

SUBSTANCE MISUSE

IN THE

WESTERN HEALTH BOARD

PREVALENCE,

PRACTICE AND PROPOSALS

REPORT

TO THE

COMMUNITY ADDICTION TEAM

1996

Saoirse Nic Gabhainn & Simon Comer
Centre for Health Promotion Studies
Department of Health Promotion
University College Galway

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1. Context

The Community Addiction Team was launched in January 1996 by Mr E. Hannon, Chief Executive Officer of the Western Health Board. The team was set up at the request of the Department of Health as part of a nationwide effort to combat the misuse of drugs. This is part of the action campaign to combat drugs launched by the Minister for Health in 1995 which has led to dialogue with regional Health Boards regarding the extent of the problem in each area. The objectives of the Community Addiction Team are to identify the extent of the substance misuse problem and to develop local preventive strategies. The team comprises representatives from interested parties within the area of the Board including; the Health Education Service, Special Hospital Care, General Hospital Care, Adolescent and Family Services, Community Care, Public Health, Galway Voluntary Youth Council, Department of Education, Galway Chamber of Commerce, Garda Síochána, National Parents Council, University College Galway Students Union and the Department of Health Promotion, UCG.

At the inaugural meeting of the Community Addiction Team it was agreed that a research project be undertaken to collate and review what is known about substance use, misuse and prevention in the Western Health Board region. Following further discussions with members of the team, the Centre for Health Promotion, University College Galway submitted a research protocol which undertook to address a number of objectives related to the provision of;

- A review of international literature in the field of the prevention of substance misuse.
- The collation and evaluation of related research and project work conducted within and/or commissioned by the Western Health Board which relate to substance use, availability, precursors and effects of substance use.
- A review of international, national and regional policy on substance misuse and demand reduction in particular.
- An examination of the organisation, co-ordination and delivery of services provided by the Western Health Board.
- An assessment of service responses from non-governmental and voluntary agencies in conjunction with the Health Services in relation to substance misuse within the region.

- A comprehensive action plan to be developed based on the above and in consultation with service providers and policy makers.

In May 1996, this protocol was submitted for authorisation to the Department of Health and funding was confirmed in June 1996.

The present report contains the findings of the research conducted and the recommendations for action from the Community Addiction Team, it comprises a number of sections. First a review of the substance use prevention literature is presented, this covers the major areas of prevention activity and issues that need to be considered in the choice of any policy or strategy. Next a review of what is known about substance use in the Western Health Board region. This is an overview of the scale of the problem and allows the problem of drug use to be seen in perspective. The third section is a review of international, national and regional policy on substance misuse. This is intended to assist in framing WHB strategy with other policy developments. A study of organisations and individuals within the board revealed a number of important issues for consideration and these activities and findings are contained in the fourth section. The final section contains the recommendations for action across a number of areas of activity; Organisation and Management of services within the Board, Policy Developments, Research and Evaluation, Training and Education, Environmental Interventions and Primary, Secondary and Tertiary Prevention.

This report is presented by the Community Addiction Team of the Western Health Board in conjunction with the Centre for Health Promotion Studies, Department of Health Promotion, University College Galway. It has been prepared by Saoirse Nic Gabhainn & Simon Comer under the direction of Professor Cecily Kelleher. We acknowledge the assistance of all the organisations and individuals who have assisted us in this exercise, especially the staff of the Western Health Board, this includes the various groups in the WHB Region, Nationally and Internationally, all of whom are listed in the appendices. Thanks are also due to Anne Kavanagh, Diploma student in the Department of Health Promotion, UCG who assisted with the literature searches. Particular thanks are due to the members of the Community Addiction Team who provided constructive feedback on earlier drafts especially: Frank Kavanagh, Jacky Jones, Pat Dolan, Seamus Mannion and Fiona Walsh.

2. What works in the prevention of drug misuse

This section covers the literature review conducted on prevention issues in the area of substance use. Documents, reports and academic texts were identified through a series of literature searches using the online services of Psychlit, Medline and the Social Science Citation Index. Key words were identified and were searched for in combination with one another. The key words adopted were: Drug(s), Alcohol, Substance (mis) (ab) use, Prevention, Education, Evaluation Intervention and Program (me). Appropriate review documents and selected other reports published in English since 1990 were selected. A number of other bibliographies were also searched for relevant works; The annotated bibliography on drug misuse in Ireland from the Health Research Board, the work of (Depiawo & Van Hasseh, 1994; Hoban et al., 1994), and publication lists from the Economic and Social Research Institute, the Sociological Association of Ireland, Psychological Society of Ireland, the National Institute on Drug Abuse (US), the Institute for the study of Drug Dependence (UK) and the Standing Conference on Drug Abuse (UK). What follows is a review of current literature regarding perspectives on drug use, models of prevention and their evaluation, newer trends in addressing the problem, indications of fruitful ways forward and finally issues to be addressed in any strategic policy.

Perspectives on drug use

The use of psychoactive substances in the population is widespread, particularly among youth. Authors, especially from the US have traditionally addressed this issue from the perspective that all drugs are dangerous, any drug use is harmful and the ultimate objectives of any drug interventions must be to cease or avoid use at any level. As such the concentration has been on epidemiological studies and correlates or predictors of initiation into drug use or problematic use (Swadi, 1992). More recently and with the advent of greater interest in the issue from non-medical professionals a wider picture is emerging of the role of drugs and drug use in culture (Grant & Johnstone, 1991) and the social contexts of drug use for young people (Hirst & McCamley-Finney, 1995; Plant, 1994).

Various factors, including the media influence the perspective of a society on 'drugs' and research evidence can sometimes fly in the face of what is considered obvious, both in aetiology, prevalence, trends and prevention (Hansen & O'Malley, 1996). For example,

use is declining in Afro-American youth in the US (Bass & Williams, 1993) and in many areas is below the rates for white youth. It is important to guard against stereotypes and be mindful of the source information about drugs. The notion of peer group pressure as an important precursor of drug use among young people has been losing ground. Research findings suggest that young people who use drugs have friends who take drugs or obtain their drugs from friends. This has been often been interpreted as evidence of young people pressurising other young people. Where research participants have been asked in a qualitative fashion about this issue, they have indicated that they are more likely to be putting pressure on drug users to share their substances than the other way around (Hirst & McCamley-Finney, 1995), it appears that they actively seek out other young people who will support their efforts to try drugs (Sheppard et al., 1985). Young people tend to share ideologies with their peer group and will gravitate towards others involved in activities they see as desirable (Colman, 1984; LaMarine, 1993).

The popular idea of 'gateway drugs' such as alcohol and cannabis and the perceived inevitability of their use leading to more dangerous patterns of consumption has come increasingly under attack in recent years (e.g. Swadi, 1992; Yu & Williford, 1994). Although later 'hard' drug use is usually preceded by earlier 'soft' or legal drug use, this is not always the case and youth can and do stop at various stages along the way (Coombs et al., 1986), the trajectory is not unidirectional. Regular alcohol use usually precedes experimentation with illegal drugs but for most young people drug use starts and finishes with experimentation. Research evidence suggests that most adolescents 'mature out' of illegal substance use (Swadi, 1992). Indeed, Shedler & Block (1990) report on a prospective longitudinal study of young people and indicate that for their sample, experimentation (primarily with marijuana) was associated with higher levels of later psychological adjustment when compared with frequent users who were maladjusted and lifetime abstainers who were relatively anxious, emotionally constricted and lacking in social skills. None of this is to suggest that no peer pressure or gateway drugs exist, or indeed that experimental drug use should be encouraged, merely that it is important to look beyond the stereotypes or reliance on media fed explanations of phenomena.

