drugnet IRELAND
Issue 50
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Alcohol and Drug Research Newsletter

Prevalence of drug use and blood-borne viruses in Irish prisons

See pages 7-11.

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→ State laboratory analyses street-level heroin and cocaine

EWODOR international conference held in Dublin

Prof Eric Broekaert, Ghent University, Karen Biggs, Phoenix Futures, Pauline McKeown, CEO Coolmine, Minster Alex White, Rowdy Yates MBE, University of Stirling, and Natalie Kennedy, Coolmine Therapeutic Community at the EWODOR conference. (Photo: Maxwells Photography).

The European Working Group on Drugs Orientated Research (EWODOR) conference took place on 22–23 May in Trinity College Dublin, in partnership with Coolmine Therapeutic Community. This is the first time the conference has been held in Ireland. EWODOR was established in 1983 and aims to provide a forum for researchers and health professionals in the drugs area to share research experience and expertise.

Minister for State Alex White TD opened the conference, while Rowdy Yates MBE, executive director of EWODOR, set the scene for the participants around the theme of the conference, 'Gender and diversity'. There was a wide range of presentations given by 35 international experts and academics over the two days. The keynote speakers were: Ms Karen Biggs (Phoenix Futures, UK), Prof Eric Broekaert (Ghent University, Belgium), Prof Shane Butler (TCD), Dr Joanne Fenton (HSE), Mr Ted Fleming (NUI Maynooth), Dr Ilse Goethals (University College Ghent, Belgium), Ms Di Hilton (Phoenix Futures, UK), Dr Paula Mayock (TCD), Ms Mary Moore (Irish Probation Service), Ms Pauline McKeown (Coolmine Therapeutic Community), Ms Romy Paust (Coolmine Therapeutic Community), Dr Steve Pearce (NHS, UK), Ms Kathleen Yates (NHS, UK) and Mr Rowdy Yates MBE (University of Stirling, UK).

A number of the delegates also gave presentations. Paula Mayock (TCD) spoke about her study on young women and their initiation into heroin use. Anne Marie Carew (HRB) and Kat Bahramian (Pavee Point) gave a joint presentation on Travellers in drug treatment. Anita Harris (Coolmine Therapeutic Community) presented the findings of the 'Parenting under Pressure' (PUP), the first to be run in Ireland. Di Hilton (Phoenix Futures, UK) spoke about her experiences of prison-based therapeutic communities in the UK.

The email and discussion list for EWODOR can be found at www.jiscmail.ac.uk/cgi-bin/webadmin?A0=EWODOR

(Suzi Lyons)

HRB Health Research Board
Improving people's health through research and information

Health Research Board moves office

The Health Research Board has moved to new offices. The new building is on the same street as our previous offices in Knockmaun House. The National Documentation on Drug Use is located on the ground floor of the new building. Our new address is:

Health Research Board
Grattan House
67-72 Lower Mount Street
Dublin 2

Phone numbers, email addresses and other contact details have not been changed.

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UN can't agree on abolition of death penalty for drug offences

Ministers and government representatives attending the high-level segment of the 57th Session of the UN Commission on Narcotic Drugs (CND), held in Vienna on 13–14 March 2014, agreed a Joint Ministerial Statement (E/CN.7/2014/L.15). The contents are outlined in 'Towards UNGASS 2016' elsewhere in this issue of *Drugnet Ireland*.

In its report on the debate and round-table discussions leading to the formulation of the joint ministerial statement (E/CN.7/2014/16: Chapter II), the CND reported that Greece made a statement on the death penalty, speaking on behalf of the EU and its member states (including Ireland) and 29 other countries. The representative stated that those he spoke for 'deeply regretted that the Joint Ministerial Statement did not include language on the death penalty, that they had a strong and unequivocal opposition to the death penalty, in all circumstances, and that they considered that the death penalty undermined human dignity and that errors in its application were irreversible'.

UN and death penalty for drug offences *(continued)*

The Greek representative went on to state that imposing the death penalty for drug offences was against the norms of international law, specifically article 6, paragraph 2, of the International Covenant on Civil and Political Rights. He also noted the UN General Assembly resolution, supported by an unprecedented number of member states and adopted in 2012, calling for a moratorium on the use of the death penalty. He welcomed the recent decision by the International Narcotics Control Board (INCB) to call on countries still applying the death penalty to consider its abolition for drug-related offences.

The statement by the Greek representative was supported by the representative for Switzerland. Speaking on behalf also of Norway and Liechtenstein, the Swiss representative said that the fight against the death penalty was an integral part of their human rights policies. He stated that the silence of the Joint Ministerial Statement on the death penalty was regrettable and that the Statement did not therefore reflect their concern about the death penalty or take into account the position expressed on the subject by other entities within the UN system, i.e. the General Assembly, the Human Rights Committee, the UN Secretary-General, the Executive Director of the UN Office on Drugs and Crime (UNODC) and the INCB. He requested that the report of the Session reflect that these countries' agreement to the adoption of the Joint Ministerial Statement was given on the understanding that capital punishment was not compatible with the commitment to ensuring that the drug problem was addressed with full respect for all human rights and the inherent dignity of all individuals.

The representative of the Islamic Republic of Iran, speaking also on behalf of 16 other countries, stated that the issue of the death penalty was not in the mandate of the CND. He argued that there is no international consensus on the abolition of the death penalty, that the death penalty is not prohibited under international law, including the three drug control conventions, and that the decision to use it or not is a criminal justice matter to be decided by the competent authorities in individual states. He concluded by stating that the death penalty is an important component of the system of the administration of law and justice and that it is imposed only for the most serious crimes, including drug trafficking, and that it serves as a deterrent. He noted that Iran has proper legal safeguards in place that took into account national policies and prevented any miscarriage of justice.

(Brigid Pike)

UN body passes drug resolutions

The Commission on Narcotic Drugs (CND), the UN's drug policy-making body, met in Vienna between 13 and 21 March 2014 for its 57th Session. For the first two days Ministers and representatives of member state governments undertook a high-level review of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem. The conclusions of this review are described in 'Towards UNGASS 2016' elsewhere in this issue of *Drugnet Ireland*.

In the second week of the session the CND passed 11 resolutions. They included the following:

Drug abuse prevention through sport: promoting a society free of drug abuse through sport and the Olympic ideal (E/CN.7/2014/L.4/Rev.1)

Member states and sporting organisations are encouraged to use sporting events as a platform for promoting social inclusion and to promote equal access to sports as a means of drug prevention.

Promoting prevention of drug abuse based on scientific evidence as an investment in the well-being of children, adolescents, youth, families and communities (E/CN.7/2014/L.8/Rev.1)

Member states are invited to expand the coverage and quality of drug abuse prevention systems, interventions, including information dissemination and periodic evaluations.

Supporting recovery from substance use disorders (E/CN.7/2014/L.9/Rev.1)

Member states are invited to:

- improve understanding of the importance of supporting sustained recovery;
- provide measures to ensure non-stigmatising attitudes to those seeking help or in recovery, to help reduce marginalisation and discrimination, and to promote social reintegration;
- consider providing appropriate treatment and support to meet individual needs through the recovery process;
- gather scientific evidence on recovery and recovery-oriented programmes;
- facilitate exchanges on developing a chronic-care approach to the treatment of substance use disorders similar to approaches for other chronic conditions ; and
- support and sustain recovery programmes in schools, universities, workplaces, communities and other domains.

Enhancing international cooperation in the identification and reporting of new psychoactive substances and incidents involving such substances (E/CN.7/2014/L.11/Rev.1)

Member states are urged to use and follow the scheduling processes of the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances , including providing the World Health Organization with timely information and identifying a national government focal point to coordinate information provision on substances for effective review by the Expert Committee on Drug Dependence. Member states are also encouraged to consider the provisional application of control measures as established under the 1961 and 1971 conventions to strengthen

UN body passes drug resolutions *(continued)*

domestic regulatory controls, particularly regarding new psychoactive substances, while ensuring their availability for medical, scientific and industrial purposes.

Education and training on drug use disorders (E/CN.7/2014/L.13/Rev.1)

Member states are invited to strengthen professional knowledge and skills for those working with people affected by substance use disorders. The resolution highlights the need to strengthen the capacity of competent and experienced trainers; to ensure that training programmes adopt a multi-disciplinary approach, drawing on areas such as medicine, psychology, education and the social sciences; and to strengthen intersectoral collaboration involving health and law enforcement professionals.

Providing sufficient health services to individuals affected by substance use disorders during long-term and sustained economic downturns (E/CN.7/2014/L.14/Rev.1)

Member states are encouraged to ensure that measures taken at the national and local level in response to long-term and sustained economic downturns do not disproportionately affect the implementation of comprehensive and balanced national drug demand and supply reduction policies. They are also invited to continue providing the best attainable coverage, accessibility and quality with regard to health and social care services to all people who are or may be affected by substance use disorders.

(Compiled by Brigid Pike)

The Mentor Foundation is the only NGO working on a global basis to prevent drug misuse and promote health and well-being among children and young people.

During the opening Queen Sylvia of Sweden, as patron of the Mentor Foundation, urged governments all over the world to reduce the availability of drugs in order to protect children's lives in accordance with their recognised rights, and to remember that 'we cannot afford to lose our children'.

Regional drug strategies across the world

In March 2014 the EMCDDA released a 'paper' giving a comparative analysis of regional drug strategies across the world.[1] The paper explores the drug strategies and action plans adopted over the last five years by six intergovernmental organisations, involving 148 countries in four continents. The purpose of the EMCDDA paper is to inform decision-makers, professionals and researchers working on international drug policy about the way in which countries in the same region have decided to strategically approach drug-related security, social and health problems.

Intergovernmental organisations that have adopted regional drug strategies and actions plans

1. African Union (AU)
2. Economic Community of West African States (ECOWAS)
3. Organization of American States (OAS)
4. Association of Southeast Asian Nations (ASEAN)
5. Shanghai Cooperation Organisation (SCO)
6. European Union (EU)

Drug policy principles

The EMCDDA paper analyses the main principles, objectives and approaches adopted in the various intergovernmental drug strategies. The analysis highlights five key principles adopted to varying degrees in the different regions:

- Respect for human rights in implementing drug policy is prominent in the EU, OAS and AU strategies. The EU's drug strategy explicitly mentions the European Charter of Fundamental Rights while that of the OAS refers to the Universal Declaration of Human Rights. The strategies and plans of the ECOWAS, ASEAN and SCO organisations place particular emphasis on the individual's right to safety and security and the threat that drug use and trafficking pose to these rights.
- Common and shared responsibility for drug policy, i.e. aiming to reconcile the goals and aspirations of producing and consuming countries, is strong in the OAS document and is mentioned in both African documents and in the EU strategy.
- The reduction of poverty and fostering development are central to both African strategies.
- Effective law enforcement as the *sine qua non* of peace, security and stability is highlighted in both Asian strategies.

Policy approaches

The approach of the strategies and plans is similar, focusing on reducing the drugs phenomenon and organising activities around supply reduction and demand reduction pillars. The EMCDDA paper reports that there is more diversity in approaches to demand reduction than in those to supply reduction, which are relatively uniform.

- *Supply* reduction approaches adopt a common paradigm of doing 'more and better'. More collaboration among national law enforcement services, more intelligence-led activities and more exchange of data and intelligence are among the measures most often mentioned. The intention to monitor law enforcement and supply reduction activities and their results is seen as 'an interesting innovation'.
- *Preventing* drug use is mentioned in all the strategies, but the measures described to achieve this goal are diverse, ranging from mass media campaigns to interventions tailor-made to address specific risk factors or populations.

Regional drug strategies *(continued)*

- *Treatment* – most strategies call for evidence-based practice. All set the goal of drug treatment in the same broad terms – to treat addiction and promote social reintegration. Recovery from addiction and full reintegration and resocialisation of drug addicts into society is the objective most often mentioned. Some strategies focus on improving the effectiveness of treatments through better access, wider coverage and better quality.
- *Reducing harm* (and risk) caused by drugs is specifically addressed only in the EU strategy. It is referred to in the OAS strategy, albeit with different wording – a reduction of the adverse consequences of drug abuse.
- *Evaluation* – the drugs strategy of the OAS is said to stand out because it promotes evaluation and assessment in all areas: 'The document suggests integrating the scientific community into the design, implementation and evaluation of policies, and invites member countries to promote periodic and independent evaluations in the areas of demand and supply reduction, linking the results of evaluation to the allocation of resources.'

Regional policy issues

The EMCDDA paper suggests that regional drug strategies introduce a third political dimension, located between national plans, which aim to address purely national or local issues, and policy declarations at the UN level, which represent a very broad consensus. The paper highlights 'specificities' that do not emerge in the UN context and which are too varied to be analysed at national level:

- All regions express overall support for international drug control principles.
- Drugs strategies are part of a wider regional integration process, often of an economic nature.
- Regional drugs strategies help to foster a unified regional vision on drugs.
- Accountability and obligations imposed on members of the regional associations because of the common drugs strategy are largely of a political, rather than a legal or binding, nature.
- The development of regional drugs strategies has helped to rebalance drugs policy, favouring a more health-oriented approach.
- Regional strategies put a strong emphasis on monitoring systems to collect data, analyse trends and support decision-making towards evidence-based policies.

Although it is too soon to say how these regional policies will influence international drug control policy, the authors of the EMCDDA paper suggest that they represent an interesting policy development within the international drugs policy scene, and are 'well worth a look'.

(Brigid Pike)

1. European Monitoring Centre for Drugs and Drug Addiction (2014) *Regional strategies across the world: a comparative analysis of intergovernmental policies and approaches.* EMCDDA Papers. Luxembourg: Publications Office of the European Union. www.drugsandalcohol.ie/21543/

Towards UNGASS 2016

Ministers and government representatives attending the high-level segment of the 57th Session of the UN Commission on Narcotic Drugs, held in Vienna on 13–14 March 2014, agreed a Joint Ministerial Statement (E/CN.7/2014/L.15). This statement contains the participants' conclusions with regard to progress in implementing the Political Declaration and Action Plan on the world drug problem, agreed in 2009. It will inform the preparations for and deliberations at the UN General Assembly Special Session (UNGASS) on the world drug problem in two years' time.

