit drugs or the power of criminal organisations.'
- Invest in activities that can both prevent young people from taking drugs in the first place and also prevent those who do use drugs from developing more serious problems. Eschew simplistic 'just say no' messages and 'zero tolerance' policies in favour of educational efforts grounded in credible information and prevention programs that focus on social skills and peer influences. The Commission points out that the most successful prevention efforts may be those targeted at specific at-risk groups.
- Focus repressive actions on violent criminal organisations, but do so in ways that undermine their power and reach while prioritising the reduction of violence and intimidation. Law enforcement efforts, according to the Commission, should focus not on reducing drug markets per se but on reducing their harms to individuals, communities and national security.
- Begin the transformation of the global drug prohibition regime. Replace drug policies and strategies driven by ideology and political convenience with fiscally responsible policies and strategies grounded in science, health, security and human rights – and adopt appropriate criteria for their evaluation.
- Break the taboo on debate and reform.
  www.globalcommissionondrugs.org

On 14 June 2011 the **Think Tank for Action on Social Change (TASC)** launched a report on health inequalities in Ireland. Authored by TASC Head of Policy Sinéad Pentony and Sara Burke, health policy analyst and journalist, ***Eliminating health inequalities – a matter of life and death*** outlines the interrelationship between economic inequality and inequality of health outcomes. At the launch, Professor Joe Barry, Chair of the TASC Health Inequalities Advisory Group, said: 'This report illustrates how responses to the current economic crisis are disproportionately impacting on low-income and vulnerable groups, to the detriment of their health in both the short and the long term. The publication of this report is timely, as it coincides with the launch of the Government's consultation on a new public health policy.' Recommendations in the report include:

- the establishment of an independent review of health inequalities, to report within 12 months;
- an equality statement to be published as part of the annual budgetary process, examining the distributional impact of proposed taxation and spending measures on all income levels and on specific demographic groups;
- taxation to be gradually raised to Western European levels, with the increased revenue to be used for higher health and education spending;
- increased and targeted investment in early childhood care and education;
- implementation of a universal social health insurance model.
  www.tascnet.ie

In June 2011 ***The Lancet*** published an article on the findings of a study of psychiatric disorders and mortality among people in homeless shelters in Denmark between 1999 and 2009.[1] The study had found increased rates of psychiatric morbidity (particularly substance abuse) and vastly increased mortality rates, but had also found that homeless people with mental disorders did not have increased mortality compared with homeless people who were not mentally ill, although there was a relative increase in people with substance abuse. A separate commentary on the findings observed:[2]

> … any additive risk between mental and physical illness on rates of mortality seems to be limited to substance abuse. This finding is interesting and might indicate that mentally ill homeless people who are not substance abusers have better access to health services than do homeless people without mental illness, perhaps as a result of specialist services introduced after the identification of the high rates of mental illness. … Mentally ill people who do not abuse substances might also spend less time homeless than do those with alcohol and drug problems, and substance abuse might be associated with a higher number of risk factors for natural and non-natural causes of death. … The findings suggest that integrated psychiatric and substance abuse treatment is necessary to address inequalities, and further treatment trials on the best strategies to treat dual-diagnosis homeless patients and homeless young people are needed. Such enhanced treatment is likely to confer additional benefits, including reduction in violent crime, specific causes of mortality including suicide, and victimisation. Services need to be integrated and flexible: assertive community treatment could offer one approach, possibly with community support.

(Compiled by Brigid Pike)

1. Nielsen SF, Hjorthøj CR, Erlangsen A and Nordentoft M (25 June 2011–1 July 2011) 'Psychiatric disorders and mortality among people in homeless shelters in Denmark: a nationwide register-based cohort study' in *The Lancet*, 377(9784): 2205–2214.
2. Geddes JR and Fazel S (25 June 2011–1 July 2011) 'Comment – Extreme health inequalities: mortality in homeless people' in *The Lancet*, 377(9784): 2156–2157.