Blackman (1996) presents an interesting perspective on the issue of drugs in youth culture and argues that drug use is supported by the ideology of consumer capitalism which validates immediate gratification. He argues that drug use has been normalised in youth culture and is perceived and experienced as being largely unproblematic. Drug use, largely of drugs like Cannabis and Ecstasy are identified with positive experiences for the individual user (Parker et al., 1995; Plant, 1994). Coffield & Gofton (1994) report that

young people approach 'soft' drugs with the same rational matter of fact way that they approach other consumer products. They search for value for money and weigh up the potential benefits and risks of taking any particular drug in a particular situation. This interpretation is confirmed by Hirst & McCamley-Finney (1995) who report on a series of qualitative studies with young people in Sheffield. The dominant theme emerging from their work suggests that drugs are a part of many young people's lives but are not a central issue even for drug users. They are surprised by the lack of understanding many adults have of the drugs scene and drug using and indeed focus on this ignorance of their social world in order to further distance themselves from adults in general and prevention efforts in particular.

Perspectives on primary prevention

Irrespective of the potential adaptivity of experimental drug use, most efforts at prevention have been at the primary stage. That is they attempt to eliminate all use and first use in particular. The emphasis on this aspect of prevention is clear from the literature but it must be considered that most of the available literature stems from the US, which has taken a very strict approach to drug use (Newcomb, 1992; Peele, 1986). European literature is more recent and tends to excel in more qualitative research and sociographic theory.

Information based approaches

Early approaches to interventions were based on the idea that people were rational and that the provision of good quality information would allow people to garner the consequences of drug use, that they would decide not to use drugs and therefore would not. This approach often involved a description of the pharmacology of various drugs and the effect they had on the body as well as the use of scare tactics which involved giving the public frightening stories about what would happen if they took drugs. Although intuitive, these type of initiatives failed at almost every hurdle and sometimes even increased use (Blum, 1976). Not until further information became available from a variety of social science disciplines and theories abounded about predictors of behaviour (e.g. Becker & Rosenstock, 1984; Azjen & Fishbein, 1980) and how to influence them did the 'science of prevention' become based on empirical research. Unfortunately many attempts were premised largely on untested or incomplete theories.

‘Just say no’, decision-making and social skills approaches

In the 1980s two separate approaches appeared in the US to the issue. The first approach during this time was to view drug taking as a form of natural behaviour (Einstein, 1980) and the promotion of safer drug taking and alternative methods for altering ones consciousness safely. The second has been seen as a backlash against the encouragement of rational decision making and responsible drug use (Kurzman, 1976) which was beginning to be popularised in the late 1970’s. This posited that all use is bad, total abstinence is the only option and thus the ‘Just say no’ media and government backed campaign reigned. DARE, Drug Abuse Resistance Education is the most widely dispersed programme based on these ideas (Koch, 1994). However effect sizes are reported to be relatively small and therefore not promising despite its wide appeal and implementation (Dukes et al., 1996; Ennett et al., 1994). Subsequent interventions continued to focus more on the individual than the drug, and were based on the notion of helping with values clarification and decision making (sometimes referred to as affective), and later, enhancing general social skills. The underlying rationale was that stable well-adjusted people would not want to use drugs (Montagne & Scott, 1993). While many programmes based on such perspectives did succeed in enhancing social or decision making skills, the expected impact on the level of individual drug use rarely materialised (NIDA, 1986).

Social Influence Models

The situation in Europe tended to be less policy led and more reliant on research and theoretical developments in the drug use and prevention field. There are various opposing views as to the usefulness and impact of programmes based on different models of behaviour (Tobler, 1986; Hansen, 1992) and there are no clear leaders in the field. Refinements of both the decision making models and social skills enhancement continue to be both popular and widely supported. Social influence models of prevention are increasingly advocated (Botvin & Botvin, 1992; Dom & Murji, 1992). These target the social influences that young people may be under in relation to drugs, particularly among peers, the family and the wider community and could be perceived as more specific and targeted examples of the social competency/social skills approaches. These models tend to involve making participants aware of potential influences, teaching specific skills to resist them and targeting perceived social norms regarding substance use. There is not necessarily any knowledge or decision making related objectives to such programmes, but they do often involve peers as tutors or educators. Evidence on the effectiveness of these programmes is promising, even more so when combined with other techniques

(Botvin & Botvin, 1992; Hansen 1996; Tobler. 1992). The journey is not over as prevention is far from being an exact science. Nevertheless it is not practical or even necessary to wait until there is definitive knowledge on how to effect behaviour in an ethically acceptable manner (Westermeyer, 1989). Sufficient evaluation data exist to enable a best practice model to be developed and widespread agreement exists on the most appropriate forms of interventions for some settings.

Evaluative data

While methodological difficulties abound in all applied research, especially evaluation, many authors have attempted to tease out the components of successful programmes. The most regularly cited and quoted reviewers in this field are Tobler (1986; 1992) and Hansen (1992). Many authors have been pessimistic about the outcomes from prevention interventions (e.g. Moskowitz, 1989; Plant, 1990; 1994) and there is no doubt but that they are not entirely effective. Knowledge levels and attitudes are more regularly altered (Morgan et al, 1996; Nic Gabhainn & Kelleher, 1995) than is behaviour. There is much controversy surrounding this in the literature (Tobler, 1992). As most evaluations are short term and the objectives of most interventions are long term, researchers sometimes argue that there has not been sufficient time for an impact on behaviour to be shown. Others argue that given the low prevalence of most substance use, huge sample sizes would be required to identify behavioural changes with any reliability. Altering of attitudes and knowledge are sometimes characterised as valid outcomes in themselves, ones which may indeed have the long term effect of altering social norms in relation to substance use (Montagne & Scott, 1993).

Nevertheless, the reviews of Tobler and Hansen have set about comparing approaches with one another. Hansen & (O'Malley (1996) compare the two evaluative reviews and find that they do indeed complement each other. Programmes were categorised into four major groups; information only, affect only, social influence and multi-component (sometimes referred to as comprehensive). Hansens collection of 45 evaluations and Toblers 143 were recategorised according to these four groups and average effect sizes calculated for all those falling into the specific category. Only those that could be adequately categorised and for which it was possible to calculate effect sizes were included. Most effect sizes (ES) range from -1 to +1, where -1 means that a 100% reduction in a particular behaviour or disorder was noted and +1 means that a 100% increase in the behaviour was found. In this case, the larger the ES the greater the impact of the programme on drug use. Table 1 contains an abridged version of Hansen &

O'Malleys (1996) original. N refers to the number of studies included in that group. Tobler restricted column refers to studies that met certain methodological adequate criteria: follow-up, control groups).