Excerpts from the draft statement, and summaries of certain sections, are presented below. (The numbered paragraphs below relate to the paragraph numbers in the draft Statement. The Statement contains 78 paragraphs in total.)

Preamble

2. The UN Conventions 'constitute the cornerstone of the international drug control system'.
3. 'Commitment to achieving the targets and goals, and implementing the provisions, set out in the Political Declaration and Action Plan [on the world drug problem, agreed in 2009], is reaffirmed.
6. The drug problem continues to pose a serious threat to the health, safety and well-being of all humanity, in particular youth – 15 years after the commitments made at the last UNGASS on the world drug problem to a drug-free world.
8. Member states reaffirm their 'determination to tackle the world drug problem and to actively promote a society free of drug abuse in order to ensure that all people can live in health, dignity and peace, with security and prosperity.'
11. In light of discussions in some regions on how to address the world drug problem, member states emphasise the importance of 'a broad, transparent, inclusive and scientific evidence-based discussion'.
15. The role of civil society in addressing the world drug problem merits special mention. Member states note its 'important contribution to the review process' and that representatives of affected populations and civil society entities 'should be enabled to play a participatory role in the formulation and implementation of drug demand and supply reduction policy'.

Towards UNGASS 2016 *(continued)*

General achievements, challenges and priorities for action

17 & 19. The global illicit supply of and demand for narcotic drugs and psychotropic substances under international control has remained 'largely stable during the past five years'. There is now a better understanding of the problem, more widespread development and use of national strategies, updating of legal frameworks, and the creation and strengthening of capacities within law enforcement and health institutions.

23. The world drug problem 'should continue to be addressed in a comprehensive, integrated and balanced manner, in full conformity with the three drug control conventions ... as well as all human rights, fundamental freedoms and the inherent dignity of all individuals'.

25–29. Member states specifically note the need for strengthening the partnerships between public health, justice and law enforcement sectors, a better understanding of the social and economic drivers of the world drug problem, the emerging challenge of polydrug 'abuse' in some regions, the serious and evolving challenge that amphetamine-type stimulants continue to pose for international drug control efforts, and the danger that economic and financial constraints may disproportionately impact on drug policies, in particular 'adequate provisions of related health measures'.

A. Demand reduction – achievements, challenges and priorities for action

1 & 3. Member states recognise that 'drug addiction is a health problem'. They also note that various member states have implemented comprehensive drug demand reduction programmes and 'a broad range of alternatives to conviction and punishment in appropriate drug-related cases of a minor nature or in cases in which the person who abuses drugs has committed an offence as outlined in the relevant provisions of the international drug control conventions'.

6–13. Member states need to increase focus, in conformity with the three international drug control conventions, on:

- drug-related health effects, taking into account the specific challenges faced by vulnerable groups such as children, adolescents, vulnerable youth, women, including pregnant women, people with medical and psychiatric comorbidities, ethnic minorities and socially marginalised individuals;
- formulating and implementing a broad system of primary prevention and early intervention;
- strengthening public health systems, particularly in the areas of prevention, treatment and rehabilitation;
- developing or strengthening national monitoring mechanisms that collect and analyse data on current trends in demand, including possible gaps in the provision of appropriate public health, educational and social services;
- ensuring access for all to comprehensive drug demand reduction measures, taking into account the specific needs of women and children;
- reducing the transmission of HIV among injecting drug users by 50% by 2015;
- implementing measures aimed at minimising the negative public health and social impacts of drug 'abuse';
- deepening knowledge of the challenges posed by new psychoactive substances (NPS) and developing comprehensive and integrated approaches to the detection, analysis and identification of NPS, trends and possible negative health and other impacts.

B. Supply reduction – achievements, challenges and priorities for action

15. 17. & 20. Progress was noted with respect to measures related to the illicit production and supply of narcotic drugs and psychotropic substances, including the exchange of information and best practices, regional and international coordination, capacity building, cross-border operations and maritime control. Progress was also noted in the development of a consolidated international response to the increasing availability of NPS that may pose risks to public health and safety, including the development of a global reference point, the Early Warning Advisory and cooperation in the identification and reporting of such substances, in order to increase data collection, improve collective understanding and find effective policy responses.

22. Law enforcement measures alone cannot address the challenges.

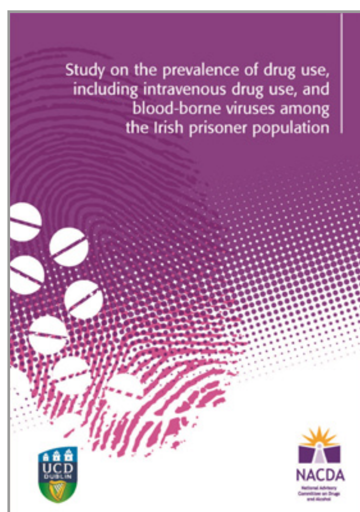
23. There is a need to 'scientifically evaluate, where appropriate, drug supply reduction measures, in order to direct government resources to initiatives that have proved to be successful.'

24–25. There is an urgent need to respond to the serious challenges posed by the increasing links between drug trafficking and corruption, organised crime, terrorism and money-laundering. 'The effective application of and respect for the rule of law contributes to combating the world drug problem and facilitates efforts to hold drug traffickers and perpetrators of related crimes accountable for their actions.'

28–32. Specific supply reduction challenges include new psychoactive substances; synthetic opioid analgesics not under international control, in particular tramadol; precursor chemicals; and the illicit cultivation of opium poppy, coca bush and cannabis plant and illicit drug production, manufacture, distribution and trafficking.

(Compiled by Brigid Pike)

Prevalence of drug use and blood-borne viruses in Irish prisons, 2011



Background

The National Advisory Committee on Drugs and Alcohol (NACDA) has published the results of a survey estimating the extent of drug use and the prevalence of blood-borne viruses among the prison population in Ireland.[1] The survey questionnaire was completed by a random sample of prisoners between February and April 2011. Oral fluid samples were obtained to assess use of specific drugs (cannabinoids, opiates, methadone, cocaine and benzodiazepines) in the 24 to 72 hours preceding the survey and to detect the presence of hepatitis B, hepatitis C and HIV infections. Flexibility was required in different prisons to accommodate prison schedules, security arrangements and prisoner availability.

Of the 1,666 randomly selected prisoners, 824 took part in the study, giving a response rate of 49.5%, which is much lower than that achieved in previous Irish prison studies[2-4] and lower than that required for a robust prevalence estimate. Completed questionnaires and oral fluid analysis were available for 46% (771/1,666) of invited participants. Of the 886 prisoners who attended the information session, 7% (62) declined to participate in the study. Field workers reported that reasons given by 47% (780) of prisoners for not attending the information session included unavailability, attendance at the gym, school or workshop, mistrust, suspicion, cynicism, apathy, and concerns regarding mandatory drug testing and DNA sample collecting.

Most respondents were male (95%) and Irish (92%). The average age was 31 years, and 50% were aged 28 years or under. Almost one-in-four respondents (23%, 186) received no schooling or primary education only compared to one-in-five of the general population in Ireland and only 13% (105) reported having some third-level or completed third-level education compared to 31% in the general population. Sixty per cent (483) had been in custody for more than one year, and 52% (419) had spent more than three of the past ten years in prison. More than one in ten had been homeless for more than seven days in the year before the survey. More women (46%) than men (22%) reported that they had been homeless in the 12 months prior to the survey.

This article summarises four key areas addressed in the report:

- prevalence of drug use among prisoners;
- prevalence of injecting drug use;
- prevalence of blood-borne viral infection; and
- prison drug treatment and harm-reduction services.

Prevalence of drug use

Lifetime prevalence (ever used)

The drugs most commonly used among the prison population were cannabis (87%), cocaine powder (74%) and benzodiazepines (68%) (Table 1). There was no difference between men's and women's lifetime use of cannabis, cocaine or benzodiazepines (Tables 2–5). Lifetime heroin use was high at 43% (Table 4). Women were significantly more likely than men to use heroin (64%), methadone (60%) and crack cocaine (59%) at some point in their life (Tables 2–5). It is important to note that some of the methadone and benzodiazepine use was prescribed, and most of the illicit drug use occurred outside the prison environment.

Last-year prevalence (recent use)

Cannabis, at 69%, was the drug most commonly used in the year prior to the survey, followed by benzodiazepines, at 55% (Table 1). The 25–34-year-olds were significantly more likely to have used heroin (36%) compared to the older (20%) or younger (30%) age groups (Table 4). Of those who had used a drug in the last year, a majority in each case had used the drug while in prison: 88% had used cannabis; 85% benzodiazepines; 87% other sedatives or tranquillisers; 87% methadone; 84% heroin; 66% other opiates; and 52% crack cocaine.

Table 1 Prevalence of drug use among Irish prisoners, inside or outside prison, 2011

	Cannabis	Cocaine powder	Crack cocaine	Heroin	Methadone	Benzodiazepines	Other sedatives or tranquilisers
Lifetime use (ever used)	708 (86.9%)	600 (74.2%)	284 (35.6%)	348 (43.3%)	262 (32.6%)	547 (67.8%)	466 (58.2%)
Last-year (recent) use	554 (68.6%)	226 (28.6%)	92 (11.7%)	233 (29.5%)	167 (20.9%)	434 (54.6%)	367 (46.3%)
Last-month (current) use	349 (43.4%)	41 (5.3%)	15 (1.9%)	87 (11.1%)	106 (13.3%)	229 (29.0%)	367 (46.3%)
Past 24–72 hour use	31 (4.0%)	Not available	Not available	2* (0.3%)	103 (13.3%)	83 (10.7%)	Not available

*Opiates

Prevalence of drug use in prisons *(continued)*

Table 2 Prevalence of cannabis use among Irish prisoners, inside or outside prison, by age and gender, 2011

Cannabis use	All	Male	Female	18–24 years	25–34 years	35–64 years
Lifetime use (ever used)	708 (86.9%)	670 (87.0%)	38 (84.4%)	241 (94.9%)	297 (92.5%)	162 (70.4%)
Last-year (recent) use	554 (68.6%)	523 (68.6%)	31 (68.9%)	210 (84.0%)	231 (72.6%)	105 (45.7%)
Last-month (current) use	349 (43.4%)	332 (43.7%)	17 (38.6%)	128 (51.2%)	148 (46.8%)	67 (29.4%)
Past 24–72 hour use	31 (4.0%)	31 (4.2%)	0	9 (3.8%)	14 (4.5%)	8 (3.8%)

Last-month prevalence (current use)

Cannabis (43%) was the drug most commonly used in the past month, followed by benzodiazepines (29%). One-hundred-and-three prisoners (13%) tested positive for methadone in the 24 to 72 hours prior to the survey and 106 reported being prescribed methadone daily in the last month. Eighteen per cent of those who tested positive for methadone were in the 25–34-year age group. Women were significantly more likely to test positive for methadone than men (33% vs 12%).

Use in previous 24–72 hours

Oral fluid sample testing for drug use in the previous 24–72 hours found that proportionally more women than men were on daily methadone maintenance. Four per cent (31), all men, had used cannabis in the 24–72 hours before the survey, and 11% (83) had used benzodiazepines. Women (20%) were two times more likely to test positive for benzodiazepine use than men (10%).

Methods of heroin use

Two-hundred-and-twenty-six prisoners said they were 'doing heroin now'. Seventy-five per cent of current heroin users reported smoking (or chasing the dragon) as their only method of choice, with 13% reporting injecting and 1% snorting as their only method. Only a very small proportion (1.3%) currently used all three methods of administration. The proportion of those who smoked and snorted was 1.3%, whereas 9% both smoked and injected.

Prescription drug use in prison

High usage of benzodiazepines and other sedatives and tranquillisers, and of methadone and other opiates was reported by participants. The vast majority (85%) of prisoners who reported taking methadone in prison in the month prior to the survey had taken it on prescription. A minority of prisoners had taken benzodiazepines (14%) and other sedatives (22%) under medical supervision (or on prescription). A large proportion reported having taken unprescribed benzodiazepines in prison in the previous month.

Lifetime prevalence (ever injected)

Over 26% reported having ever injected drugs, with women (44%) more likely to have a lifetime history of injecting drug use than men (24%). Thirty-four per cent of the 25–34-year age group were more likely to have injected than their older (22%) or younger counterparts (18%). The most common drug injected was heroin (19%), followed by cocaine powder (13%). Women were more likely than men to have injected heroin (43% vs 18%), cocaine powder (32% vs 12%), mephedrone (16% vs 4%), methylone (11% vs 2%) and any other drug (14% vs 4%).

Last-year prevalence (recent injectors)

The most commonly injected drug in the last year was heroin (7%), followed by cocaine powder (3%), benzodiazepine (3%) and steroids (2%). More women than men had injected heroin (21% vs 6%), cocaine powder (14% vs 3%), mephedrone (13% vs 2%), methylone (7% vs 1%), amphetamines (7% vs 1%) and benzodiazepines (11% vs 2%), with no significant differences across age groups.

Last-month prevalence (current injectors)

The numbers reporting injecting in the last month were low (1 to 8 people injecting each drug). Cocaine powder was injected by eight respondents (1%), heroin by seven (0.9%), benzodiazepines by four (0.5%) and steroids by four (0.5%).

Age at first use of drugs

Fifty per cent of cannabis users had used it by their 14th birthday. Half of all benzodiazepines users had used it by their 17th birthday. The median age for first use of cocaine powder was 18 years, and for heroin 19 years. Among heroin injectors, the average length of time between moving from smoking to injecting heroin was 2.8 years. The median age for commencing injecting head shop drugs such as methylone and mephedrone was 24 years, and for steroid injecting 22 years.