Southern Regional Drugs Task Force annual report 2010

The Southern Regional Drugs Task Force (SRDTF) annual report for 20101 contains information relating the task force, budgets, staffing, treatment outcomes and operational issues. The section on treatment outcomes analyses data on community-based drugs initiatives (CBDIs) returned to the National Drug Treatment Reporting System (NDTRS) in the Health Research Board.

CBDI services were accessed by 505 clients in 2010, comprising 202 concerned persons (family members or close friends of substance users) and 303 people who sought treatment for their own addiction.

Of the 303 who sought treatment:

- More than one-third (35%) were under the age of 18, and three-quarters (76%) were under the age of 25 years.
- The majority (72%) lived with parents or family.
- 30.0% were still in school, and an additional 30.0% were students.
- Cases were mainly self-referred (29.0%), referred by family members (22.1%), court, probation or police (18.2%), or social services (8.6%).
- The most common main problem substance reported by cases presenting for treatment were alcohol (46.5%), cannabis (27.1%), opiates (10.6%), other substances (including hallucinogenic, non-benzodiazepine-sedatives, head shop substances, and other unspecified medications) (6.6%), and benzodiazepines (5.0%). Ecstasy, cocaine, other stimulants, and volatile inhalants were also reported, but to a lesser extent.

- 90.4% were treated; 9.6% of those assessed did not commence treatment (4.0% were unsuitable, 2.6% were referred/transferred to another service for treatment, 2.3% did not accept the place offered).

Of 179 cases discharged from treatment in 2010, 30.3% had completed treatment or were transferred to another service provider for additional treatment; 42.1% refused further sessions or did not return for subsequent appointments; 20.0% did not wish to attend further sessions as they considered themselves to be stable. The client's condition on discharge was classified by service providers as stable if they had responded to treatment, and unstable if they had not responded. Of the 179 cases analysed, the majority (51.1%) were stable; 43.8% had a family member or significant other involved in their treatment.

(Anne Marie Carew)

1. Black C (2011) *Southern Regional Drugs Task Force annual report 2010*. Cork: Southern Regional Drugs Task Force. www.drugsandalcohol.ie/15132

Premier screening of RADE film, *Birthday*

Pom Boyd, Darren Balfe and Jenna Duff at the film screening

RADE (recovery through arts, drama and education) aims to engage drug users with the arts and therapeutic supports and provide a platform for their artistic expression.

A special screening of *Birthday*, the last in a trilogy of short films made by RADE, was held in the Irish Film Institute on Tuesday, 11 October. *Birthday* was written by Pom Boyd in collaboration with RADE participants. The film challenges negative stereotypes of drug users. Michael D Higgins TD launched the screening.

Participants in the RADE programme develop their creative potential by working on painting, drawing sculpture, film making and creative writing, and can apply these skills in other aspects of their lives, such as education and employment. Several of those involved in the creative programme read from a new collection of their work called *Frontier Folk* before the screening.

Recent publications

On our shelves

Books recently acquired by the National Documentation Centre on Drug Use.

Chilling out: the cultural politics of substance consumption, youth and drug policy
Shane Blackman

Open University Press (2004) reprinted 2010

ISBN: 978-0-335-20072-6

Controversies in drugs policy and practice
Neil McKeganey

Palgrave Macmillan (2011)

ISBN: 978-0-230-23595-3

www.drugsandalcohol.ie/15978

Legalization of drugs
Mark D Friedman

Heinemann Library (2011) Hot Topics

ISBN: 978-1-4329-4872-6

www.drugsandalcohol.ie/15980

Journal articles

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

Risk of drug-related mortality during periods of transition in methadone maintenance treatment: A cohort study

Cousins G, Teljeur C, Motterlini N, McCowan C, Dimitrov BD and Fahey T
Journal of Substance Abuse Treatment, 2011; 41(3): 252–60.
www.drugsandalcohol.ie/15442

This study aims to identify periods of elevated risk of drug-related mortality during methadone maintenance treatment (MMT) in primary care using a cohort of 3,162 Scottish drug users between January 1993 and February 2004. Deaths occurring during treatment or within three days after last methadone prescription expired were considered as cases 'on treatment'. Fatalities occurring four days or more after leaving treatment were cases 'off treatment'. Sixty-four drug related deaths were identified. The greatest risk of drug related death was in the first two weeks of treatment. Risk of drug-related death was lower after the first 30 days following treatment cessation, relative to the first 30 days off treatment. History of psychiatric admission was associated with increased risk of drug-related death in treatment. Increasing numbers of treatment episodes and urine testing were protective. History of psychiatric admission, increasing numbers of urine tests, and co-prescriptions of benzodiazepines increased the risk of mortality out of treatment. The risk of drug-related mortality in MMT is elevated during periods of treatment transition, specifically treatment initiation and the first 30 days following treatment dropout or discharge.