Table 1: Effect size meta-analysis from two prevention outcome reviews

Source/ Type	Hansen		Tobler		Tobler restricted	
	N	ES	N	ES	N	ES
Information	5	0.17	14	0.09	3	0.05
Affect	11	-0.01	25	0.05	14	0.02
Social Influence	12	0.19	37	0.18	16	0.27
Multicomponent	3	0.13	25	0.37	20	0.37

The larger the ES the greater the impact of the intervention programme

Tobler (1992) clearly identifies comprehensive or multicomponent programmes an effective and argues for their adoption. She also reviews the use of peers in influence initiatives and directs considerable attention to their potential for interventions. Botvin & Botvin (1992) come to the same conclusion and are particularly impressed by the potential that peer education holds. Hansen (1992) is also social influence and comprehensive programmes are most effective in preventing onset of substance use. Wodarsld & Smyth (1994) discuss these comprehensive models in more depth. Arguing that they are not only characterised by drawing on multiple components within school settings but for maximum effectiveness include other of the young persons environment. From this perspective they can also interventions targeted at the family, community as well as organisational aspects school.

Mediating Factors

There are however numerous other intervening or mediating factors which must also be considered in the implementation of a prevention programme. Hansen considers (1992) the importance of fidelity to original programmes as central in order to ensure effective outcomes. Teacher training and background as well as adherence to the programme contents are equally important. Initiatives developed for one population or target group may not be as relevant or useful with another (Rogers, 1995). This issue is particularly relevant to the West of Ireland as the nature of drug use differs as does the school system

as well as the underlying social system in which potential drug users live. The applicability of findings from another situation is unknown. For example, any programme adopted in the West might do well to consider the possibility of emigration of the young people involved. Other factors known to be of influence in school based programmes include the length of the programme; short term interventions are likely to have short term outcomes (Dryfoos, 1991; Lavin et al., 1992). In addition, the school climate and hidden curriculum as well as explicit and clear school policy must work in tandem with the ideology of the intervention (Bushong et al., 1992; NWHB. 1996).

Conyne (1994) reviews elements of successful programmes and suggests that in order to have the desired primary prevention impact, they must involve a collaborative ethic and have empowerment as a superordinate goal. They should work within a social ecology framework and use multifactorial methods. He also argues that factors that place people at greater risk for drug use and those that appear to protect people against use should be explicitly targeted for change and enhancement respectively. The importance of non-school settings and using risk and protective factors is discussed further below.

Focusing interventions

Social influence models are examples of what are considered universal programmes (Gorman, 1992), and as such have been considered suitable for large scale population intervention. They are based on a particular model of aetiology which sees adolescence as a vulnerable period (Kandel and Logan, 1984) and are based primarily on social learning theory (Bandura, 1977) and problem behaviour theory (Jessor, 1988). Gorman (1992) while accepting the positive outcome findings associated with social influence models, argues that all adolescents are not at the same level of risk and that a generic model will not have the same potential for prevention as targeting specific groups would have. Thus the concept of levels of vulnerability is introduced. There are a number of key risk factors associated with drug use and their identification and alteration is a key way forward according to Gorman (1992). The competition between universal programmes and targeted risk factor interventions is referred to as Kreitmans (1986) preventative paradox. Should prevention efforts target those at high risk who are characterised by the highest probability of negative outcomes or the population as a whole among whom the largest absolute numbers of problems are found (Grant & Johnstone, 1991). One reason for targeting those with a number of risk factors has been that they are frequently not found among wider population samples such as school students.

A number of authors agree with this risk factor perspective and the aetiology of drug use has been widely discussed (e.g. Farrell & Taylor, 1992; Hawkins et al., 1992; Newcomb & Bentler, 1989). It is important to remember that there are few methodologically sophisticated studies in this area and the majority of what is known stems from correlational designs. Thus while certain factors may be associated with initiation into drug use or later problematic use, the relationships are not necessarily causal. A large number of correlates or predictors of substance use have been identified including low-self-esteem (Miller, 1994) or self-efficacy (Turner et al., 1996), impulsivity (Pogge et al., 1996), sensation seeking (Newcomb, 1996), extroversion & neuroticism (Quirk et al., 1996) and possessing a deviant self image (Ross et al., 1996). There is also evidence that genetics (Farrell & Taylor, 1992; Tarter, 1995) or neurological data (Van Heeringen, 1995) can assist in the identification of high risk individuals.

The most stable indicator is peer drug use (Newcomb & Rentier, 1989; Swadi, 1992), but there has been considerable debate concerning the interpretation and usefulness of such a finding. It is not surprising that people who use drugs have friends who also use drugs and it is considered impractical, though not impossible, to try and identify people through their friendship networks. Further efforts have been directed at locating factors which can be more easily identified. Many authors break down the range of risk factors into categories such as individual level, family level and community level and argue that it should be the combination of a number of risk factors that results in any individual being perceived at high risk (Hawkins et al., 1992; Newcomb & Bentler, 1989). In addition the literature has identified what are called protective factors, which are hypothesised to protect or insulate the individual against initiation or problematic use.

Hawkins et al. (1992) provide a thorough review of risk and protective factors and define risk as those factors that precede and are predictive of drug use. They divide risk factors into contextual factors and individual and interpersonal factors. Table 2 presents an overview of their findings.

**Table 2: Risk factors for the onset and problematic substance use
(adapted from Hawkins et al., 1992)**

Type of Risk	Actual Risk	Example Reference
Contextual	Laws and norms favourable towards behaviour	Levy & Sheflin, 1985
Contextual	Availability	Maddahian et al., 1988
Contextual	Extreme economic disadvantage	Famngton et al., 1990
Contextual	Neighbourhood disorganisation	Pagan, 1988
Individual	Physiological factors	Shedler& Block, 1990
Interpersonal	Family use & attitudes	Brook et al., 1990
Interpersonal	Poor & inconsistent family management practices	Brook et al., 1990
Interpersonal	Family conflict	Simcha-Fagan et al., 1986
Interpersonal	Low bonding to family	Penning & Barnes, 1982
Interpersonal	Early and persistent problem behaviours	Lemer & Vicary, 1984
Interpersonal	Academic Failure	Robbins, 1980
Interpersonal	Low degree of commitment to school	Johnston et al., 1985
Interpersonal	Peer rejection in early school years	Hawkins et al., 1987
Interpersonal	Association with drug using peers	Brook et al., 1990
Interpersonal	Alienation and rebelliousness	Shedler& Block, 1990
Interpersonal	Early onset of drug use	Kandel, 1982
Interpersonal	Favourable attitudes towards drug use	Kandel et al., 1978

These risk factors and Hawkins et al.'s (1992) interpretation of them have also been adopted by the NWHB (1996). Others approach the issue from the perspective of early identification. For example Swadi (1992) argues that abuse should be suspected or at least investigated when adolescents or preadolescents are in receipt of services associated with parental substance use, sexual or physical abuse, dropping out of school, teenage pregnancy, economic disadvantage, delinquency or mental health problems. Lamarine (1993) reports that longitudinal studies have shown that there are psychological differences between later abusers and experimenters, the abuse being the result of poor psychological health rather than the reverse. Another typology has been proposed by Newcomb & Bender (1989). They suggest that risk factors can be categorised according to the six groups contained in Table 3.