First use and first injection

Of those who reported having ever used heroin (smoking or injecting), 146 (43%) said they had taken it for the first

Table 3 Prevalence of cocaine use among Irish prisoners, inside or outside prison, by age and gender, 2011

Cocaine use	All	Male	Female	18–24 years	25–34 years	35–64 years
Lifetime use (ever used)	600 (74.2%)	571 (74.6%)	29 (65.9%)	210 (83.7%)	262 (81.9%)	121 (53.1%)
Last-year (recent) use	226 (28.6%)	208 (27.8%)	18 (41.9%)	96 (38.9%)	101 (32.3%)	26 (11.8%)
Last-month (current) use	41 (5.3%)	40 (5.4%)	1 (2.4%)	11 (4.6%)	19 (6.1%)	10 (4.6%)
Past 24–72 hour use	1	1	Not available	Not available	1	Not available

Prevalence of drug use in prisons *(continued)*

Table 4 Prevalence of heroin use among Irish prisoners, inside or outside prison, by age and gender, 2011

Heroin use	All	Male	Female	18–24 years	25–34 years	35–64 years
Lifetime use (ever used)	348 (43.3%)	319 (42.1%)	29 (64.4%)	94 (37.8%)	159 (50.2%)	90 (39.7%)
Last-year (recent) use	233 (29.5%)	212 (28.4%)	21 (46.7%)	74 (29.7%)	112 (36.0%)	45 (20.4%)
Last-month (current) use	87 (11.1%)	81 (11.0%)	6 (13.3%)	27 (10.9%)	40 (12.9%)	19 (8.8%)
Past 24–72 hour use	2* (0.3%)	2* (0.3%)	0	0	1* (0.3%)	0

*Opiates

time in prison and these were more likely to be men (46%) than women (17%). Twenty-one per cent of women and 6% of men (8% overall) who had ever injected heroin reported having injected it for the first time in prison. Of the 69 who had started injecting in prison, 16 (24%) injected steroids while 12 injected heroin.

Of injectors who had injected in the past year, 13 of the 19 recent steroid injectors had injected in prison, 9 of 56 recent heroin injectors had done likewise, as had 7 of 23 recent benzodiazepine injectors and 7 of 25 recent cocaine injectors.

Prevalence of blood-borne viral infection

Risk factors for viral infection reported by prisoners were:

- Sharing injecting paraphernalia: Of those who reported having ever injected drugs and answered the questions on sharing equipment, 48.8% (84/172) shared needles, 49% (81/165) syringes and 52% (84/162) other injecting equipment. A greater proportion of females (78%) reported sharing needles and syringes compared to males (46%).
- Sexual behaviour: Self-reported rates of unprotected sex (having sex without a condom) were high both while in prison (62%) and outside prison (51%). Less than 2% of men reported that they had ever had sex with other men (1.5% outside prison and 0.9% in prison).
- Tattooing: More than two-thirds (68%) of participants had borstal or tattoo markings, and 35% had had a tattoo done in prison.

Hepatitis C prevalence: oral fluid test

The overall prevalence of hepatitis C was 12.9% among the prisoners tested, and 41.5% (83/200) among those who were injecting drug users (Figure 1). Prevalence of hepatitis C varied with the type of drug injected; the proportion of positive hepatitis C tests among different injector types were: 54% (80/149) of heroin injectors tested positive for hepatitis C, 66% (66/100) of cocaine injectors, and 62% (42/68) of benzodiazepine injectors, and 27% (14/66) of steroid injectors (Figure 2). It is important to note that National Drug Treatment Reporting System data indicates that there is likely to be significant overlap between heroin, cocaine and benzodiazepine injectors. The prevalence rate in the Irish population has been estimated at 0.5–1.2%[5] – much lower than the rate experienced by either prisoners or injecting drug users.

A previous study reported a prevalence rate for hepatitis C of 37% among prisoners and 81% among injectors; however, these were mainly heroin injectors.[2]

The concordance analysis revealed that 21 (9%) of those who thought they were negative had a positive test result and three (1%) of those who reported being positive had a negative test result.

Multivariate analysis indicated that five factors were associated with hepatitis C infection: being female, being over 25 years old, having a history of injecting drug use, sharing injecting equipment and having had tattoos done in prison.

Hepatitis B prevalence: oral fluid test

The prevalence of hepatitis B was 0.3% among the prisoners tested. The prevalence of hepatitis B in the general population in Ireland is low (< 1%).[6]

A previous prison study found prevalence rates for hepatitis B of 9% among prisoners and 18.5% among injectors in prison.[2] The introduction of blood-borne viral testing and hepatitis B vaccination in the Irish Prison Service in 1995 accounts for the reduction of hepatitis B infection among drug users in prison.

The concordance analysis indicated that eight people (3%) think they have a disease that they do not have and one person (0.4%) has a disease that he does not know he has and may not be taking the necessary precautions to prevent spread of infection to others.

Table 5 Prevalence of benzodiazepine use among Irish prisoners, inside or outside prison, by age and gender, 2011

Benzodiazepine use	All	Male	Female	18–24 years	25–34 years	35–64 years
Lifetime use (ever used)	547 (67.8%)	516 (67.7%)	31 (68.9%)	203 (80.2%)	229 (71.8%)	109 (48.4%)
Last-year (recent) use	434 (54.6%)	406 (54.1%)	28 (62.2%)	174 (69.3%)	188 (59.9%)	68 (30.9%)
Last-month (current) use	229 (29.0%)	211 (28.3%)	18 (40.0%)	79 (31.5%)	106 (34.0%)	43 (19.7%)
Past 24–72 hour use	83 (10.7%)	74 (10.1%)	9 (20.0%)	25 (10.4%)	40 (12.9%)	18 (8.5%)

Prevalence of drug use in prisons *(continued)*

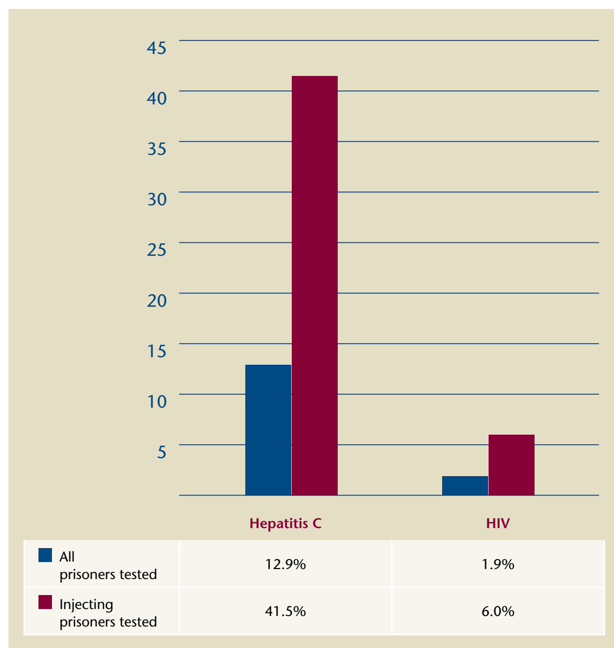


Figure 1 Prevalence of hepatitis C and HIV among prisoners tested

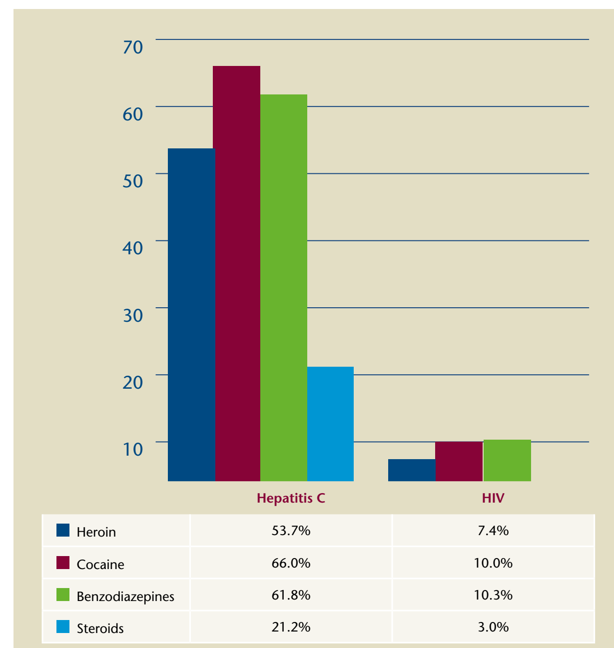


Figure 2 Prevalence of hepatitis C and HIV in injecting drug user prisoners tested, by type of drug injected

HIV prevalence: oral fluid test

Fifteen participants tested positive for HIV, resulting in a prevalence of 1.9% among prisoners and 6.0% among injecting drug users in prison (Figure 1). Figure 2 presents the prevalence of HIV among injecting drug users by type of drug injected and demonstrates that the prevalence of HIV is between 7% and 10% among hard drug users. The Irish population prevalence is estimated to be 0.2% (15–49-year- olds).[7]

In a previous Irish prison study, prevalence of HIV was 2% among all prisoners and 3.5% among injectors.[2]

The concordance analysis revealed three (1.4%) people who thought they were negative were positive and one (0.4%) prisoner who thought he was positive was negative.

While the numbers who tested positive for HIV were small (15/657), four factors were found to be associated with HIV infection: being female, having a history of injecting drug use, sharing injecting equipment, and male-to-male sexual contact.

Steroid injectors

Of note, there were 69 self-reported steroid injectors, of whom 16 had started to inject in prison and 13 had injected in prison in the last year. Fourteen steroid injectors tested positive for hepatitis C and two for HIV. This study identifies a new cohort of injecting drug users and hepatitis C infection.

Co infection: oral fluid test

Fourteen per cent (106/777) of prisoners had serological evidence for blood-borne virus infection. No prisoner tested positive for all three viruses, and there was no co-infection with hepatitis B and HIV. However, 10 participants (1.3%) were found to be co-infected with hepatitis C and HIV. One (0.1%) was co-infected with hepatitis B and hepatitis C. The one factor identified as being significantly associated with co-infection was ever having shared injecting drug equipment.

Prison drug treatment and harm-reduction services

Participants were asked if they ever needed different types of drug treatment or harm reduction services while in prison. They were also asked whether those services were available to them (within a reasonable time frame) and, if available, whether they used those services. The different types of service were analysed by overall prison population, then by prison drug use category (see box) and by injecting drug use. Some of the main results are summarised below.

Overall treatment needs

The greatest proportion of respondents expressed a need for addiction counselling in prison (44%), while the smallest proportion expressed a need for alcohol detoxification (14%). Nineteen per cent of participants expressed a need for benzodiazepine detoxification, and the same proportion expressed a need for opiate detoxification.

The availability of specific drug treatments varied among participants who expressed a need for them. It ranged from low (22% for benzodiazepine detoxification) to high (73% for methadone maintenance treatment).

Overall, a high proportion of participants who needed a drug treatment service, and for whom it was available in prison, used the service, ranging from 95% for methadone maintenance to 78% for alcohol detoxification. The authors note that availability also varied across prisons (see below).

Need by prison drug use category

The need for services varied by prison drug use category. As might be expected, the expressed need was highest in the 'very high' drug use category prisons. The highest need in all prison categories was for addiction counselling, ranging from 56% in the 'very high' drug use category to 38% in the 'low' drug use category. The need for a more specific intervention, methadone maintenance treatment (MMT), ranged from 6% in the 'low' drug use category to 46% in the 'very high' drug use category.

Prevalence of drug use in prisons *(continued)*

Prison drug use category

The authors used a post-hoc hierarchical clustering model to categorise prisons based on prisoners' self-reported use in the previous 12 months of the six drugs included in the EMCDDA 'problem drug use' definition.

By this method they identified four prison clusters based on levels of drug use, which they categorised as 'low', 'medium', 'high' and 'very high'.

(For detailed description of the method used, see pp. 38–41 of the report.)

An analysis of the reported availability of services (among those who needed them) by prison drug use category was also done. This showed a wide range of availability across categories. For example, in 'very high' drug use prisons 88% reported that MMT was available, compared to 49% in 'medium' drug use prisons. In the 'very high' drug use prisons, availability of drug-free wings or landings (28%) or drug-free programmes (32%) was reported as low. Where these services were available there was high uptake, particularly in the 'high' and 'very high' drug use category prisons.

A sub-group of participants comprising those who had ever injected (IDUs) was analysed by prison drug use category. The expressed need for services was higher across all categories of prison drug use. The need was particularly high for addiction counselling (ranging from 62% to 82%) and drug-free treatment programme (ranging from 53% to 74%). The authors state that the results for the availability of services and high uptake of services for this group were similar to those in the general prison population as reported above.

Overdose history

While over a quarter (27%) of all prisoners reported ever overdosing, the proportion among injecting drug users was much higher (58%). There were significant differences between genders, as women were more likely than men to report a history of overdose (44% compared to 26%). This difference was even more apparent for injecting drug users (80% compared to 55%). There were no significant differences between the age groups.

Almost a quarter (24%) of participants reported the need for information on overdose prevention, but only a quarter (25%) of those reported that it was available. However, where the information was available, almost all (88%) were able to access it.

As might be expected, the expressed need for this information was highest in the 'very high' drug use prison category (33%) and lowest in the 'low' use category (17%). In spite of the high number who reported ever overdosing, participants reported limited availability of this information for those who needed it in the 'high' (27%) and 'very high' (25%) category prisons. However, where this information was available, there was very good uptake, ranging from 75% in the 'low' use category to 100% in the 'very high' use category prisons.

Key messages

The authors conclude that prisoner populations reflect a profile of social disadvantage and the verified reported rates for drug use[8] and blood-borne viral infections are much higher than those in the general population.[5-7] A considerable proportion of all prisoners reported ever overdosing, the proportion among injecting drug users was much higher. Where drug treatment is available, its uptake is very high.

Recommendations for drug treatment

- Prisoners on methadone treatment should be placed on an HSE clinic list or GP list to ensure that there is continuity of treatment on release from prison. This would reduce the risk of overdose and early relapse.[9]
- If a prisoner is engaging with counselling, where possible there should be continuity of this treatment on release in order to support transition out of prison and into the community.[9]
- A full range of drug treatment, encompassing an integrated clinical and psychological approach, should be available in all closed prisons.[9]
- There is a need for drug-free wings and drug-free areas not only for prisoners who do not use drugs but for those who wish to prevent relapse.[9]
- As the women's prison was included in the 'very high drug use' category of prison, it is recommended that there be a specific strategy for the needs of women in order to improve their outcomes.[9]

Recommendation for overdose

- There is a need for a health promotion strategy in the prisons to include overdose prevention.