Prevalence, predictors and perinatal outcomes of peri-conceptional alcohol exposure – retrospective cohort study in an urban obstetric population in Ireland

Mullally A, Cleary BJ, Barry J, Fahey T and Murphy DJ
BMC Pregnancy & Childbirth, 2011; 41(3): 252–260. Epub 11 April http://www.biomedcentral.com/1471-2393/11/27.
www.drugsandalcohol.ie/15475

A cohort study of 61,241 women who booked for antenatal care and delivered in a large urban maternity hospital between 2000 and 2007. Self-reported alcohol consumption at the booking visit was categorised as low (0-5 units per week), moderate (6-20 units per week) and high (>20 units per week).

Of the 81% of women who reported alcohol consumption during the peri-conceptional period, 71% reported low intake, 9.9% moderate intake and 0.2% high intake. Factors associated with moderate alcohol consumption included being in employment, Irish nationality, private health care and smoking. Factors associated with high consumption included maternal age less than 25 years and illicit drug use. High consumption was associated with very preterm birth (<32 weeks gestation) even after controlling for socio-demographic factors. Only three cases of Fetal Alcohol Syndrome were recorded (0.05 per 1000 total births), one each in the low, moderate and high consumption groups.

Public health campaigns need to emphasise the importance of peri-conceptional health and pre-pregnancy planning. Fetal Alcohol Syndrome is likely to be under-reported despite the high prevalence of alcohol consumption in this population.

Gateway transitions in rural Irish youth: implications for culturally appropriate and targeted drug prevention

Van Hout MC and Ryan R
Journal of Alcohol & Drug Education, 2011; 55(1): 7–14.
www.drugsandalcohol.ie/15182

In recent times rural areas in Ireland are indicating comparable drug availability and prevalence of use to urban settings, with the recognition of development of unique rural drug subcultures (NACD, 2008). Additionally, there is a dearth of research on drug-use initiation and transitions among Irish youth, and most particularly outside of the urban context. This letter presents snapshot quantitative findings from a large scale concurrent mixed method study on rural youth substance use in the South East of Ireland. It aims to discuss the observed quantitative findings with reference to potential implications for the design of culturally appropriate and drug specific drug education initiatives in rural Ireland.

Commentary on 'The research translation problem: alcohol screening and brief intervention in primary care – real world evidence supports theory'

Klimas J, Field CA, Barry J, Bury G, Keenan E, Lyons S *et al.*
Drugs: education, prevention and policy, 2011, 24 June; Early online.
www.drugsandalcohol.ie/15393

Recent publications *(continued)*

The paper by McCormick *et al.* (2010) provides real-world examples of best practice for implementing alcohol screening and brief intervention (SBI) in primary care. We commend the authors for that and also wish to highlight the additional challenges involved in implementing SBI in primary care among vulnerable populations, especially problem drug users. To explore the scientific evidence on implementing best practice in SBI for problem alcohol use among problem drug users, we conducted a Medline search with the following keywords: setting (primary care),target behaviour (problem alcohol use), population (problem drug users) and implementation strategies (e.g. guidelines, barriers or enablers). The majority of papers we identified concerned the general adult population and we consider this literature in conjunction with that specific to problem drug users, where relevant.