Table 3: Risk factors for drug use adapted from Newcomb & Bentler (1992)

Type of risk	Actual risk
Social structural	Low socio-economic status
Family & Socialisation	Parental use, disturbed families, low religious commitment
Educational	Poor school performance, early school leavers
Psychological	Low self-esteem, Neuroticism, impulsivity
Attitudinal	Tolerance for deviance
Behavioural	Lack of law abidance, deviant behaviour
Emotional	Need for excitement. Sensation seeking
Psychopathological	Stress, Anxiety, Depression

Hansen & O'Malley (1996) report on the major types of risk factors and presents data which allows comparison between them. Average correlations between types of risk factors and drug use are presented. It is pointed out that these are correlations with use rather than with abuse or misuse. Correlations are an indication of the type of relationship that exists between two or more variables. Correlations range in size from -1 to +1, where -1 is a perfect negative relationship (negative meaning that as the scores on one variable increases the scores on a second decrease, such as level of education attained and likelihood of being unemployed) and +1 is a perfect positive relationship (positive meaning that as the scores on one variable increase, the scores on a second also increase, such as childrens height and age). In this case, the higher the correlation, the stronger the relationship between the risk factor and drug use. The correlations are presented below in order of the strength of the relationship.

- Perceived attitudes to drugs amongst others 0.38
- Drug use by peers 0.37
- Prior or current other drug use 0.36
- Attitudes towards drug use 0.29
- Drug use by others 0.27
- Bonding and commitment to school 0.27
- Beliefs about health consequences 0.20
- Self-esteem 0.17
- Participation in recreational activities 0.14
- Home factors 0.13
- Gender 0.07

Irish Authors have also addressed the issue of risk factors or predictors of substance use. These are extremely useful in providing culturally appropriate risk factors but are limited because of the small number of such studies. Data only exist on a restricted number of factors. The strength or existence of relationships is only known for those variables that were included in the respective studies. Loftus (1997) provides a comprehensive list of risk and protective factors across the individual, school, family and community. Although very useful and in keeping with the factors discussed here, these are not referenced and it is unknown from where they were derived. Kiernan (1995) adapted the questionnaire of Morgan & Grube (1990) and therefore both report on similar potential risk factors. Grube & Morgan (1990) report on the structure of problem behaviours among adolescents in Dublin and conclude that general deviancy did not account for variations in problem behaviours. This is in contrast to findings from the US and they warn that the general deviance hypothesis (Newcomb & Bender, 1988) may be culturally dependent and not applicable to Irish youth. In 1990 Grube & Morgan also reported on contingent consistency effects in the prediction of substance use for the same sample. They found that regardless of age, current substance use behaviours were predicted by perceived substance use by friends, especially when this was accompanied by favourable attitudes to substance use. In relation to changes in alcohol use, Morgan & Grube (1997) report that these have increased along with changes in normative perspectives of use. That is changes in beliefs about consequences of drinking and in the perceived social support for drinking were associated with changes in drinking behaviour. These studies all point to the importance of the perceived normality or acceptability of substance use as predictors of use behaviours.

Kiernan reports on correlates of drug use in WHB adolescents (1995). She found significant correlations for perceived approval of father, mother, best friend and other friends. She also presents large differences in prevalence rates for those who report that they have friends who use drugs (77% who say all their friends use drugs have tried them, while 11% who say none of their friends report trying them). Kiernan (1995) also reports significant associations between perceived consequences of drug use and attitudes to drugs with drug use behaviour. The less severe they thought the consequences were and the more favourable their attitudes, the more likely they were to have ever experimented. There were also significant relationships between 'social bonding' and drug use, those who felt closer to their parents and friends, who felt they got on well in school or in the training centre, who were less deviant and who prayed regularly were all less likely to have ever tried drugs. Finally Kiernan (1995) also reports significantly higher prevalence rates among early school leavers (33%) as opposed to school students (23%) or Travellers

(10%). Note that while the rates for Traveller youth are significantly lower than for either of the other groups, 10% still represents significant involvement in drug experimentation among this cultural group. Taken together these Irish studies provide good evidence of the importance of perceived social norms on the substance use behaviours of Irish youth.

Protective factors in drug use are those characteristics of the individuals or their interpersonal world which work to both mediate and moderate exposure to risk as well as the risk itself. Although sometimes conceived as the opposite to risk factors, this concept is more useful when employed to help explain why individuals who appear to be exposed to similar risks respond differently. Rutter (1985) explains this in terms of vulnerability or resilience. Resilient children are perceived to possess more social skills and higher self-efficacy. The extent of the research conducted on protective factors and mechanism is considerably less than that on risk factors. Nevertheless, Garmezy (1985) identified a number of factors which protected children in extremely disturbed families. The possession of a positive temperament, external support systems and external positive value systems were all identified in the more resilient children. Studies of indigenous peoples have indicated that 'Cultural Wholeness' can also serve as a protective factor or curative agent (Brady, 1995). It appears likely that the low levels of any individual risk factor could assist in protecting against high levels of the other (Hawkins et al., 1992). For example, high levels of academic achievement and commitment to school could operate against negative home factors or low social self-esteem (negative or poor self perceptions related to the interpersonal or public realm).

There is therefore considerable overlap in what are considered to be the main risk factors, but care must be taken not to overstate the case. Some that appear most intuitive (e.g. self-esteem) are not as important as others that may be less so (perceived attitudes of others). The individual risk factor approach has not been entirely successful in predicting use and so individuals with one or two risk factors should not be stereotyped, rather the existence of a greater selection of risks should be present before the issue of use can be investigated. These risk factors are based primarily on characteristics of the individual but for a focused or targeted approach to be taken these also need to be translated into population groups. For example, early school leavers could represent those with low academic achievement and low commitment to school. Those with family and behavioural problems may be represented by attenders at a child guidance clinic or those in receipt of the services of social workers. Those at risk because of peer use could be identified through schools or communities where substance use is known to be relatively widespread. Kroger (1994) in his review of prevention work for the European

Commission converges with the above review on a number of issues. Specifically he agrees on the primacy of the social influence approach, on the importance of programme length, on the potential use of peer leaders and importance of risk and protective factors as well as the benefit incurred from a multi factorial approach. He also emphasises the importance of commencing primary prevention prior to the initiation of drug use.

Timing Prevention Interventions

One approach to the timing of prevention stems from the idea of drug use as an epidemic (Hughes & Rieche, 1995; Kaplan et al, 1994). The epidemic analogy posits that the appropriate intervention should be based on what is known about the nature of the problem and that resources be allocated according to the best return for investment. Prevention should be timed to the appropriate period of the epidemic (Kaplan et al, 1994). Before there is evidence of any problem, but only if the potential problem is considered important, prophylactic measures should be taken, and measures to ensure a quick response of services when and if needed should be implemented. When evidence is weak but the problem is starting then the potential for intervention is greater, it should be at primary level and those at greatest risk should be targeted. When the problem is widespread, the objective of interventions are to avoid as many associated problems for as many people as possible. Tasks at that stage involve identifying high risk users and lifestyles and employing specific measures to reduce associated risk. Muramoto & Lesahn (1993) also approach primary prevention from the perspective of appropriate interventions according to stages of use, but they work primarily on an individual rather than a population level. Nevertheless their recommendations mirror those above.

Prevention activities in non-school settings

While most interventions internationally have been undertaken with school going populations (Lavin et al., 1994), and evidence is mounting that interventions can be successful in school settings (Conyne, 1994), advances are continuing with other population groups and settings. Numerous authors have provided overviews of such substance use prevention efforts over the last few years. Logan (1991) categorises them according to the contexts in which they are used. Wodarski & Smyth (1994) also take this approach but divide the work they discuss into the three levels of prevention. The basic approaches above are detailed and specific interventions based upon them are discussed by Montagne & Scott (1993). The main settings addressed in the literature are; Schools and Peers, Family and Community.