(Carrie Garavan, Jean Long and Suzi Lyons)

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2. Allwright S, Bradley F, Long J *et al.* (2000) Prevalence of antibodies to hepatitis B, hepatitis C, and HIV and risk factors in Irish prisoners: results of a national cross sectional survey. *British Medical Journal*, 321 (7253): 78–82.
3. Long J, Allwright S, Barry J *et al.* (2001) Prevalence of antibodies to hepatitis B, hepatitis C, and HIV and risk factors in entrants to Irish prisons: a national cross sectional survey. *British Medical Journal*, 323 (7323): 1209–1213.
4. Hannon F, Kelleher C and Friel S (2000) *General healthcare study of the Irish prison population*. Dublin: Stationery Office.
5. Thornton L, Murphy N, Jones L *et al.* (2012) Determination of the burden of hepatitis C virus infection in Ireland. *Epidemiology and Infection*, 140(8):1461–1468.
6. Health Protection Surveillance Centre (2011) *Annual Report 2010*. Dublin: Health Protection Surveillance Centre.
7. UNAIDS (2010) Global report: *UNAIDS report on the global AIDS epidemic 2010*. Geneva: UN joint programme on HIV/AIDS (UNAIDS). www.drugsandalcohol.ie/14272
8. National Advisory Committee on Drugs (2011) *Drug use in Ireland and Northern Ireland: first results from the 2010/2011 drug prevalence survey. Bulletin 1*. Dublin: National Advisory Committee on Drugs & Public Health Information and Research Branch.
9. National Advisory Committee on Drugs and Alcohol (2014) *Main findings and recommendations arising from the study on the prevalence of drug use, including intravenous drug use, and blood-borne viruses among the Irish prison population. Executive summary*. Dublin: National Advisory Committee on Drugs and Alcohol. www.drugsandalcohol.ie/21750

Annual review of the drug situation in Europe

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published *European drug report 2014: trends and developments* on 27 May.[1] The report summarises the latest trends across the 28 EU member states, and Norway and Turkey. Accompanying the report is a series of online interactive Perspectives on Drugs (PODs) providing deeper insights into important issues. The Health Research Board (HRB) provides the Irish figures for the EMCDDA report.

The EMCDDA reports an overall stable situation and decreases in the use of the more established drugs. In the case of synthetic drugs, including stimulants, new psychoactive substances and medicinal products, the situation is becoming increasingly complex as these drugs become more prominent in drug markets in Europe. Both the quantity of heroin and the number of seizures have fallen considerably in recent years and the numbers entering treatment for heroin use continue to decline. There are an estimated 1.3 million problem opioid users in Europe and increasing numbers of those entering treatment for the first time are using synthetic opioids. Opioids were implicated in most of the 6,100 overdose deaths in Europe in 2012. There are wide national variations in both the number of overdose deaths and the proportion of deaths attributable to synthetic opioids.

Commenting on the report, European Commissioner for Home Affairs Cecilia Malmström said: 'This annual analysis from the EMCDDA provides us with a critically important window on Europe's evolving drugs problem. I am deeply concerned that the drugs consumed in Europe today may be even more damaging to users' health than in the past. There are signs that the ecstasy and cannabis sold on the street are getting stronger. I also note that the EU Early Warning System, our first line of defence against emerging drugs, is coming under growing pressure as the number and diversity of substances continue to rise sharply.'

EMCDDA Director Wolfgang Götz added: 'We see that progress has been made in Europe on some of the major health policy objectives of the past. But the European perspective can obscure some important national differences. Our latest data show how encouraging overall EU trends on overdose deaths and drug-related HIV infections, for example, sit in sharp contrast to worrying developments in a few Member States.'

Cannabis

- The EMCDDA estimates that around 14.6 million young Europeans (aged 15–34), used cannabis in the last year, 8.5 million of these aged 15–24 (13.9% of this age group).
- The use of cannabis in Europe has stabilised or is declining, especially among younger age groups. The situation does vary between countries. Of the 13 countries that have conducted new surveys since 2011, five reported an increase in last-year prevalence among young people (aged 15–34) and eight reported a decrease.
- Around 1% of European adults (aged 18–64) use cannabis on a daily, or almost daily, basis. In 2012 clients entering drug treatment for the first time identified cannabis as their main problem drug more frequently than any other drug.
- In Europe more than three-quarters of reported drug offences involve cannabis. While the focus has been on controlling the supply and trafficking of cannabis rather than on personal use, the numbers of reported possession and use offences have increased steadily over the past decade.
- Public opinion surveys in Europe show that attitudes are polarised around the legal status of cannabis. Regulatory changes in some states in the US and in some Latin American countries have contributed to this debate.

Opioids (mainly heroin)

- The average prevalence of problem opioid use among adults (aged 15–64) in 2012 is estimated at around 0.4%. This is the equivalent of 1.3 million problem opioid users in Europe.
- In Europe 46% (180,000) of all clients who entered treatment in 2012 were users of opioids (mainly heroin).
- The number entering specialist drug treatment for the first time for heroin use fell from a peak of 59,000 in 2007 to 31,000 in 2012, accounting for 26% of all clients entering treatment for the first time.
- In 17 European countries more than 10% of first-time opioid clients entering specialised treatment in 2012 were misusing opioids other than heroin, including methadone, buprenorphine and fentanyl. In some countries, these drugs now represent the most common form of opioid use.
- The number of opioid users for whom injecting is the main route of administration has fallen since 2006. Of the opioid clients entering treatment in 2012, 38% reported injecting the drug.
- Injecting continues to play a major role in the transmission of blood-borne infectious diseases such as hepatitis C and, in some countries, HIV/AIDS. There were 1,788 newly reported HIV diagnoses attributed to injecting drug use in 2012, slightly more than in 2011 (1,732), continuing the upward trend observed since

Annual review of drugs in Europe *(continued)*

2010. Across the 18 countries for which data are available for the period 2011–12, injecting drug use accounts for an average of 64% of all hepatitis C virus (HCV) diagnoses and 50% of the acute diagnoses notified (where the risk category is known).

- Drug use is one of the major causes of mortality among young people in Europe. Heroin or other opioids are present in the majority of reported fatal overdoses. Most countries reported an upward trend in the number of overdose deaths from 2003 up to 2008/09, when overall levels first stabilised and then began to decline. Overall, around 6,100 overdose deaths were reported in 2012. This is similar to the number reported in 2011, which represented a decrease from the 6,400 cases in 2010 and 7,100 in 2009. Typically, those dying of drug overdoses are in their mid-thirties or older, and their average age at death is rising, suggesting an ageing cohort of problem opioid users.
- The quantity of heroin seized in 2012 (5 tonnes) was the lowest reported in the last decade, and equivalent to only half of the quantity seized in 2002 (10 tonnes). Declining seizures in the EU have been accompanied by increasing seizures in Turkey where, each year since 2006, more heroin has been seized than in all EU countries combined.

Cocaine

- Cocaine is the most commonly used illicit stimulant drug in Europe, although most users are found in a small number of countries. It is estimated that about 2.2 million young adults aged 15–34 (1.7% of this age group) used cocaine in the last year.
- Denmark, Spain and the United Kingdom, countries which have had highest prevalence rates for cocaine use among young adults over the past few years, reported a peak in use in 2008 and a steady decline since then. Recent data from 11 of the 12 countries reporting on surveys between 2011 and 2013 show a fall in prevalence.
- Cocaine was the main problem drug for 55,000 (14%) clients entering specialised drug treatment in 2012. The number of clients entering treatment for the first time who cited cocaine as their primary drug has been decreasing in recent years, from a peak of 38,000 in 2008 to 26,000 (18% of all first-time entrants to treatment) in 2012.
- Across the 19 countries reporting data, at least 500 deaths related to cocaine use were recorded in 2012. This is a slight increase from 2011 when there were 475 deaths recorded.
- In 2012, around 75,000 seizures of cocaine were reported in the European Union. There has been a continuous decline in the number of such seizures since 2008, when 95,000 were reported. The quantity of cocaine seized has also declined, from a peak of 120 tonnes in 2006 to 71 tonnes in 2012.

Other stimulants and new psychoactive substances

- Data on new psychoactive substances (NPS) are based on notifications by member states to the EU Early Warning System (EWS). During 2013 the EWS identified 81 NPS, 29 of which were synthetic cannabinoids, 13 were new substituted phenethylamines, seven were synthetic cathinones, one was a tryptamine and one a piperazine, and 30 were compounds which did not conform to the readily recognised chemical groups (including plants and medicines).
- Since 2005 the EWS has identified more than 50 substituted cathinones, the best known example of which is mephedrone, controlled in Europe since 2010 and becoming increasingly important in the stimulants market in some countries. Cathinones are generally snorted but there is evidence of increased rates of injecting among high-risk users in some countries.
- Around 1.5 million Europeans used amphetamines during the last year. There appears to be some geographical spread in the use of methamphetamines beyond the Czech Republic and Slovakia, but use remains low.
- Ecstasy refers to the synthetic substance MDMA. The quantity of ecstasy tablets seized in Europe has been increasing slowly since 2009 after a steady decline over the previous seven years. Ecstasy producers have reportedly responded to strengthened controls and the targeted seizure of PMK, the main precursor chemical for the manufacture of MDMA, by using non-controlled substances and converting them into the precursor chemicals necessary for MDMA production.

EMCDDA Perspectives on Drugs

Along with its *European drug report 2014* the EMCDDA provides additions to its *Perspectives on drugs* (PODs) series, published online.[2] These PODs provide reviews of key aspects of the European drug situation. The new PODs explore:

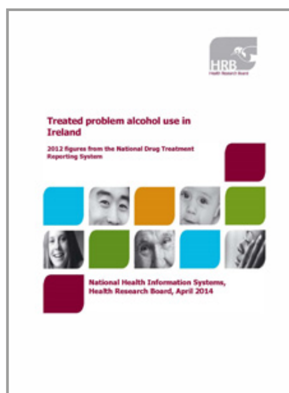
- Emerging concerns relating to stimulant use, with a focus on cathinones detected in the last few years and trends in injecting of these drugs;
- New developments in Europe’s cannabis market, with particular interest in the increasing dominance of domestically-cultivated herbal products and the rise in potency of both herbal and resin forms of the drugs;
- Internet-based treatment, noting the developments in this area over the past 10 years and the integration of tested psychosocial techniques into new web-based delivery systems;
- Medications to treat cocaine dependence, which reports on a study of a number of reviews. The study concludes that psychosocial interventions remain the mainstay of treatment for problem cocaine use.

(Brian Galvin)

Statistical data reported here are for 2012 or the most recent year available. European totals and trends are based on those countries providing sufficient and relevant data for the period specified.

1. European Monitoring Centre for Drugs and Drug Addiction (2014) *European drug report 2014: trends and developments*. Luxembourg: Publications Office of the European Union. www.drugsandalcohol.ie/21957
2. The PODs and national data and statistics are also available at www.emcdda.europa.eu/edr2014

Treated problem alcohol use in Ireland, 2008–2012



The National Drug Treatment Reporting System (NDTRS) has published the latest figures on treated problem alcohol use in Ireland in the years 2008–2012.[1] Some of the main results are summarised below.

The annual number of cases treated for problem alcohol use increased from 7,940 in 2008 to a peak of 8,604 in 2011, decreasing in 2012 to 8,336.

The number of new cases treated rose by 17.9%, from 3,833 in 2008 to 4,520 in 2011, but dropped to 4,028 in 2012. The number of previously treated cases who returned to treatment increased by 16.8% over the period, from 3,606 cases in 2008 to 4,212 in 2012.

Both the incidence and prevalence of treated problem alcohol use per 100,000 15–64-year-olds living in Ireland increased in each of the years between 2008 and 2011; both rates subsequently decreased in 2012 (Figure 1):

- The incidence increased from 119.7 in 2008 to 141.2 in 2011 and subsequently decreased to 125.1 in 2012.
- The prevalence increased from 248.2 in 2008 to 269.8 in 2011 and subsequently decreased to 261.5 in 2012.

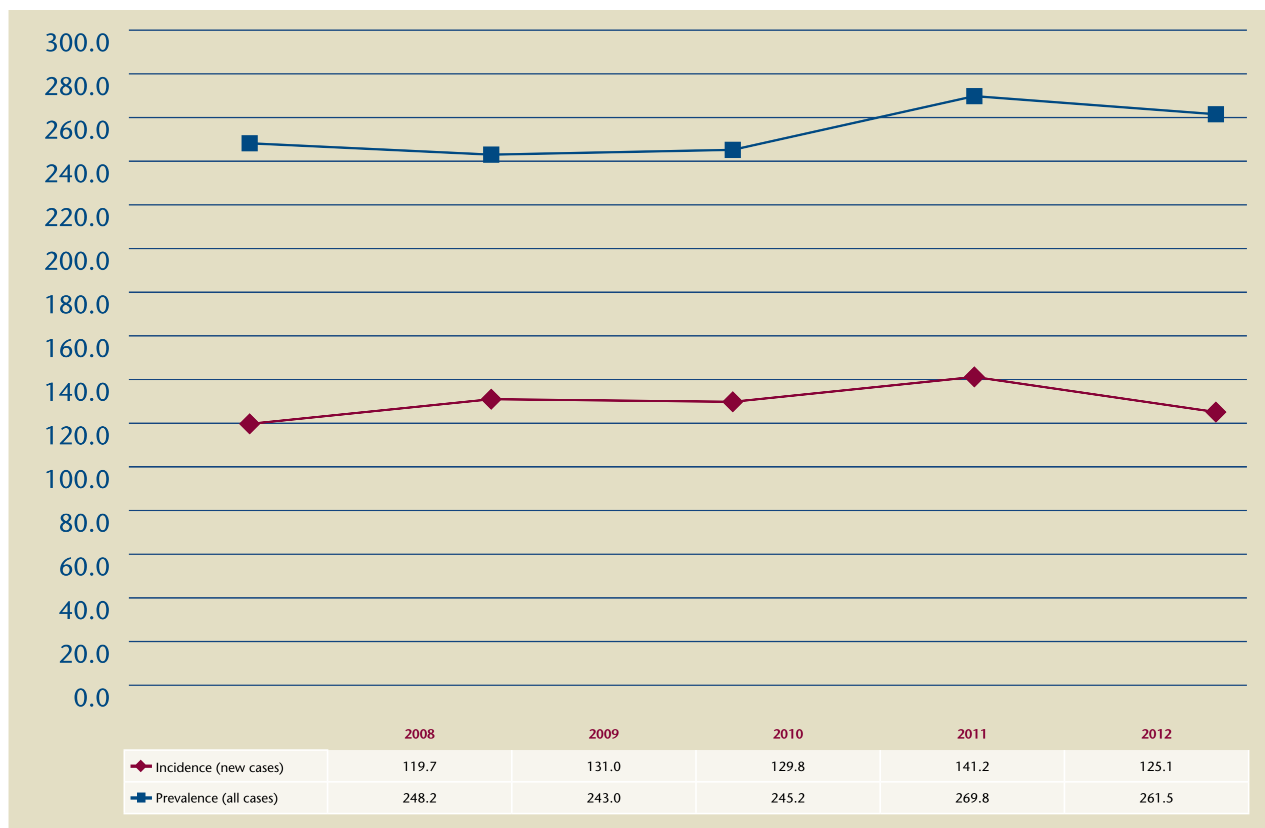
These increases in incidence and prevalence may be explained by an increase in problematic alcohol use in the population, an increase in reporting to the NDTRS, or a combination of both factors.