Forging a path for abstinence from heroin: a grounded theory of detoxification-seeking

McDonnell A and Van Hout MC
Grounded Theory Review, 2011; 10(1); 17–41.
www.drugsandalcohol.ie/15186

Through a classic grounded theory approach, this study conceptualises that the main concern of heroin users who are seeking detoxification is giving up heroin use, 'getting clean'. Forging a path for abstinence explains how people respond to their concern of getting clean from heroin. Three sub-processes make up this response; resolution (resolving to stop); navigation (deciding how to stop), and initiation (stopping use). These sub-processes are carried out by heroin users within a context of subjective levels of four significant personal resources; dependence knowledge; treatment awareness; treatment access, and alliance. The nature of the resource context greatly determines whether a heroin user seeks detoxification, or not, is response to getting clean. The substantive theory demonstrates that valuable insights are gained from studying heroin users' out-of-treatment experiences of trying to become drug free.

Suicide in Ireland: the influence of alcohol and unemployment

Walsh BM and Walsh D
Economic and Social Review, 2011; 42(1): 27–47
www.drugsandalcohol.ie/15042

We model the behaviour of the Irish suicide rate over the period 1968–2009 using the unemployment rate and the level of alcohol consumption as the principal explanatory variables.

We find that alcohol consumption is a significant influence on the suicide rate among younger males. Its influence on the female suicide rate is not well-established, although there is some evidence that it plays a role in the 15–24 age group. The unemployment rate is also a significant influence on the male suicide rate in the younger age groups but evidence of its influence on the female suicide rate is lacking. The behaviour of suicide rates among males aged 55 and over and females aged 25 and over is unaccounted for by our model. The findings suggest that higher alcohol consumption played a significant role in the very rapid increase in suicide mortality among young Irish males between the late 1980s and the end of the century. In the early twenty first century a combination of falling alcohol consumption and low unemployment led to a marked reduction in suicide rates. The recent rise in suicide rates may be attributed to the sharp rise in unemployment, especially among males, but it has been moderated by the continuing fall in alcohol consumption. Finally, we discuss some policy implications of our findings.

A prospective, randomized, multicenter acceptability and safety study of direct buprenorphine / naloxone induction in heroin-dependent individuals

Amass L, Pukelevidiene V, Subata E, Almeida AR, Pieri MC, D'Edgidio P *et al.*
Addiction, 2011, 12 July; Epub ahead of print.
www.drugsandalcohol.ie/15537

This study involved 187 opioid-dependent men and women ≥15 years of age in 19 sites in 10 European countries from March 2008 to December 2009. The primary objective was assessment of patient response to direct and indirect BNX induction (proportion of patients receiving the scheduled 16-mg BNX dose on day 3 [i.e. first day post-induction]). Secondary assessments included illicit drug use, treatment retention and compliance, withdrawal scale scores, and safety.

The authors concluded that direct BNX induction was a safe and effective strategy for maintenance treatment of opioid dependence. Response to high-dose direct BNX induction appears to be similar to indirect BPN-to-BNX induction and was not associated with reports of intravenous BNX misuse.

Outcome of heroin-dependent adolescents presenting for opiate substitution treatment.

Smyth BP, Fagan J and Kernan K
Journal of Substance Abuse Treatment, 2011, 20 Sep; Epub ahead of print
http://www.drugsandalcohol.ie/15964

Because the outcome of methadone and buprenorphine substitution treatment in adolescents is unclear, we completed a retrospective cohort study of 100 consecutive heroin-dependent adolescents who sought these treatments over an eight-year recruitment period. The participants' average age was 16.6 years, and 54 were female. Half of the patient group remained in treatment for over one year. Among those still in treatment at 12 months, 39% demonstrated abstinence from heroin. The final route of departure from the treatment program was via planned detox for 22%, dropout for 32%, and imprisonment for 8%. The remaining 39% were transferred elsewhere for ongoing opiate substitution treatment after a median period of 23 months of treatment. Males were more likely to exit via imprisonment (p b .05), but other outcomes were not predicted by gender. There were no deaths during treatment among these 100 patients who had a cumulative period of 129 person years at risk. Our findings suggest that this treatment delivers reductions in heroin use and that one fifth of patients will exit treatment following detox completion within a one- to two-year time frame.