The major findings in relation to school based prevention have been summarised in the previous sections. Peer interventions form one part of school or youth based interventions that are currently receiving attention in the literature. Peer interventions stem from the theory of social networks and individuals are taken from the peer group for specialised training. Peers are then used to teach and model socially acceptable behaviour (such as not taking drugs) (Logan, 1991). Often peer tutors are older than those they teach and many are actually adults with 'high credibility' to youth. In general peers are perceived as more credible sources of information than other 'adults'. Wodarski & Feit (1993) report on a unique intervention among youth in schools involving group work with peers as leaders and supporters of prosocial norms. Evidence is mounting for the effectiveness of various forms of peer led interventions, thus far the results from such approaches appear promising (e.g. Tobler, 1992; Benard, 1988).

Family based interventions take a number of forms, one of which is focusing on parental education. Such programmes usually include communication skills, child-management strategies and parenting styles (Bray, 1988). These stem from the notion that the family is the primary socialisation agent for the child and that patterns of parental behaviour can impact on child behaviour (Wodarski & Smyth, 1994). Another model focuses on families known to be at high risk, either through social work contact, through mental health service provision or through early childhood interventions (Zucker & Noll, 1987). Evidence is mounting that such programmes can impact on family function (Logan, 1991) and the popularity of parenting programmes, especially among parents is increasing. Elmquist (1995) reviewed 22 parent oriented programmes and makes the following recommendations for selecting appropriate interventions; Ensure that the programme is based on proven instructional principles, do not try and address the needs of all parents with a single programme, focus interventions according to the expressed needs of participants, try to teach a few skills well rather than having a broad base and make sure that issues specific to substance use are included.

Community approaches to drug prevention usually include a variety of approaches including those already discussed above. They are by definition broad based and are often focused on high risk communities (Wodarski & Smyth, 1994). They regularly include residents organisations, sports and recreational facilities, health service orientation as well as media campaigns and tend to build on resources already existing in a given locality. Attention is also directed towards creating alternatives for youth leisure time and

sometimes the provision of employment and training. Given the nature of implementation, most community interventions have been difficult to evaluate summatively (Logan et al., 1991). There are however a number of well designed studies which provide excellent evidence for the success of a community wide approach. Pentz et al. (1989) report on the six year Midwestern Prevention Project (MPP) which employed a quasi-experimental design. The MPP included a school programme, mass media, peer education, community organisation and health policy components. At follow up adolescents in the intervention groups reported significantly less substance use than controls. It is worth noting in this context that the evidence for the effectiveness of broad mass media campaigns held on their own is not encouraging (Wartella & Middlestadt, 1991) and that those conducted within the context of a more structured and focused intervention are more likely to be successful.

It has been widely argued that comprehensive programmes that are not only school based are required to really address this issue (Dryfoos, 1993). Thus a combination of strategies appear to work synergistically with one another to promote more effectiveness than any single initiative. Montagne & Scott (1993) recommend approaches that train communities in addressing the issues for themselves, albeit in a multi-modal fashion. These suggestions mirror the conclusions of those reviewing school based programmes who argued (e.g. Hansen 1992; Tobler, 1986) that complementing the work being conducted in schools with family or community focused intervention appeared to greatly enhance the effectiveness of prevention efforts. Pentz (1993) argues that the more successful initiatives have been theoretically and research based, involve integration with other health and prevention programmes, include multiple modalities and work at various stages across the lifespan.

The role of Health Professionals

In the context of multi-modal approaches to the drugs issues, health professionals are often asked to take on a number of new roles. These include collaborating with one another and with outside bodies, provision of accurate and appropriate knowledge, contributing to the creation of a supportive environment for non-use and early identification and screening of high risk individuals. These are central roles and may involve altering ones methods at work and thinking more holistically about ones professional responsibilities. A number of authors have provided guidelines for the further training of health professionals in such a context. Durfee et al. (1994) discuss models of on-going substance abuse education, while Werner & Adger (1995)

concentrate on the potential role of paediatricians and Accept (1981) and Bergmann et al. (1995) on the role of General Practitioners. There is also a large literature on patient education (e.g. Simmons-Morton et al., 1992) which is relevant here.

Multidisciplinary work and collaborating with community and voluntary groups is often a new experience for health professionals and is not necessarily straightforward. Strang et al. (1992) provide an overview of how community drug teams have worked in the UK and the problems which they have encountered, including difficulties associated with involving General Practitioners in the process. Nevertheless Strang et al. (1992) provide a clear model for action which when taken in conjunction with the “Practical Digest for Drug Action Teams” (Central Drugs Coordination Unit, 1996) which contains guidelines for working together at a community level in the UK, would help the formation and process of collaborative working. Others (e.g. Davis, 1996) have written about models of collaboration among professionals, specifically in attempts to help youth at risk in the school and community setting and it would also be fruitful to borrow from these source.

Collaboration with young people

The perspectives that young people hold on drug use are an essential starting point for any intervention programme (Whetton, 1993). It is considered vital to ‘start where young people are’ in order to appropriately address their issues concerning drug use. Rather than epidemiological data, what is required is qualitative information which can provide a more in depth understanding of the young people in the target group, whether that be in the school or in the community. Indeed the principle of starting where programme participants are is also adaptable to other groups that any intervention may wish to target. The focus group research reported by the NWHB (1996) fulfils just such a role. When asked about the sorts of education that they would like, the young people sampled wanted it to be direct and relevant, they wanted to hear the stories of those who had overcome drug problems and felt that while leaflets, videos and talks were useful, they should not be relied upon as the sole approach. Those who had not been exposed to drugs also wanted to see samples of the various kinds so that they could protect themselves against taking drugs unknowingly.

Hirst & McCamley-Finney (1995) also asked young people about their drug education. All those sampled were unhappy with what they had received. It was perceived as ‘too late, too superficial, irrelevant and delivered in a way that was ‘safe’ for teachers’. They

report that drug education was felt to be useful if it; began early enough, was realistic, delivered by a credible source, allowed for student input and reciprocity, was flexible and appropriately delivered (e.g. small group discussions), did not just emphasise the negative and acknowledged double standards in terms of the risks attached to legal drugs.

Marechal & Choquet (1990) report on an innovative and successful initiative which incorporated groups of young people in discussing and evaluating primary prevention materials and developing their own materials, which they then evaluated. This approach produced some significant affective and cognitive changes among participants and is an excellent example of students being involved with and directing their own learning experiences. Similar models using peers as educators have also been receiving positive reviews (Botvin & Botvin, 1992; Tobler, 1992).

Special considerations

Universal programmes are often targeted at school children and it has been in this context that they have been evaluated. This is reasonable given the developmental stages of drug use and the fact that most children can be found in schools. Targeted programmes also usually address this age group or at least youth in general. However there are some other groups that require consideration, both within the school setting and more importantly outside it. Substance use among women at all stages deserves special attention. Most research among adults has been conducted with men (Yaffe et al., 1995; Plant, 1985). Although prevalence rates among women are usually lower than for men, they do appear to have different patterns of use and there is evidence to suggest that women are less likely to 'mature out' of substance use (el Guebaly, 1995). There is widespread acknowledgement of gender specific vulnerability related to biological factors (e.g. Mann et al., 1992) as well as psychological factors (e.g. Rounsaville & Kleber, 1987). While specific data on prevention for women is rare, a large literature exists on screening and treatment issues for women (e.g. Della-Tolla, 1992; Yaffe et al., 1995) which should be considered in the planning of any interventions.