Almost one in five of those treated for problem alcohol use in 2012 also reported using at least one other substance, a similar proportion to that observed in previous years. In 2012, the most common additional drugs used by treated alcohol cases were cannabis, cocaine, benzodiazepines and ecstasy. This ranking reflects a minor change since 2008, when opiates were the fourth most common additional drug. Use of more than one substance increases the complexity of cases and leads to poorer outcomes for the patient. Information about combinations of substances used is important in terms of individual clients' care plans.

The median age at which both new and previously treated cases began drinking was 16 years. This has not changed for five years (2008–2012). The median age for all treated cases in 2012 was 40 years. The majority of those treated for problem alcohol use were male. The proportion of cases in employment decreased from 30% in 2008 to 20% in 2012.

(Anne Marie Carew)

1. Health Research Board (2014) *Treated problem alcohol use in Ireland: figures for 2012 from the National Drug Treatment Reporting System*. Dublin: Health Research Board. Available at www.drugsandalcohol.ie/21518



	2008	2009	2010	2011	2012
Incidence (new cases)	119.7	131.0	129.8	141.2	125.1
Prevalence (all cases)	248.2	243.0	245.2	269.8	261.5

Figure 1 Incidence and prevalence of treated problem alcohol use per 100,000 of the 15–64-year-old population (NDTRS 2008–2012; CSO 2012, 2013)

Cocaine use in Ireland: 2010/11 survey results

Drug use in Ireland and Northern Ireland

Bulletin 4

The National Advisory Committee on Drugs and Alcohol recently published Bulletin 4 in a series of reports on the 2010/11 survey on drug use in the general population.[1] The bulletin focuses on cocaine use in the adult population (15–64 years) and provides a profile of cocaine use. The final achieved sample was 5,134 in the Republic of Ireland. This represented a response rate of 60%. This article presents a summary of some of the main results.

Key findings

Lifetime cocaine use increased in 2010/11 when compared to 2006/7.[2] The proportion of adults who reported using cocaine (including crack) at some point in their lives increased from 5% in 2006/7 to 7% in 2010/11 (Table 1). The proportion of young adults who reported using cocaine in their lifetime also increased, from 8% in 2006/7 to 9% in 2010/11. As expected, more men reported using cocaine in their lifetime than women, 10% compared to 4%. However, the proportion of adults who reported using cocaine in the last year (recent use) remained stable between 2006/7 and 2010/11 at just under 2% (Table 1). The proportion of young adults who reported using cocaine in the last year also remained stable at 3%.

The proportion of adults who reported using cocaine in the last month (current use) also remained unchanged between 2006/7 and 2010/11 at less than 1%.

Of the 5,134 survey respondents, 7% had used cocaine powder; crack cocaine use was rarely reported (0.6%). Half of all cocaine powder users commenced cocaine use before they were 21 years old, while half of all crack users commenced before they were 23 years old. Since 2006/7 there has been no change in the median age at which either cocaine powder or crack cocaine use commenced.

Of the 26 current cocaine powder users, 95.5% used cocaine less than once per week, while 4.5% used it at least once per week. The majority of the current cocaine powder users (95%) reported snorting the drug, while the remaining 5% reported smoking it. No other form of cocaine use was reported.

Of the 76 recent cocaine powder users, only 4% obtained their cocaine from a person who was not known to them. Cocaine powder was most commonly obtained at the home of a friend (39%) or at a disco, bar or club (37%). The majority (70%) of recent cocaine powder users said that it was easy to obtain within a 24-hour period.

Of the 75 self-defined 'regular' cocaine powder users, 83% had successfully stopped taking cocaine. The most common reasons for discontinuing were: did not want to continue using it (18%), could no longer afford it (17%), concerns about its health effects (15%), pros did not outweigh the cons (14%), and no longer part of social life (13%).

Trying cocaine once or twice was perceived as a 'great risk' by 74% of those surveyed. This perception of risk was particularly marked (at 78%) among those who had never tried cocaine, compared to that of lifetime users at (30%).

Variation in cocaine prevalence was analysed by a number of socio-economic indicators (social class, work status and age ceased education) none of which proved statistically significant. However, renting from a private landlord, having a third-level education and co-habiting were all associated with a significantly higher prevalence of lifetime cocaine use.

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

(Margaret Curtin)

1. National Advisory Committee on Drugs and Alcohol, and Drug and Alcohol Information and Research Unit (2014) *Drug use in Ireland and Northern Ireland. 2010/11 drug prevalence survey: cocaine results*. Bulletin 4. Dublin: NACDA and DAIRU. www.drugsandalcohol.ie/21727
2. National Advisory Committee on Drugs, and Public Health Information and Research Branch (2008) *Drug use in Ireland and Northern Ireland. 2006/2007 drug prevalence survey: cocaine results*. Bulletin 4. Dublin: NACD and PHIRB. www.drugsandalcohol.ie/11528

Cocaine use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Lifetime	3.0	5.3	6.8	4.3	7.0	9.9	1.6	3.5	3.8	4.7	8.2	9.4
Last year	1.1	1.7	1.5	1.7	2.3	2.3	0.5	1.0	0.7	2.0	3.1	2.8
Last month	0.3	0.5	0.5	0.7	0.8	0.8	0.0	0.2	0.3	0.7	1.0	1.0

Table 1 Prevalence of cocaine use (including crack) in Ireland, 2002/3, 2006/7 and 2010/11[1,2]

Is the role of alcohol in accidental deaths under-reported in Ireland?

Media coverage of alcohol policy and alcohol-related issues generally falls into two categories. Thematic coverage deals with statistical facts and the effects of alcohol on society and the individual, while episodic reporting is a news story that reports on the person and their circumstances. It appears that most media coverage of alcohol-related risk is episodic and tends not to address the role of alcohol in the incident. Accurate reporting of alcohol-related deaths can improve support for public health messages among the general public by raising concern and awareness of the risks related to harmful alcohol use.

A recent study aimed to investigate whether the role of alcohol in accidental deaths was under-reported in Irish print media.[1] Data from the National Drug-Related Deaths Index for the years 2008 and 2009 were used to identify deaths due to alcohol poisoning and deaths due to trauma (e.g. drownings, falls) in which alcohol was also mentioned on the death certificate. Deaths due to suicide or to chronic alcohol-related medical conditions were excluded. There were 388 deaths which met the inclusion criteria. An internet search was then conducted to locate local or national newspaper reports of those deaths. The content of the article was analysed, including any direct or indirect reference to alcohol use, using a hierarchical coding system. Media reports (excluding online funeral notices) were located for only 11% of the deaths. The authors note the limitation that an internet-based search alone is likely to have missed articles that had not been put on line.

The study found that deaths due to alcohol poisoning were significantly less likely than traumatic deaths to be reported by the media, even though they represented the majority of deaths identified. When such deaths were reported, the method of death was never stated. While choking was the second most common cause of death in the inclusion group, no newspaper reports of these deaths were found. Reasons suggested by the authors for the under-reporting of the role of alcohol in poisoning and traumatic deaths included: the need for a post-mortem in some cases, a reluctance by journalists/editorial policy to speculate on the role of alcohol in the death, or a cultural reluctance to speak ill of the dead.

The authors conclude that the role of alcohol in alcohol-related deaths is under-reported in the Irish media and that an opportunity to inform the public of the consequences of harmful alcohol use is therefore missed. They recommend that journalists more proactively report on the role of alcohol in deaths, which would enable the public to make more informed decisions in relation to risks round their own drinking, and also in relation to their understanding and support of alcohol harm-reducing strategies, for example the recent Public Health (Alcohol) Bill.[2]

(Suzi Lyons)

1. Fagan J, Lyons S and Smyth B (2014) Content analysis of newspaper reports on alcohol-related deaths. *Alcohol and Alcoholism*. Published online 15 April 2014. doi: 10.1093/alcalc/agu015. www.drugsandalcohol.ie/21799
2. Department of Health (2013, 24 October) *Minimum unit pricing and regulation of advertising and sponsorship to be provided for in a Public Health Bill*. Press release issued by the Department of Health on the announcement of the proposed Bill. www.drugsandalcohol.ie/20793

How alcohol can harm others besides the drinker

The burden of alcohol-related harm is often experienced by those around the drinker, including family members, co-workers and innocent bystanders. The types of harm can include injury, neglect, property damage and public disturbances. The Health Service Executive (HSE) has published a report on the extent of this harm in Ireland.[1] The report examined alcohol harm to people other than the drinker in three settings – the general population, the workplace, and children in families – using survey data from two national drinking surveys conducted in 2006 and 2010. Both surveys had a national representative quota sample of approximately 1,000 adults who were interviewed face-to-face. For the purposes of the study reported here, data from the two surveys were combined to give a total of 2,011 respondents.

Harm to others in the general population

Over one in four people (28%) reported experiencing at least one negative consequence (family problems, being a passenger with a drunk driver, assault, property damage or money problems) as a result of someone else's drinking. The people most likely to experience these harms were those aged under 50 years, those from a lower social class and those who engaged in regular risky drinking. Women were most likely to report family problems (16%), while males aged 18–29 years were most likely to experience assault (21%).

Alcohol harm to others *(continued)*

Harm to others in the workplace

One in ten (10%) Irish workers experienced at least one work-related harm; the harms were ability to do job negatively affected, having to work extra hours, and accidents or close-calls at work. Overall, men (14%) and 18–29-year-olds (16%) were most likely to experience harms as a result of their co-workers' drinking. The overall reported rate of harm in the Irish workforce was double that reported in a similar Australian study.

Harm to children

One in ten adults reported that children for whom they had parental responsibility experienced one or more harms as a result of someone else's drinking. The harms were: being left in unsafe situations, experiencing verbal abuse, experiencing physical abuse, or being witness to serious violence in the home. Parents who were regular risky drinkers were more likely to report that children experienced at least one harm (13%). Higher rates of children witnessing serious violence in the home as a result of others' drinking were reported by parents from the lower social class.

Conclusion

It is clear that alcohol's harm to others is far reaching and can be serious. It causes significant damage across Irish society and its impact is more extensive than that reported in similar research in Canada and Australia. The author states that there is a need for 'a dedicated study specific to alcohol's harm to others' as suggested by the World Health Organization, to establish the scope and size of the problem, its impact on health and social services usage, as well as the burden and cost to Irish society.

(Deirdre Mongan)

1. Hope A (2014) *Alcohol's harm to others in Ireland*. Dublin: Health Service Executive. www.drugsandalcohol.ie/21590

Alcohol Forum conference – alcohol's harm to others

As part of National Alcohol Awareness Week, the Alcohol Forum held a conference entitled *Alcohol's harm to others: when their drinking becomes your problem* in the Convention Centre, Dublin, on 2 April 2014. Minister of State Alex White TD delivered the opening address. He spoke about the damaging impact of alcohol on the family, the workplace, and society as a whole and said that reducing alcohol consumption in Ireland is not just a task for government, but that it is also an issue where local communities can take a lead. He assured the audience that the government is committed to tackling alcohol misuse in Ireland and that the Public Health (Alcohol) Bill is being drafted in the Department of Health. He said that the conflicting interests of the drinks industry which seeks to increase alcohol consumption and public health professionals who seek to reduce alcohol consumption cannot be reconciled when it comes to formulating public health policy. He also said that the alcohol industry seeks a role for itself in public health policy areas that extends far beyond its role as producers and retailers of alcohol.

Professor Robin Room

Professor Robin Room of the University of Melbourne, and advisor to the World Health Organization, described the results of research he had undertaken in Australia which measured the range and magnitude of alcohol's harm to others. Professor Moira Plant, University of the West of England, Bristol, described the harms caused by maternal alcohol consumption during pregnancy and the damage it can cause to the developing foetus. She also described the signs and symptoms of foetal alcohol spectrum disorder, and the impact it can have throughout a person's life. Dr Helen McMonagle, rehabilitation co-ordinator with the Alcohol Forum, spoke about alcohol-related brain injury (ARBI) and its impact on the family and society.

Mr Joe Doyle, HSE National Planning Specialist, outlined how the HSE will respond to the specific recommendations in the *Steering group report on a National Substance Misuse Strategy* relating to the HSE. Dr Ann Hope, Trinity College Dublin, described the main findings of a recent Irish report which indicate that alcohol's harm to others is extensive in Ireland (see article on that report elsewhere in this issue). Dr Michael Byrne, University College Cork, described initiatives that the university has undertaken in recent years to tackle alcohol-related harm among the university's students.

The presentations may be viewed at www.drugs.ie/multimedia.

(Deirdre Mongan)

Alcohol and mental health among school students

Alcohol can contribute to the development of mental health problems as well as exacerbating pre-existing mental health difficulties. A recent Irish report, *Alcohol and youth mental health – the evidence base*,[1] profiled drinking behaviour and psychological health in 6,085 12–19-year-olds in 72 randomly selected post-primary schools in Ireland to determine the association between drinking behaviour and mental health and to identify risk and protective factors associated with adolescent drinking. Participants completed the My World Survey – Second Level (MWS–SL), which contains a battery of psychometrically reliable instruments assessing risk and protective factors of psychological health.