Upcoming events

(Compiled by Joan Moore – jmoore@hrb.ie)

November

3–12 November 2011
Cork Drug Awareness Events
Venue: Various
Organised by / Contact: Cork City Partnership and Cork Local Drugs Task Force
Email: mmagee@partnershipcork.ie, jdaly@partnershipcork.ie
Tel: (021) 430 2310
www.corkdrugsinfo.ie

Information: Cork Drug Awareness Events aim to raise awareness and signpost information so that communities, families and professionals know where to go for assistance or information on drug and alcohol services.

This series of citywide and community-based events will run over two weeks, with free admission to all except the play *Cracking Lives* (see website for details of all events). The conference, **Benzodiazepines: An Integrated Response, on Wednesday 9 November** will highlight consumption and problematic use of benzodiazepines in Ireland, and illustrate best practice (early booking essential).

3–4 November 2011
Drug Interventions: What Works? National Drugs Conference of Ireland 2011
Venue: Radisson Blu Royal Hotel Dublin 8
Organised by / Contact: Conference Steering Group /Irish Needle Exchange Forum
Email: tim@inef.ie
http://inef.ie

Information: This year's conference will build on the success of the 2010 conference, bringing together a range of national and international speakers from across the spectrum of addiction research, service provision and policy. The conference is sponsored by the HSE's National Addiction Training Programme (NATP) which worked with the Conference Steering Group, (representatives from the Irish Needle Exchange Forum, Ana Liffey Drug Project, Coolmine Therapeutic Community and the Irish Association of Alcohol and Addiction Counsellors).

Plenary speakers:
Damon Barrett – *Human rights based approach to drug policy*

Johnny Connolly – *Understanding the drugs market*

Brian Dalton – *Stimulants and contingency management: a provider perspective*

Dr Paolo Deluca – *How the Internet and social media are driving the legal highs phenomenon: findings from the ReDNet project*

Dr Joao Goulao – *Drug policies in Portugal: was decriminalisation helpful?*

Jelena Ivanovic – *Drugs.ie - your new online community of services*

Dr Thomas McLellan – *Re-thinking substance abuse: transitioning our policies and practices*

Greg Purvis – *If you build it they will come but if you don't sustain it they will leave. Implementing and sustaining evidence- based practice*

Dr Jenny Scott – *The role of the pharmacist within a pharmacy needle exchange*

Dr Andrew Tatarsky – *Substance misuse is not just a brain disease: the personal and social meanings of substance use and the critical role of integrative harm reduction psychotherapy*

Martin Woods – *Drug killings in Mexico, money laundering in London, it's all connected.*

10–12 November 2011
The 1st International NEAR conference: (Neuroscience and Evidence based practices for Addiction Recovery)
Venue: Ritz Carlton Hotel, Powerscourt, Co Wicklow
Organised by / Contact: Toranfield House and Southworth & Associates
Email: jackie.l@toranfieldhouse.com
www.nearconference.com

Information: This is Ireland's first international conference and exhibition on behavioural health including addiction disorders. Delegates will be introduced to new concepts and ideas from international and local speakers and will leave the three-day conference with an understanding of what the latest neurobiological research illustrates about addiction and an understanding of the latest evidence-based practices associated with treatment. Alastair Campbell is our guest speaker, and he will be talking about his own behavioural health issues and how he overcame them, while working in his hugely stressful career as Tony Blair's right-hand man. Other speakers include Paddy Creedon, Anne Twohig-Wall, Dr Bobby Smyth, Ewa Woydyllo Osiatynska, Rory O'Connor, Dr Susan Campling, Dr Joe Barry, Grace Ball, Dr Colin O'Gara, Rolande Anderson and Stephen Rowen.

15 November 2011
Alcohol – Where's the Harm? Exploring the public face and hidden harm of alcohol-related crime in Ireland
Venue: Royal College of Physicians, Kildare Street, Dublin 2
Organised by / Contact: Alcohol Action Ireland
Email: info@alcoholactionireland.ie
Tel: 01 878 0610
www.alcoholireland.ie

Information: Alcohol Action Ireland's conference will examine the relationship between alcohol and 'public' crime in Ireland. It will also seek to explore 'hidden' crime – sexual violence and domestic violence. The conference is free but we would ask participants who can do so to make a donation to Alcohol Action Ireland via our website in order to help us cover our costs.