Extra care should also be taken to address the potential substance abuse trends in older adults. While alcohol abuse is certainly an issue and late on-set alcoholism especially so, (late onset alcoholism has been operationalised by Atkinson et al. (1985) as the onset of drinking problems after age 40) there is little evidence of illegal drug use in this cohort (King et al., 1994). There is the possibility that this issue will come more to the fore in

the future as middle aged users get older (Kofoed, 1985). King et al. (1995) argue that the effectiveness of many prevention interventions and treatments are unclear for this group and that closer attention will need to be paid to this issue in the future. Another group which may benefit from specialist attention are the Travellers. Kiernan (1995) reported a 10% lifetime prevalence rate for the young Travellers in her sample. The health requirements of Travellers have previously been characterised as similar to the indigenous peoples of Canada and Australia (O'Donovan et al., 1995). It may be fruitful to borrow from specific targeted programmes in those countries in order to more appropriately address this group. Nevertheless, it would be vital to gain community support for any intervention directed at Travellers and full cognisance should be given to their cultural and political values and organisations during any such activity (Gray et al., 1995).

In addition to the groups mentioned above, and although not the focus of this review, it is useful to begin to reorient treatment services to young people. If targeting of high risk youth is implemented and health professionals are trained in early identification and screening of problematic users then it would be essential to have appropriate facilities in place to accommodate a likely increase in clients. Ross (1995) outlines the essential elements in treating adolescents, while Bergmann et al. (1995) argues that such treatment can be effective, especially when referrals come early in the individuals history of problem use. Promising initiatives with this age group are reviewed by Jenson et al. (1995) who outline both traditional and non-traditional interventions.

On-going evaluation & research

The importance of on-going monitoring and evaluation of initiatives is discussed in almost every text. Given the scale of resources allocated to such activities it is surprising that policy makers do not enforce their allegiance to this more regularly (EMCDDA, 1995). Evaluation theory has progressed substantially and methods now exist for the adequate evaluation of all kinds of interventions. First it is important to pay attention to all evaluative reviews of any programmes which are under consideration for adoption. In this context faithfulness to the original programme (Hansen & O'Malley, 1986) and a realistic appraisal of its cross cultural adaptability (Grube & Morgan, 1990) are essential. In addition it is important to assess the acceptability of any intervention to the target group or population (Callaway et al., 1995).

If any alterations or adaptations are planned, the programme or initiative may need to be re-piloted (Rodgers, 1995) and certainly the framework for long term outcome evaluation needs to be planned prior to implementation. In choosing methods of measurement it is desirable to ensure as much international comparability in data collection as possible (Blanken, 1993). As programmes are implemented it is necessary to keep detailed accounts of the process involved. This is vital for later process evaluation or even description of activities undertaken (Coggans et al., 1991). Cost-effectiveness and economic evaluations are becoming more popular in the literature (e.g. French, 1995; Maynard et al., 1987) and detailing all aspects of the evaluation will greatly assist this procedure. Finally, all evaluation efforts should be exposed to the public (Nic Gabhainn & Kelleher, 1995), many are considered internal documents and the potential to assist other planners, policy makers and implementors is lost.

In addition to evaluation research the on-going collection of epidemiological data is essential to guide prevention activities. This is useful at a population level and at a risk group level. Other epidemiological methods such as the early warning systems as used in Heroin Epidemics (Hughes & Rieche, 1995) and the youth risk behaviour surveillance system in US (Kolbe et al., 1995) are also adaptable and useful to planners. These allow information regarding new patterns of drug use or new drugs on the market to flow quickly to those who are in a position to influence policy and strategic responses.

Conclusion

Evidence for the effectiveness of many of the earlier forms of primary prevention is weak and effect sizes appear to depend on a large number of factors. Rather than just attempting prevention work in order to be seen to be doing something (Smelson, 1993), it is essential that genuine efforts work to provide the best possible prevention activity according to what is known in the literature. Social influence school programmes (Botvin & Botvin, 1992) and more comprehensive interventions (Hansen, 1996; Tobler, 1992) appear to offer the best chance of success. However, it is important to take potential mediating factors into account when planning any intervention. It can also be profitable to work on other aspects of the issue simultaneously. That is the early identification of those at risk (according to what is known about drug use aetiology) and the bolstering of protective factors at an individual, family and community level. These should be combined with secondary prevention and rehabilitation initiatives and support for those concerned with the control of supply in order to provide a fully integrated service. All these require training for staff and a full programme of evaluation, both process oriented

and outcome focused. Such a proposal clearly demands the commitment both ideologically and materially of a wide range of partners. The WHB would be in a position to take the lead but must collaborate and negotiate with a variety of other statutory and voluntary groups, not least members of its own staff.

3. What we know about substance use in the Western Health Board Region.

A number of organisations and researchers have addressed the issue of substance use among youth in the WHB region over the last few years albeit from different perspectives. The following section describes briefly the various studies and the comparative findings are presented. These studies have used different methods with different age groups to ask different questions. Rather than this being perceived as a weakness, it could be considered that the information garnered from one survey could illuminate and validate the other. Nevertheless, it is not possible to directly compare rates of substance use and the differences in the studies, particularly in relation to age group, must be considered. The other two main sources of information regarding drug use in the region stems from the Health Research Board and the Gardai. In 1997 the HRB published its first National report on treated drug misuse in Ireland (O'Higgins & Duff, 1997) which includes a breakdown of treatment episodes per Health Board for the year 1995. The Garda Commissioner's Reports on Crime includes data on the numbers charged with drug offences under the 1977 Misuse of Drugs Act across various counties and regions of the country.

Moroney (1993) reports on a survey of 'Smoking, alcohol and other drug use' among post-primary school pupils in county Roscommon and the Elphin Diocese Area of County Galway. Moroney surveyed 2632 pupils in 13 schools as part of his work with the Roscommon Regional Youth Services (age range 13-17+). Although the methodology adopted for this sampling is not clear, it represents a major effort to collect and disseminate information on youth substance use.

McHale (1994) presents the results of a large scale data collection exercise representing 40 out of 47 post-primary schools in the Galway city and county (N=2799). This survey was conducted in the context of public health doctors providing education on AIDS/STDs. The pupils involved were in their pre-leaving certificate year and thus their ages ranged from 15-18. The questionnaire employed asked questions about drug and alcohol use as well as sexual behaviour. It also covered knowledge and preferred sources of education on potentially risk behaviours.

The Western Health Board has also supported the collection of accurate and comprehensive information through their support of Keirnan's (1995) thesis on the substance use among adolescents (aged 12-18+) in the region. A stratified sampling procedure was employed for post-primary schools which resulted in data from 2576 pupils in 37 schools being collected. In addition, she surveyed 211 out of school youth, conducting a census study of early school leavers attending training centres within the board area. The survey instrument was a modified version of that developed by Grube & Morgan (1990; 1994) and covered cigarette, alcohol and other drug use behaviours as well as attitudes towards these substances.

Hope & Kelleher (1995; 1997) report on a large scale intervention study conducted under the auspices of the European Community Europe against Cancer initiative. This study involved collecting baseline data from a seven worksites across Galway County and City. As part of this work data was collected from students in UCG regarding a range of health behaviour and lifestyle factors including; alcohol, tobacco and drug use. A total of 1683 students were randomly selected by timetable slot from among the first year and fourth year students across each faculties.