Alcohol consumption among students

Overall, 49% reported never drinking alcohol, while 22% drank alcohol less than once a month, 18% drank alcohol monthly and a further 10% drank alcohol weekly. Alcohol consumption increased as students progressed through school; 83% of first-year students were non-drinkers, compared to 9% of sixth-years. Patterns for males and females were broadly similar. The typical volume of alcohol consumed per drinking occasion among 1st, 2nd and 3rd years was 1–2 drinks. Among 4th years, 38% consumed 3–4 drinks, while 69% of 6th years consumed at least five drinks, with 14% consuming 10 or more drinks on a typical drinking occasion. This steady progression was most evident among females. Binge drinking was defined as six or more standard drinks on a single drinking occasion. Overall, 30% reported never binge drinking, with rates ranging from 63% of 1st years and 10% of 6th years. According to the AUDIT (Alcohol Use Disorders Identification Test) criteria, 10% of junior cycle students and 35% of senior cycle students had a harmful pattern of drinking.

Alcohol and mental health

On the Depression, Anxiety and Stress Scale (DASS), 11% displayed mild levels of depression, 11% displayed moderate levels, 4% severe levels and 4% very severe levels. A strong association was observed between harmful drinking and severity of depression. Among junior cycle students, 2% were classified as possibly being alcohol dependent and 12% of these as having severe depression. Similar patterns were observed for those in the senior cycle, and the patterns observed for depression were also evident for anxiety and stress. Protective factors such as personal competence, family cohesion and life satisfaction were significantly related to alcohol behaviour; those with harmful drinking patterns had lower levels of these protective factors than those who did not drink in a harmful manner.

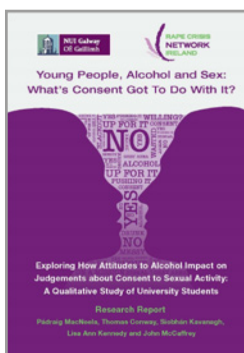
Conclusions

The results indicate that alcohol consumption among adolescents is associated with mental difficulties and the authors conclude that addressing alcohol behaviour may reduce the risk of mental health difficulties and may also increase protective factors. They state that this will require a multi-faceted approach involving parents, schools and the wider community and that international research suggests that key interventions include school strategies focusing on strengthening personal and social protective factors; family approaches such as increasing family cohesion; and community strategies such as reducing alcohol availability through regulation.

(Deirdre Mongan)

1. Fitzgerald A and Dooley B (2013) *Alcohol and youth mental health – the evidence base. Psychiatry Professional*, 2(1): 6–8. www.drugsandalcohol.ie/21265

How attitudes to alcohol affect judgements about sexual behaviour



The Rape Crisis Network Ireland commissioned NUI Galway to undertake a qualitative study to explore university students' attitudes to alcohol use and consent to engage in sexual activity[1] and to build on previous Irish research,[2] which demonstrated a high rate of co-occurrence of rape and heavy drinking by perpetrators and/or victims. A total of 187 young adults in an Irish university took part in the study; four focus groups were held with 24 females, three focus groups were held with 20 males, and an online survey using open-ended questions was completed by 143 students.

The context for consent – alcohol's role in student life

Analysis of the focus groups' data revealed that alcohol plays a key role in students' social interactions. It acts as an icebreaker, gives confidence, helps to overcome shyness, and helps students to form friendships. Drinking is the norm and students fear exclusion from their peer group if they do not join in and drink. Regarding sexuality, alcohol is perceived by students to be an enabler, which helps them to approach a person of the opposite sex. Alcohol provides 'Dutch courage' and is often the main reason that a couple get together.

Consent to sex: reading implicit signs

Consenting to sex was described as being largely implicit; consent is usually given through non-verbal signs, rather than verbally. In general, males increase the extent of physical intimacy until the female indicates that she wants

Alcohol and sexual behaviour *(continued)*

the male to stop. Hook-up encounters present problems regarding consent as the two individuals have not built up any trust with each other. In these circumstances, body language and flirting were considered to indicate consent. One of the male focus groups stated that 'most lads will know if she's up for it', and if a partner agreed to leave the nightclub with you, this could be interpreted as a clear sign of interest in sex.

Alcohol had an impact on both the provision and understanding of consent. Providing consent if one or both of the partners were drunk was difficult, especially during hook-up encounters, which were more likely to occur when alcohol was consumed. The students stated that in these situations alcohol made it more likely that consent would be assumed rather than being explicitly provided verbally. A problematic issue was determining if one partner was drunk beyond the point of giving consent. The threshold the students identified for being unable to give consent could be considered as high. Males said that a female was able to give consent 'as long as she could talk'. However, if one partner was a lot drunker than the other, the less drunk person could be at risk of 'taking advantage' of the other person. It was considered wrong to have sex with someone whose ability to provide consent was less effective than your own.

Alcohol and sexual assault

Both male and female focus group participants clearly believe that sexual assault is wrong and that it has serious and long-lasting consequences for victims. There was consensus that it is important not to blame the victim when sexual assaults occur. Alcohol plays an important role in sexual assaults; it lowers inhibitions, which in turn leads to loss of control; it can cause males to lose their ability to regulate their drive for sex; it can make women lose their ability to refuse sex; and it can remove a victim's ability to report what has happened. There was also a belief that alcohol consumption can undermine a victim's credibility when it comes to reporting a rape or assault.

Analysis of the online survey found that the responses were consistent with those made by focus group participants.

Conclusions

The authors recommend supporting 'systematic, communication-based approaches', to change current attitudes to alcohol and non-consenting sexual activity, and they state that approaches are required to enable young people to understand the meaning of consent. They conclude that 'young people should be regarded as partners to health professionals, peer educators, and others in achieving change in the status quo. The use of active, stimulating methods of engagement should help youth move from principles to practice in their critical thinking about consent'.

(Deirdre Mongan)

1. MacNeela P, Conway T, Kavanagh S et al. (2014) Y*oung people, alcohol and sex: what's consent got to do with it? Exploring how attitudes to alcohol impact on judgements about consent to sexual activity: a qualitative study of university students*. Galway: Rape Crisis Network Ireland. www.drugsandalcohol.ie/21286
2. Hanly C, Healy D and Scriver S (2009) *Rape and justice In Ireland: a national study of survivor, prosecutor and court responses to rape*. Dublin: The Liffey Press. www.rcni.ie/wp-content/uploads/Exec-Summary.pdf

Forced labour and the drug trade

Forced labour in the production of cannabis is the subject of a research report by the Migrant Rights Centre Ireland (MRCI).[1] According to MRCI, this phenomenon involves human trafficking for the purpose of criminal exploitation. The study examined trafficking for cannabis production 'specifically focusing on cases and reports where Vietnamese and Chinese nationals were involved' (p.1). The research is part of a wider European study led by the Anti-Slavery International (ASI) Race in Europe project. ASI has identified a trend in victims being trafficked from Vietnam to Ireland via the UK in recent years.

In Ireland, human trafficking for criminal exploitation has only recently been criminalised, under the Criminal Law (Human Trafficking) (Amendment) Act 2013. Consequently, there is limited available data on the effect of the legislation. The MRCI study involved semi-structured interviews with members of the legal profession, the Anti-Human Trafficking Unit (AHTU) of the Department of Justice and Equality which was established in 2008, the Human Trafficking Investigation and Co-ordination unit within An Garda Síochána, established in 2009, and the Chaplain Service at Mountjoy prison. An analysis of media articles and press releases was also conducted and a number of case studies are presented in the MRCI report.

Forced labour and the drug trade *(continued)*

The report highlights the increase in domestic cannabis cultivation in Ireland in the last five years, noting the dismantling of 500 cannabis cultivation sites by the gardaí during 2011. It refers to a recent EU drug market study by the European Monitoring Centre for Drugs and Drug Addiction and Europol which reported the involvement of Vietnamese and Chinese organised crime groups (OCGs) in cannabis cultivation in Ireland.[2] According to the MRCI, there were 80 people of Asian origin in Irish prisons in 2013 for drug-related offences, with 50 of these in custody for cannabis cultivation. The report refers to numerous newspaper and online media articles about cases involving Vietnamese and Chinese nationals, and presents two MRCI case studies, which are abridged below.

> Mr W was offered the opportunity to move to Ireland from the UK, where he had been paid below the minimum wage for a number of years. He was offered work in a Chinese restaurant as a porter. On arrival in Ireland, he was taken to a small house in a rural location. He was told to water the plants in the house and that, if he tried to escape, he would be killed by the recruiter's boss, who was Irish. W escaped and contacted An Garda Síochána. He was hospitalised for a number of days suffering from exposure. He was then arrested on drugs charges and later imprisoned. The courts requested An Garda Síochána to conduct an assessment of human trafficking. Trafficking was not identified by the relevant Garda in this case.
>
> Mr B, a Vietnamese national was offered a job in Ireland as a gardener. He was smuggled out of Asia and ended up in an industrial estate in rural Ireland. He was locked in a barn and ordered to look after hundreds of plants and control the hoses, lights and heaters. He slept on a mattress and was brought food once per week. He had no idea what country he was in, but he knew he was minding a cannabis factory. When police located the barn, they found B locked inside. Through an interpreter he told them he had been kept as a slave, forced to tend to the plants and threatened with violence. He told them he had received no money. B was charged with possession of the plants and faces a mandatory minimum ten-year prison sentence.

The report states that, 'out of all the Vietnamese nationals who have been arrested and charged with cannabis cultivation since 2010, no cases of trafficking for forced labour have been identified by an Garda Síochána' (p.5). As a consequence, 'potential victims are being prosecuted, convicted and imprisoned for crimes they may have been forced to commit – while their traffickers enjoy impunity' (p.5). MRCI argues that the inability of An Garda Síochána to identify victims in such circumstances has created the need for such victims to be 'formally identified' by an agency like the Health Service Executive, with the co-operation of MRCI, so that victims can receive the care and attention they require.

Included among the other recommendations of the study are the following:

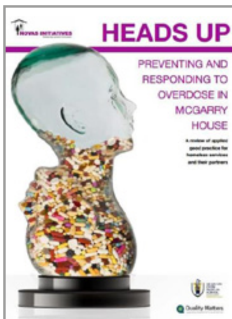
- All cases of potential trafficking for forced labour in cannabis production should be investigated for human trafficking by An Garda Síochána.
- An independent national rapporteur should be appointed by the government to identify trends in human trafficking and address problems of lack of identification and prosecution.
- Victims should be provided with a reflection and recovery period, safe accommodation, health care, counselling and financial supports where they have been identified as a suspected victim of human trafficking.
- Training needs to be provided by ASI and MRCI for investigators, prosecutors, judiciary, and the legal profession to equip them with the skills to identify such potential victims.
- A non-punishment clause should be included in the Criminal Law (Human Trafficking) Act 2008 to ensure that victims of trafficking are exempt from prosecution for offences that they were forced to commit.

MRCI intends to conduct further research in this area in the future as more information becomes available.

(Johnny Connolly)

1. Migrant Rights Centre Ireland (2014) *Trafficking for forced labour in cannabis production: the case of Ireland*. Dublin: MRCI. www.drugsandalcohol.ie/21642
2. European Monitoring Centre for Drugs and Drug Addiction, Europol (2013) *EU drug markets report: a strategic analysis*. Luxembourg: Publications Office of the European Union. www.drugsandalcohol.ie/19227. For a review of this study, see Connolly J (2013) EU drug markets – a strategic analysis. *Drugnet Ireland*, (45): 8–9.

Preventing and responding to overdose in homeless accommodation in Limerick



The voluntary agency Novas Initiatives is the largest provider of homeless accommodation in the Mid-West area. McGarry House was opened by Novas in 2002 in Limerick city and provides homeless accommodation for 30 individuals and long-term supported housing for 37 individuals. In recent years the staff have observed a change in the profile of their residents, with escalating and more chaotic drug use: between May 2012 and November 2013 the staff responded to 34 overdose incidents.

In response to this, Novas commissioned a research project in order to gain a better understanding of the problem of overdose in McGarry House and to assess their responses to such incidents.[1] The aim of the research was to: 1) understand the experience of overdose among residents and staff; 2) understand the risk-taking behaviour of the residents; and 3) identify ways to improve knowledge and reduce the risk of overdose and increase effective bystander response.

A mixture of qualitative and quantitative methods was used: semi-structured interviews with 15 staff and 15 residents; an on-line survey of 20 staff; a postal survey of four GPs; focus groups with staff, residents and professional stakeholders; and a systems review of the policies and procedures. The small sample size was identified as a limitation by the authors, with 50% of residents, nine key stakeholders and four (out of the 15 GPs invited) taking part in the research. Recall bias may also have been an issue in the case of participants who may have used drugs, particularly benzodiazepines, which can affect memory.

Profile of residents

Of the 114 people who lived for a time in McGarry House in the course of 2012, 11% were aged under 21 years, and almost half (48%) were aged under 30 years. The percentage of residents presenting with drug use issues had risen from 17% in 2010 to 27% in 2012.

Of the 15 residents who participated in the study, almost all had an extensive history of both illicit drug use (heroin, street methadone, crack cocaine, street benzodiazepines and Z-drugs, novel psychoactive drugs) and licit drug use (alcohol, prescribed methadone, benzodiazepines and Z drugs). Over half (8, 58%) reported that they injected frequently.

Experience of overdose:

- 73% (11) had ever overdosed.
- 93% (14) had witnessed another person overdosing in the past year.
- 85% (17) of staff had been on shift when an overdose occurred.

Of those who overdosed:

- 100% (11) had overdosed in the past year.
- 91% (10) reported benzodiazepines as the most common drug involved in their overdose.
- 82% (9) had overdosed more than once.
- 82% (9) reported heroin involvement in their overdose.
- 72% (8) of overdoses involved more than one drug.
- 64% (7) were with someone when they overdosed.
- 46% (5) reported alcohol involvement in their overdose.
- 36% (4) had overdosed in the six months prior to the interview.

One of the themes to come from the study was that, while residents were at high risk of overdose, participants expressed ambivalence about the extent of their risk. Of those who discussed this, many felt it was unlikely that they would overdose again, or were not concerned about the risk or worried about overdosing. This was despite the fact that over half of residents interviewed felt that overdose was an inevitable or unavoidable part of drug use. Almost all agreed that they could reduce their overdose risk; however, the perceived degree of difficulty in doing this varied between residents.