Conference will be opened by Minister of State Róisín Shortall. Confirmed speakers include:

- International research expert on alcohol-related harm Dr Ann Hope
- DIT lecturer in economics Sean Byrne, author of the HSE report on alcohol-related costs to society
- Director of the Garda Juvenile Diversion Progamme, Superintendent Colette Quinn
- HSE South Health Promotion Officer, Sandra Coughlan
- Rape Crisis Network of Ireland, Director of Advocacy, Dr Cliona Sadlier
- SAFE Ireland Director, Sharon O'Halloran

Upcoming events *(continued)*

- Christine Toft of the Alcohol Concern (UK) Embrace project

13–17 November 2011
54th ICAA Conference: The place of recovery in treatment: Strength through Diversity – An Inclusive Approach
Venue: London, England
Organised by / Contact: International Council on Alcohol and Addictions (ICAA)
Email: peterorstad@aol.com
www.icaa.ch

Information: Endorsed by the Medical Council on Alcohol and located in the British Medical Association Conference Centre, the conference will be addressed by leading international figures from the field of addictive behaviours. Topics addressed will include national and international policy, prevention programmes, findings from psychopharmacology, assessment, harm reduction, accessing services and addiction medicine.

December

1 December 2011

Growing Up in Ireland Annual Conference 2011
Venue: D4 Berkeley Hotel, Lansdowne Road
Organised by / Contact: ESRI / Claire Delaney
Tel: 01 863 2053
Email: guiconference2011@esri.ie
www.growingup.ie

Information: The third annual research conference of *Growing Up in Ireland* – the National Longitudinal Study of Children will be opened by Frances Fitzgerald TD, Minister for Children and Youth Affairs, who will launch some key findings from the recently completed Infant Cohort (at 3 years) as well as some of the first longitudinal findings from the study.

The keynote speaker is Professor Edward Melhuish, Professor of Human Development at Birkbeck, University of London, an internationally recognised expert in the study of child development and childcare and has extensive experience with longitudinal studies. A total of 24 papers will be presented by researchers from a wide range of third-level and research institutions. These will be based on data from *Growing Up in Ireland's* Child and Infant Cohorts and will focus on a range of topics including health, parenting, education and childcare.

Early booking is encouraged and bookings should only be made on the official registration form (see our website).

5–7 December 2011
The Global Addiction Conference
Venue: Universidade Catolica, Lisbon, Portugal
Organised by / Contact: Cortex Congress Ltd
Email: peterorstad@aol.com
www.globaladdiction.org

Information: Global Addiction is a new electronic portal for educational services in the area of addiction medicine. The Global Addiction Conference has grown out of the EAAT (European Association of Addiction Therapies) conferences, the last of which was in 2009. Global Addiction aims to cover all topics relating to the understanding and treatment of addictive disorders. This includes pre-clinical, neurophysiological mechanisms through diagnostic and treatment strategies to societal guidelines and health economics. This conference brings speakers from across the globe and from the whole spectrum of topic areas pertinent to addiction. The EMCDDA will participate in a session on 'Innovation and quality'. Cross fertilisation of ideas and best practice will be a fundamental part of the programme.

8–9 December 2011
European Society for Prevention Research: 2nd International Conference and Members' Meeting
Venue: Lisbon, Portugal
Organised by / Contact: EUSPR / European Monitoring Centre for Drugs and Drug Addiction
Email: barbara.zunino@oed.piemonte.it
www.euspr.org

Information: The title of this conference is 'Synergy in prevention and health promotion: individual, community, and environmental approaches'. While there is sufficient knowledge about the effects of some health education programmes and school-based interventions, our understanding of how interventions brought at the level of the environment might work is poor. In order to fill this gap, the scientific evaluation of environmental interventions, as well as of complex community interventions should become a priority. Keynote speakers will explore environmental approaches to prevention, comparing with individual and community level approaches. Also covered will be pathways to prevention, and the methodological challenges in undertaking prevention research at these different levels.

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