Finally Nic Gabhainn et al. (1996) and Colohan (1996) report on a series of studies of high risk youth in Galway City. These interview studies employed the methods and interview schedule of Bagnall & Plant (1991), to survey 173 and 200 young adults between the ages of 15-25 during the summers of 1993 and 1996 respectively. These studies employed researchers to call to every house in a defined geographical area which is considered disadvantaged because of the housing and employment status of its residents. Young people who agreed to be interviewed (refusal rate 5%) were asked questions about their alcohol, tobacco and illegal drug use as well as their sexual behaviour and knowledge about HIV transmission. They were also asked about other illegal activities such as shoplifting and joyriding.

Similarities and differences between the studies

Moroney (1993), McHale (1994) and Kiernan (1995) have all collected data from school pupils in the classroom. This covers the vast majority of youth in the region. However the geographical areas and age ranges vary. Moroney covers primarily Roscommon and his range was 13-17+, McHale covers Galway and her range is 15-18, while Kiernan covers the whole board area with a range from under 13 to over 18. Hope & Kelleher (1995;

1997) have covered University Students in a similar style, that is in the lecture theatre with a self-completion questionnaire. Both Kiernan (1995), Nic Gabhainn et al. (1996) and Colohan (1996) have collected data from out of school youth, but the collection methods and age groups as well as location differ. Kiernan surveyed from training centres using self-completion questionnaires, throughout the whole board area, while Nic Gabhainn et al. and Colohan have interviewed a wider and older age range in a tightly contained area of Galway City. This later work also differs because it surveys the same area twice and can therefore give an indication of changes occurring in substance use patterns.

Although these studies are not methodologically identical, they can provide a range of information about substance use and risk-taking among adolescents and youth within the Western Health Board region.

Lifetime and current use rates for legal drugs

The tables below present the findings from these surveys and special attention should be paid to the differences between studies when interpreting the rates or percentages engaging in particular behaviours. First the information on tobacco and alcohol is presented followed by data on illegal drug use.

Table 4: Tobacco use reported across studies

Author	Age group	Area	% ever smoked	% smoke now
Moroney '93	13-17+	Roscommon	58	28
McHale '94	15-18	Galway	not reported	not reported
Kiernan '95	12-18+	AUWHB	67	39
Nic Gabhainn '93/96	15-25	Galway City	64/54	53/46

Hope & Kelleher (1997) report current smoking rates for male and female first year University students as 18% and 17% respectively, while the rates for fourth years are 26% and 22%. Differences in social class and demographic composition in these samples are likely to account for the variation in reported rates.

Table 5: Alcohol use reported across studies

Author	Age group	Area	% ever tried alcohol
Moroney '93	13-17+	Roscommon	53
McHale '94	15-18	Galway	68
Kiernan '95	12-18+	AUWHB	67
Nic Gabhainn '93/96	15-25	Galway City	83/66

Kiernan defined current drinking as having drunk in the last month and reports that 30% of boys and 47% of girls are current drinkers. McHale reports that 46% of boys and 21% of girls drink alcohol at least weekly and that the proportion of alcohol drinkers varies significantly across type of school and geographic location. Those pupils from mixed schools and those in rural areas were more likely to report that they were drinkers. Nic Gabhainn et al. report that 55% of their sample had had a drink in the last week and 70% in the last month.

Moroney (1993) reported the modal consumption per drinking episode as between 1-3 pints or 1-3 spirit measures, while Nic Gabhainn et al. (1996) reports the mean units consumed at a drinking occasion was reported to be 8.32 (sd 6.3). 29% of those surveyed by Moroney (1993) said that they had been drunk, and in the whole WHB, Kiernan (1995) found that 48% of her sample said that they had been drunk. Nic Gabhainn et al. (1996) report average weekly consumption of alcohol at 21.52 units per week (sd 21.96), but with 29% of males drinking over 35 units a week and 4% of females drinking more than 30 units a week. Hope & Kelleher (1997) examine the frequency of binge drinking, which is calculated by the proportion of students who drank more than a specified amount during their last drinking episode. This amount is five pints or equivalent for males and four pints or equivalent for females. They report that 36% of First year males and 19% of First year females could be classified as binge drinkers while the rates for Fourth years were 26% and 22%.

Alcohol use can be broken down into age groups and the following table contains data from Kiernan and Nic Gabhainn et al. This is particularly useful in order to gather information on when young people start to drink thus how prevention activities should be timed.

Table 6: Lifetime prevalence of drinking alcohol across age groups

Age/Study	% Kiernan '94	% Nic Gabhainn et al. '93/96
13 and under	25	not included
14	46	not included
15	70	62/32
16	71	72/38
17	84	85/52
18	86	76/84
19	not included	87/94
20	not included	85/82

This table indicates that the most young people are starting to drink alcohol well below the legal age and that even at very young ages rates of use are relatively high. Note that rates have decreased substantially for the younger groups in the Nic Gabhainn et al. surveys over the three year intervening period.

Lifetime and current illegal drug use rates

All studies asked whether respondents had ever tried any illegal or non-prescription drug. Both Kiernan and Moroney asked if they had ever tried to use various substances to get 'high'. Nic Gabhainn et al. asked if they had ever tried drugs not prescribed by a doctor while McHale reports that her percentages refers to those who said they had used drugs. The next table presents these rates.

Table 7: Drug use reported across studies

Author	Age group	Area	% ever tried illegal drug
Moroney '93	13-17+	Roscommon	20
McHale '94	15-18	Galway	11
Kiernan '95	12-18+	AUWHB	24
Nic Gabhainn '93/96	15-25	Galway City	25/34

There is relatively good agreement across studies, with the possible exception of McHale (1995) which might be attributable to methodology employed in the classroom and the close identification of the research with statutory services. Both the Moroney and Kiernan studies asked whether various substances had been used by respondents during the

previous month, While the Nic Gabhainn et al. surveys asked about use over the last six months. Either of these can be taken to indicate current usage rates. It is important to remember that a rate of 0% does not mean that there is no reported usage, merely that the numbers reporting were sufficient to be calculated as more than 0.5%.

Table 8: Rates of illegal substance use in the previous month across studies

Substance	Moroney '93 % Last month	Kiernan '94 % Last month	Nic Gabhainn '93/96 % Last six months
Cannabis	4	9	15/24
Volatile substances	6	6	0/2
Amphetamines	not reported	1	4/1
Heroin/Opiates	2	0	1/0
Cocaine	2	1	1/0
Magic Mushrooms	2	3	not reported
LSD	2	2	5/2
Ecstasy	not reported	1	not reported/6

Hope & Kelleher (1997) also report on regular drug use. Students were given a number of options to choose between in response to how often they had used any illegal drugs in the last 12 months. 'Regularly' was the most frequent option provided. 9% of First year males and 5% of first year females said they were regular users, while 8% and 7% of fourth years reported being regular users.

Kiernan breaks down the drug prevalence rates by county within the Health Board area and this is the only independent source of information about Mayo. She also separates Galway county from Galway City. Given that direct comparability is possible within this study the following table should prove useful.