Of the residents who had witnessed an overdose, the majority reported carrying out appropriate emergency responses, e.g. checking level of consciousness, breathing and pulse. However, some reported carrying out interventions which were not effective or potentially harmful: walking the person around (risk of fall and injury); putting the person in the bath (risk of drowning); and injecting with salt water. Four participants stated that they were concerned about calling an ambulance for fear of personal consequences if the gardaí also arrived.

More than half of the residents interviewed felt that they knew 'very little' or 'some' about the causes of overdose, but 87% were interested in taking part in overdose prevention training, including provision of naloxone.

The researchers also noted that while McGarry House promoted a low-threshold ethos, e.g. by providing safe disposal bins for needles, some residents still worried about negative consequences if they disclosed their drug use.

Another theme emerging from the research related to interagency prevention and response. The external agencies acknowledged the vital role of McGarry House in overdose prevention and were keen to develop interagency protocols and structures. At the time of the research, Novas was working with the HSE to improve interagency co-ordination, with a focus on providing clarity around maintaining confidentiality while striving to prevent overdose. Another example of interagency work was liaison with the ambulance service in order to speed up processes and improve communication.

Two themes emerged in relation to the challenges McGarry House staff faced in responding to overdose. While there was very much a 'coping culture' there was a need to ensure effective support for staff, and for further development of confidence, capacity and learning opportunities.

Responding to overdose among the homeless *(continued)*

One of the particular issues raised by staff concerned pregnant women who had continued to use drugs, some intravenously, during their pregnancies (in the period before the research was conducted). The staff reported this as extremely stressful (indeed, one woman had given birth in the hostel) and, while pregnancy does not increase the risk of overdose, the consequences of any overdose has implications for both the woman and her unborn child.

The recommendations made in the report are summarised below.

- Develop a peer education programme for residents on understanding risks, prevention and management of overdose.
- Provide consistent harm reduction information that is agreed at an interagency level.
- Update overdose policy which can be reviewed as required. Review the client risk assessment form.
- Train staff in additional effective overdose prevention interventions, e.g. motivational interviewing and cognitive behavioural therapy to address the ambivalence to overdose risk expressed by some clients.
- Continue to work to, and promote with residents, an evidence-based low-threshold approach.
- Clearly communicate to residents that their personal information is treated confidentially and only shared for risk management.
- In consultation with staff, develop and provide appropriate supports to staff in the event of an overdose.
- Explore, with other agencies, the opportunities for a naloxone distribution programme.
- Develop and formalise interagency protocols to improve communication and information sharing in relation to overdose, with the HSE and emergency services in particular.
- Develop person-centred assessment training in collaboration with the Homeless Persons Centre in Limerick city to improve information gathering of risk factors from residents.
- Improve understanding with GPs and pharmacists by developing a standard information letter which explains the role of McGarry House in overdose prevention.
- Support the development of an interagency response to care for pregnant women who use drugs, e.g. employment of a regional drug-liaison midwife.

(Suzi Lyons)

1. Dermody A, Gardner C, Quigley M and Cullen W (2013) *Heads up: preventing and responding to overdose in McGarry House, Novas*. Limerick: Novas Initiatives. www.drugsandalcohol.ie/22183

Forensic Science Laboratory analyses street-level heroin and cocaine

An analysis of heroin and cocaine seizures submitted to the Forensic Science Laboratory (FSL) between April 2010 and March 2012 sought to assess the current status of these particular drug markets, 'in order to track changes in the markets, and for comparison to reported European data'.[1] The study also sought to establish whether purity plays a role in the pricing of street drugs. This is particularly important in the Irish context as, under the terms of Section 15a of the Criminal Justice Act 1999 (as amended), a mandatory minimum sentence of 10 years applies where a person is convicted of possession of drugs with a market value of €13,000 or more. For the purposes of this legislation, the market value is interpreted as the maximum value a drug could realistically be expected to obtain at street level when purchased by an end user.

Street-level purity data give an indication of the purity of the substance reaching the end user. Unlike markets for legitimate goods, in the illicit drug trade the quality of the commodity is not regulated or guaranteed and therefore is something than can only be assessed by the user after consumption. As a consequence, just like restaurant meals or used cars, illicit drugs are referred to as 'experience goods', as their quality is only fully knowable after use.[2] A further complicating factor is that adulterants are added to drugs not only to bulk them up for sale but also to enhance or mimic the effects of the drug for the user. So, for example, where a user might believe the drugs s/he consumes are of a good quality, this does not necessarily mean that they are of a higher purity.[3]

In the FSL study, quantitative analysis to determine drug purity was carried out on randomly selected street-level seizures on a monthly basis during the two-year period of the study. Data were also collected on the type and frequency of adulterants detected in the seizures. Price information for a subset of the cases quantified and also for a number of cases not quantified was obtained from An Garda Síochána.

FSL analyses heroin and cocaine *(continued)*

Findings in relation to heroin seizures

Analysis conducted by the FSL as part of a National Advisory Committee on Drugs and Alcohol/Health Research Board (NACDA/HRB) study of illicit drug markets in Ireland found an average heroin purity of 45% in a sample of 131 heroin seizures from four distinct markets in 2008/2009.[4] In the current study, in a sample of 239 diamorphine (heroin) cases the mean purity was 47% for 2010, 30% for 2011 and 24% for the first three months of 2012. The study reveals 'a general decline of diamorphine purity over the time period, with the 2012 average being nearly half the average purity obtained for 2010' (p.2).

Of the 239 heroin samples analysed, 81% contained adulterants/dilutants. The frequency of detected adulterants increased from 67% of cases in 2010 to 100% in 2012. This may help explain the drop in purity during the same period as it was also found that 'the mean purity of heroin samples with no detected adulterants was 58%, whereas the mean purity… containing adulterants was 31%' (p.2). The main adulterants found were caffeine and paracetamol, usually together.

Coomber (2006), in a discussion of drug adulteration, points out that one of the reasons caffeine is commonly found with heroin is that, when heroin is smoked or 'chased', caffeine has been shown 'to enable a higher amount of the heroin (around 76%) to be recovered (i.e. the amount of heroin left available in the 'smoke' which is inhaled), after volatization (the heating, melting and then vaporization of the drug for inhalation or 'chasing') than when compared to pure heroin alone'.[5] Heroin is also commonly adulterated with paracetamol because the latter has approximately the same melting point as heroin and also has analgesic (pain-killing) properties.

The Garda National Drugs Unit (GNDU) provided price data for 144 street-level heroin cases submitted to the FSL between 2010 and 2011. The powder weights for these packs ranged from 0.097g to 1.862g, with an average price per gram of €116.71. The most frequent street-pack prices were €20, €25 and €50. There was a correlation between pack sizes and prices, leading the authors to conclude that 'the driving factor for diamorphine prices may not be perceived quality, but perhaps the quantity of drug sold, or customer demand in times of limited diamorphine supply' (p.3).

Findings in relation to cocaine seizures

In the NACDA/HRB study referred to above, a forensic analysis of 93 samples of cocaine found that purity levels were generally very low, averaging 14% across the four local drug markets studied. The current study, where purity was determined for 217 cocaine cases over the 2010–2012 period, made a similar finding, with the average purity remaining fairly stable, at 15% for 2010, 19% for 2011 and 17% for the first three months of 2012. The study also recorded a larger degree of variation in the purities of cocaine samples when compared to those for diamorphine. Ninety-nine per cent of samples contained one or more adulterants, with the main ones being lignocaine, levamisole, phenacetin, caffeine and benzocaine. According to Coomber (2006), referring to similar findings from research on the UK drug market, given that these are all substances that have either analgesic and/or stimulant properties, this shows the 'purposive nature of such cutting', or adulteration.[6] Pricing data were obtained from the GNDU for 17 cocaine seizures for which purity was determined during the study period but no correlation was found between price and purity.

When the findings of the study for 2010 were compared to similar data compiled by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), it was found that Ireland's mean purity of diamorphine was the second highest after Turkey and that it ranked the third most expensive after Sweden and Latvia. With regard to cocaine data for 2010, it was found that the mean purity of cocaine in Ireland was the lowest reported to the EMCDDA, while the price per gram was the second highest after Luxembourg.

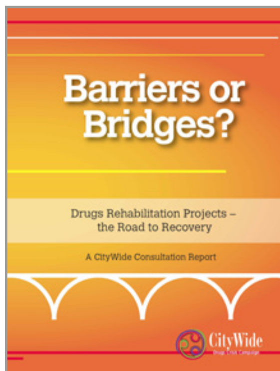
The compilation and reporting of drug purity trend data in studies such as this can enhance our understanding of illicit drug markets and also the impact of drug law enforcement interventions on the behaviour of such markets. Studies such as this enable us to provide some context to changes in the behaviour of street-level drug markets. For example, it is worth speculating whether the decline in heroin purity since 2010 identified in this study may be linked to the heroin drought of that year, and also whether the poor quality of heroin may have contributed to the rise in the street sale and use of benzodiazepines by opiate users in recent years.[7]

Comprehensive chemical profiling of drug seizures can also indicate links between seizures in different locations, thereby providing intelligence on patterns of drug supply. Information on the types of adulterants used to bulk up drugs for street sale and/or to enhance their quality for the end user can provide important public health information. At present, however, the purity of drugs in Ireland is not routinely tested (quantified) due to the resource implications such an endeavour would entail. The development and reporting of indicators in the drug supply area such as seizures, price and purity data are currently a priority of the EMCDDA, in collaboration with Europol and the European Commission.[8]

(Johnny Connolly)

1. Boyle M, Carroll L, Clarke K *et al.* (2014) What's the deal? Trends in Irish street-level heroin and cocaine 2010–2012. *Drug Testing and Analysis*, Published online 24 March. DOI: 10.1002/dta.1639. www.drugsandalcohol.ie/21608
2. Reuter P and Caulkins J (2004) Illegal 'lemons': price dispersion in cocaine and heroin markets. *Bulletin on Narcotics*, LVI, (1 & 2) 141–165. New York: United Nations Publications. www.unodc.org/pdf/bulletin/bulletin_2004_01_01_1_Art6.pdf
3. For further discussion of the role of adulterants in drug markets see Coomber R (2006) *Pusher myths: re-situating the drug user*. London: Free Association Press.
4. Connolly J and Donovan A (in press) *Illicit drug markets in Ireland*. Dublin: National Advisory Committee on Drugs and Alcohol, and Health Research Board. Some of the purity data from this study were reported in the following: Irish Focal Point (2011) *2011 National Report (2010 data) to the EMCDDA by the Reitox National Focal Point. Ireland: new developments, trends and in-depth information on selected issues*. Dublin: Health Research Board. www.drugsandalcohol.ie/16812
5. Coomber R (2006) p. 73.
6. Coomber R (2006) p. 76.
7. Irish Focal Point (2011) *2011 National Report (2010 data) to the EMCDDA by the Reitox National Focal Point. Ireland: new developments, trends and in-depth information on selected issues*. Section 1.2, p.20. Dublin: Health Research Board. www.drugsandalcohol.ie/16812
8. Connolly J (2011) First European conference on drug supply indicators. *Drugnet Ireland*, (36): 12. www.drugsandalcohol.ie/14696

Barriers or bridges?



A CityWide consultation report on the impact of budgetary cuts on Drug Rehabilitation Projects (DRPs) has identified significant challenges for such projects in terms of maintaining their crucial work with recovering drug users.[1] The report concludes that changes introduced to the Community Employment scheme in order to increase its focus on labour market activation have not taken into account the distinct role of DRPs. In particular, the research found that recent budgetary changes had led to a change in the profile of those applying for places on the projects. The major impact is 'on the one hand, the fall in applications for places [on DRPs] from people who are on One Parent Family Payment or Disability payments and the increase in applications from people who are on Job Seekers Payment' (p.30).

As set up, DRPs were largely based on a model of working with people who were on methadone and attending clinics. They also provided a financial incentive for people parenting alone and for those in receipt of disability payments to address their addiction problems. Budget 2012, the report concludes, 'wiped out' this incentive. The majority of projects have seen a decrease in the number of women joining projects and 'a spike in applications from younger men over the past two years; this younger cohort may never have used heroin, but use a cocktail of illegal drugs, tablets and alcohol. This provides a more challenging environment in which to deliver rehabilitation programmes' (p.30).

Calling for a change in the way such projects are managed in the future, Anna Quigley, co-ordinator of CityWide, stated at the launch of this report: 'We must address the issues identified in the report if we are to maintain and build on the achievements and successes of DRPs in our communities to date. The DRPs were set up and are operating as a core element of the National Drugs Strategy and an urgent review to address these issues should take place through the structures of the NDS led by Minister Alex White TD.'

1. CityWide Drugs Crisis Campaign (2014) *Barriers or bridges? Drugs rehabilitation projects – the road to recovery.* A CityWide consultation report. Dublin: CityWide. www.drugsandalcohol.ie/21512. See also the two related videos at www.drugsandalcohol.ie/21589.

AAI leaflet on alcohol and pregnancy

In March 2014 Alcohol Action Ireland produced an information leaflet in conjunction with the country's three largest maternity hospitals, the National Maternity Hospital, the Rotunda Hospital and the Coombe Women & Infants University Hospital. *Alcohol and Pregnancy*[1] warns of the dangers of drinking during pregnancy and advises that the optimal approach for pregnant women is to abstain completely from alcohol consumption.

Exposure to alcohol during pregnancy increases the risk of impairment of the physical and mental development of the unborn child. Alcohol passes through the placenta from the mother's bloodstream to that of the child. An adult liver can break down a unit of alcohol in one hour. However, the underdeveloped liver of the unborn child does not have this capacity.

The effects of alcohol on the unborn child are manifold and may be expressed through a variety of mental and physical development issues with life-long consequences. In particular, the impact of alcohol can manifest in the form of Foetal Alcohol Syndrome (FAS) or Foetal Alcohol Spectrum Disorder (FASD).

FAS is caused by a high level of exposure to alcohol throughout pregnancy and results in growth retardation, facial defects and pronounced learning and behavioural difficulties. FASD refers to a spectrum of less pronounced but more common difficulties resulting from exposure to alcohol in the womb. Despite appearing healthy, children with FASD can experience a range of issues such as sight and hearing impairment, as well as social, cognitive and learning difficulties.

Women who drink heavily during pregnancy are also at increased risk of complications, in particular, miscarriage, premature delivery and stillbirth.

The risk of impairment to the unborn child increases with the level of alcohol consumed. However, the exact level at which alcohol consumption becomes harmful is not known. As a result, women can receive conflicting advice. This leaflet advocates that since alcohol is a known toxic substance without a clearly defined level of safe consumption, it is best for pregnant women to abstain completely once they know that they are pregnant or are trying to conceive.

Pregnant women who are concerned about their alcohol consumption are advised to consult their health professional. They are encouraged to maintain a good support network during pregnancy, to ask their partner to also reduce their drinking, and to stay active. Meeting friends in a cafe rather than a bar, choosing fruit juices or non-alcoholic drinks, as well as eating healthily and not smoking or consuming harmful drugs, are also advocated.

(Margaret Curtin)

1. Alcohol Action Ireland (2014) *Alcohol and pregnancy*. Dublin: AAI. www.drugsandalcohol.ie/21647

The Talbot Centre celebrates 30 years of service

Mary Cotter and Liam Roe, Project Leaders The Talbot Centre, Addiction Service, HSE, DNE

The Talbot Centre in Dublin's north inner city is the longest established drug prevention and education service for children, young people and their families in Ireland. The centre celebrated its 30th anniversary in March 2014 with the launch of a special commemorative booklet, *Thirty years of the Talbot Centre*.[1]

Services provided by the staff at the centre include support, advocacy, brief interventions, family work, substance/drug education, prison visits, family therapy, recreational activities, counselling, and education and training programmes for local community workers and school staff.

The commemorative booklet, with contributions from service users and representatives from some of the many voluntary, community and statutory groups linked with the centre, reflects on the work of the centre since its inception, its key milestones and how it has evolved and reshaped its services to reflect the changing nature of drug use and behaviours of young people in the area.

Speaking at the anniversary event, the director general of the Health Service Executive, Tony O'Brien, said:

> The centre is a model of best practice as a drug prevention education project and plays a unique role within the HSE Addiction Service by providing support to young people with problems associated with substance misuse and family support for those living with individuals who have an addiction. Their preventative work with children and young people not using drugs but considered at risk is an important component of the work of the centre.

Uniquely positioned at the heart of the community, the centre has offered a safe place for many children, young people and families to work through the challenges in their lives. Part of the charm and strength of the centre is that it is small – it has six staff and is based in what could be a family home, where the atmosphere and ambience is homely. One parent spoke movingly about how counselling sessions at the centre had changed his attitude to a drug user in the family and helped him to cope much better with the situation.

Dr Siobhan Rooney, consultant psychiatrist, spoke of the centre's reassuring approach:

> When you walk through the door of the Talbot Centre, you are met with a warm, calm and welcoming atmosphere. The staff are professional, empathetic and hugely committed to their work. There is a healthy scepticism and intelligent filtering of what work needs to be prioritised by the staff in the service and the young person and their families always come first. My lasting impression is a sense of reassurance of what is being provided there and I know this is what young people and their families must feel when they leave to go back into the chaos they have to face.

Project leaders Mary Cotter and Liam Roe confirmed the Talbot Centre's approach to its work: 'If it is too narrow to work with the child or young person in isolation from the family, it is too narrow to work with the family in isolation from the community.'

(Mary Cotter and Liam Roe)

1. Talbot Centre project team (2014) *Thirty years of the Talbot Centre*. Dublin: The Talbot Centre. www.drugsandalcohol.ie/21605

Recent publications

Journal articles

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

Drinking motives and links to alcohol use in 13 European countries

Kuntsche E, Nic Gabhainn S, Roberts S *et al.*
Journal of Studies on Alcohol and Drugs, 2014, 75(3): 428–437.
www.drugsandalcohol.ie/21828

The purpose of this study was to test the structure and endorsement of drinking motives and their links to alcohol use among 11–19-year-olds from 13 European countries, including Ireland.

The findings confirmed the hypothesized four-dimensional factor structure. Social motives for drinking were most frequently indicated, followed by enhancement, coping, and conformity motives, in that order, in all age groups in all countries except Finland. This rank order was clearest among older adolescents and those from northern European countries. The results confirmed that, across countries, social motives were strongly positively related to drinking frequency, enhancement motives were strongly positively related to frequency of drunkenness, and conformity motives were negatively related to both alcohol outcomes. Against our expectations, social motives were more closely related to drunkenness than were coping motives, particularly among younger adolescents. The findings reveal striking cross-cultural consistency. Health promotion efforts that are based on, or incorporate, drinking motives are likely to be applicable across Europe. As social motives were particularly closely linked to drunkenness among young adolescents, measures to impede the modeling of alcohol use and skills to resist peer pressure are particularly important in this age group.

Emotional labour in harm-reduction practice in Ireland: an exploratory study

Fabianowska J and Hanlon N
Irish Journal of Applied Social Studies, 2014, 13(1): 53–65.
www.drugsandalcohol.ie/21634

Arlie Russell Hochschild's concept of emotional labour has been applied extensively in the analysis of the emotional, relational and identity processes in a wide variety of service occupations, and to a lesser extent to caring occupations where the central goal is nurturing. It has featured infrequently in social care in general and has not featured significantly in academic debates in Ireland. The paper is based on a small qualitative study of social care workers in harm reduction [HR] day services in the Dublin region. The aim of the research study was to explore how emotional labour impacts on workers employed in day harm reduction services. The paper highlights the centrality of emotional labour in negotiating and managing a sense of professionalism and personal space within a highly stressful area of social care. The workers' emotional labour involved a process of embodying professionalism, an empathic alertness in their relations with service users, emotional distancing from traumatic experiences, and developing caring spaces in personal and professional life. By considering the emotional labour of care workers, we can better understand the construction of identity within particular contexts. The research raises questions about the status of Harm Reduction and other emotional workers, the sufficiency of the knowledge base for practitioners, and important issues about how to develop and organise caring workplaces.

The ebb and flow of attitudes and policies on alcohol in Ireland 2002–2010

Hope A
Drug and Alcohol Review, 2014, 33(3): 235–241.
www.drugsandalcohol.ie/21601

This paper examines the level of public support for alcohol control policies during a period of policy evolution in Ireland. A comparison of attitudes to alcohol policy at three points in time was undertaken. The first survey took place in 2002 and was repeated in 2006 and 2010 using a national quota sample of 1000 adults with face-to-face interviews. Policy areas examined were drunk-driving, price, availability and promotion.

In 2002, the highest level of public support was for drink-driving countermeasures (84% favoured random breath testing) and measures to restrict alcohol promotions (67% favoured restrictions). Support for stricter measures on price and availability was lower. Trends showed a decline in support for tax increases and for early closing time, whereas support for fewer outlets (off-trade) increased.

When public concerns (level of support) for stricter alcohol policies were seen to be meet, as occurred with price and hours through increased tax and reversal of opening hours, public concern/support declined. When concerns were not met, as with outlets, support continued to rise most likely influenced by greater number of off-trade outlets and cheaper alcohol. Support for liberal alcohol policies was low and the majority favoured the status quo on price and availability. Public support for policy is one element of the complexity of policymaking along with consensus building across government and management of vested interests, so that the policy outcome is seldom assured.

Down in the wards: point prevalence of antidepressant and benzodiazepine use

Keenan R and O'Hare J
Irish Medical Journal, 2014, 107(5).
www.drugsandalcohol.ie/21557

Letter: The point prevalence use of anti-depressant (AD) use in Ireland in 2011 was 5.5 % and benzodiazepine (BDZ) use was 4.1%. Depression is under-recognised and under-treated in hospitalised patients but the prevalence of AD use in acute general medical inpatients has been little studied internationally and unknown in Ireland. We report the point prevalence of AD and BZD use in a general medical hospital inpatient population.

Recent publications *(continued)*

A prospective cohort study of alcohol exposure in early and late pregnancy within an urban population in Ireland.
Murphy D, Dunney C, Mullally A *et al.*
International Journal of Environmental Research and Public Health, 2014,11(2): 2049–2063.
www.drugsandalcohol.ie/21551

Most studies of alcohol consumption in pregnancy have looked at one time point only, often relying on recall. The aim of this longitudinal study was to determine whether alcohol consumption changes in early and late pregnancy and whether this affects perinatal outcomes. We performed a prospective cohort study, conducted from November 2010 to December 2011 at a teaching hospital in the Republic of Ireland. Of the 907 women with a singleton pregnancy who booked for antenatal care and delivered at the hospital, 185 (20%) abstained from alcohol in the first trimester but drank in the third trimester, 105 (12%) consumed alcohol in the first and third trimesters, and the remaining 617 (68%) consumed no alcohol in pregnancy. Factors associated with continuing to drink in pregnancy included older maternal age (30–39 years), Irish nationality, private healthcare, smoking, and a history of illicit drug use. Compared to pre-pregnancy, alcohol consumption in pregnancy was markedly reduced, with the majority of drinkers consuming ≤ 5 units per week (92% in first trimester, 72–75% in third trimester). Perhaps because of this, perinatal outcomes were similar for non-drinkers, women who abstained from alcohol in the first trimester, and women who drank in the first and third trimester of pregnancy. Most women moderate their alcohol consumption in pregnancy, especially in the first trimester, and have perinatal outcomes similar to those who abstain.

Genetic pre-determinants of concurrent alcohol and opioid dependence: a critical review
Martin M, Klimas J, Dunne C *et al.*
Open Access Alcohol, 2013, 1(2): 18p.
www.drugsandalcohol.ie/21527

Concurrent alcohol dependence poses a significant burden to health and wellbeing of people with established opioid dependence. Although previous research indicates that both genetic and environmental risk factors contribute to the development of drug or alcohol dependence, the role of genetic determinants in development of concurrent alcohol and opioid dependence has not been scrutinised.

To search for genetic pre-determinants of concurrent alcohol and opioid dependence, electronic literature searches were completed using MEDLINE (PubMed) and EBSCO (Academic Search Complete) databases. Reference lists of included studies were also searched. In this discussion paper, we provide an overview of the genes (n=33) which are associated with the opioid, serotonergic, dopaminergic, GABA-ergic, cannabinoid, and metabolic systems for each dependency (i.e., alcohol or opioid) separately.

The current evidence base is inconclusive regarding an exclusively genetic pre-determinant of concurrent alcohol and opioid dependence. Further search strategies and original research are needed to determine the genetic basis for concurrent alcohol and opioid dependency.

Association of educational attainment and adolescent substance use disorder in a clinical sample
Apantaku-Olajide T, James P and Smyth B P
Journal of Child & Adolescent Substance Abuse, 2014, 23(3): 169–176.
www.drugsandalcohol.ie/21868

This study explores substance use, psychosocial problems, and the relationships to educational status in 193 adolescents (school dropouts, 63; alternative education, 46; mainstream students, 84) who attended a substance abuse treatment facility in Dublin, Ireland. The study found that the 3 groups exhibited statistically significant differences in their substance use problems, with the school dropouts displaying significantly more problems. The need for early detection and intervention of at-risk students, and collaborative interagency work aimed at addressing substance use, cannot be overemphasized as strategies to ultimately prevent school dropout.

Development and process evaluation of an educational intervention to support primary care of problem alcohol among drug users
Klimas J, Lally K, Murphy L *et al.*
Drugs and Alcohol Today, 2014, 14(2).
www.drugsandalcohol.ie/21886

This paper describes the development and process evaluation of an educational intervention, designed to help general practitioners (GPs) identify and manage problem alcohol use among problem drug users.

The educational session was developed as part of a complex intervention which was informed by the Medical Research Council framework for complex interventions. A Cochrane review and a modified Delphi-facilitated consensus process formed the theoretical phase of the development. The modelling phase involved qualitative interviews with professionals and patients. The training's learning outcomes included alcohol screening and delivery of brief psychosocial interventions and this was facilitated by demonstration of clinical guidelines, presentation, video, group discussion and/or role play.

Participants (N=17) from three general practices and local medical school participated in four workshops. They perceived the training as most helpful in improving their ability to perform alcohol screening. Most useful components of the session were the presentation, handout and group discussion with participants appreciating the opportunity to share their ideas with peers. Training primary healthcare professionals in alcohol screening and brief psychosocial interventions among problem drug users appears feasible. Along with the educational workshops, the implementation strategies should utilise multi-level interventions to support these activities among GPs.

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If you would like a hard copy of the current or future issues, please contact:

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Rowdy Yates MBE, University of Stirling, Pauline McKeown, CEO Coolmine, and Natalie Kennedy, Coolmine Therapeutic Community at the EWODOR conference. (Photo: Maxwells Photography).

Upcoming events

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

September

1 September 2014
Understanding and managing cyber bullying National Cyber Bullying Conference
Venue: Main conference centre, Dublin Castle
Organised by: Bully4u and National Anti-bullying Centre, DCU
Email: jim@bully4u.ie
Web: http://bully4u.ie/national-cyberbullying-conference-ireland/

Information: This conference will be of particular interest to parents, principals, deputy principals, guidance counsellors, boards of management, parents associations, academics, legal professionals and health care professionals. Attendance at this conference will support a school management's education requirements under the government's anti-bullying guidelines. The conference will be opened by Mr Sean Kelly MEP and chaired by Ms Mary Mitchell O'Connor TD. Further information and tickets available at www.cyberbullyingconference.ie

23 September 2014
Reporting for Work under the Influence of Drugs and Alcohol – Employers Legal Obligations
Venue: The Maldron Hotel, Cardiff Lane, Dublin
Organised by: EAP Institute
Email: anita@eapinstitute.com
Web: www.eapinstitute.com/drugalcohol.asp

Information: Seminar presented by Maurice Quinlan, Director, EAP Institute. Under the Safety, Health and Welfare at Work Act 2005 all employees must ensure that they are not under the influence of an intoxicant (defined as including drugs and alcohol and any combination of drugs or of drugs and alcohol) to the extent that he or she is in such a state as to endanger his or her own safety, health or welfare at work or that of any other person.

Safety critical companies and those with safety critical workers are obliged to conduct risk assessments and identify those who would be a danger to themselves and others if they report for work under the influence of intoxicants. Seminar presented by Maurice Quinlan, Director, EAP Institute.

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