**Table 9: Rates for specific drug use in the previous month across WHB counties.
(adapted from Kiernan, 1994)**

Substance	% Galway City	% Galway	% Mayo	% Roscommon
Cannabis	24	7	6	7
Ecstasy	4	1	0	2
Volatile substances	11	5	4	8
LSD	7	1	1	1
Amphetamines	2	1	0	1
Heroin/Opiates	0	0	0	0
Magic Mushrooms	6	3	2	2
Cocaine	1	0	0	1

It should be noted that current use of volatile substances is less reliable than that of other drugs as it tends to be found in particular locations at particular points in time and to decrease relatively quickly. The high rates of cannabis use (24%) reported by Kiernan for Galway City mirror those in the previous table reported by Nic Gabhainn et al. The rates for all other substances in other areas are relatively low. Note that while tobacco and alcohol rates have decreased over the three years intervening in the Nic Gabhainn et al. studies, overall drug use and cannabis use in particular has increased.

Sources of illegal drugs

Kiernan, McHale and Moroney all asked questions about obtaining drugs, the modal response from Moroney was that pupils obtained their first drug in the home (20% of those who had ever tried drugs) while 44% of Kiernans users obtained their drugs from friends and 25% said that they got them in night-clubs and from dealers. McHales respondents reported that dealers, closely followed by friends, were the most common source of their drugs. Nic Gabhainn et al. asked about problems associated with drug use and found that very few users reported having major or minor problems (only six people in 1996) and only three reported having sought any help for their drug taking.

Age related illegal drug use

In addition to rates of use, these studies provide a source of information that could assist in planning primary prevention activities. Kiernan, Moroney and Nic Gabhainn et al. all provide drug use rates according to age. The rates of use are so low for Moroney and he presents them for each gender across each drug that it is not possible to identify a stage where drug use starts to increase and thus infer the age below which primary prevention would be most useful. The opposite is the case with the Nic Gabhainn et al. surveys. As the age ranges from 15 to 25, the use rates are higher and the overall numbers surveyed are lower (173 and 200) the percentages using or having used at any age are not sufficiently reliable to infer a pattern of change over time. The data does however show a rapid incline from age 15 to 18 and a relative plateau after that Kiernan provides the best information to address this question and her table showing lifetime prevalence rates by age group is replicated below.

**Table 10: Percentages having tried illegal drugs by age group
(adapted from Kiernan, 1995)**

Age Group	% having tried illegal drugs
13 and younger	8
14	19
15	21
16	24
17	31
18 and older	33

This table clearly indicates the increasing prevalence with age that is typical of many other regions and countries. Note the large jump between ages 13 and younger and those aged 14. There is also a substantial proportion (8%) of the youngest group who would be in first year in post-primary school who have already tried drugs. These data have clear implications for the timing of primary prevention initiatives.

Drug Education

McHale asked her respondents about whether they received alcohol or drug education in school. 71% percent said that they had received some education about alcohol and 57% about drugs, the main sources being teachers, television and radio. Urban children reported

receiving significantly more drug education. Pupils also reported their preferred source of drug education as being teachers followed by health education leaflets and parents. This section of McHales (1994) report indicates a substantial proportion of pupils in Galway City and County who report that they have not received any education at all about drugs or substance misuse.

Numbers receiving drug treatment & drug offences

The final source of information about drug taking in the boards region is that reported by O'Higgins & Duff (1997) in the Health Research Board national report on drug treatment in Ireland. With a total of 15 treatment clients (10 new) in 1995, (7 from Mayo, 4 from Galway, 1 from Roscommon and three of unknown origin. While five of those receiving treatment were between 20-24, 7 were aged 40 and over. This places the WHB at the bottom of the scale with the lowest number of clients of any Health Board. Six of these presented with a primary drug of Hypnotics or Sedatives, which are primarily obtained through prescription abuses. Three each presented with Cannabis and Stimulant abuse, two with opiate and one with stimulant abuse. These are very low numbers but may not represent all those from the boards area seeking drug treatment. It is unclear how representative they are. Nevertheless these numbers could not be used to argue for a major treatment problem in the WHB. The Garda Commission Report on crime for 1995 indicates that 163 people were charged with drug offences in Galway West, 28 in Mayo and none (the only area for which there were none) in Roscommon/Galway East.

Comparisons with other populations

While these are fruitful sources of information regarding the substance use behaviours of young people within the region, there are some other studies forthcoming which will add to a wider understanding of these figures. The first is an analogous study to that by Kiernan which is being conducted in the Southern Health Board region (Jackson, forthcoming) and the second is the National and International reports on the European Schools Project on Alcohol and Drugs (ESPAD), which will present nationally representative data (Morgan, forthcoming). Both will provide useful up to date Irish data to which WHB youth can be compared. Data does exist for post-primary schools in Dublin (Grube & Morgan, 1994; Morgan & Grube, 1989) for 1991 who report lifetime prevalences for Cannabis (15%), Amphetamines (3%), Hallucinogens (6%), and Solvents (19%). All other illegal drug use was below 2%.

The figures for WHB drug use above are analogous to those reported for other areas in Western Europe including Northern Ireland, where an omnibus survey (1996) reported lifetime cannabis use rates for 16-59 year old males and females to be 29% and 13% respectively, with Amphetamine use at 11% and 4%, LSD use at 10% and 4% and Ecstasy use at 7% and 4%.

Welsh data from Roberts et al. (1995) reports lifetime prevalences in 1994 for 15-16 year olds as; any drug (40%), Cannabis (32%), Amphetamine (12%), LSD (13%), Magic Mushrooms (17%) and Ecstasy (4%). These rates represent substantial increases over data collected in 1994 for the same population.

The Department of Health Promotion, Greater Glasgow Health Board (1995) reported on a prevalence study of drug use among 16-19 year olds in greater Glasgow. They present their rates for the last year only and again report Cannabis as the most widespread substance at 31%, both Amphetamines and Ecstasy came in at 11% and LSD was next at 8% with Magic Mushrooms at 6%.

The Institute for the Study of Drug Dependence summarised data for the U.K., and reported that for young people aged 16-19, 42% reported having taken some drug at some time of their lives, 11% had tried amphetamines, 9% Ecstasy and 8% LSD. A further 18% of 16-19 year olds had taken Cannabis in the previous year.

Rates of use in other areas of the European Union are reported in the Annual Report of the European Monitoring Centre on Drugs and Drug Addiction. These data stem from different school surveys across countries and although the age range is the same (15-16) methodologies differ and therefore rates can not be directly compared to one another.

Table 11: Lifetime prevalence rates of use of different illegal drugs among 15-16 year olds in recent nationwide school surveys (adapted from EMCDDA, 1996)

Country	% Illegal drug	% Cannabis	% Amphetamine	% LSD	% Ecstasy
Austria	10	10	nr	1	nr
Belgium¹	nr ²	15	4	2	4
Denmark	nr	18	2	0	0
Finland	6	5	0	0	0
France	15	12	2	2	nr
Greece	4	3	4	1	nr
Netherlands	nr	20	3	nr	4
Portugal	6	5	nr	0	nr
Spain	20+	19	4	4	3
Sweden	6	5	0	0	0
U.K.	33+	30	10+	12	4

The rates for all other drugs are less than 2%

Rates reported by Miller (1994) for the U.S. far outstrip available information for Ireland or the U.K. She reports on a survey of High School Seniors where in the previous month, 50% had used Cannabis, 16% Cocaine and 12% had taken Hallucinogens. There is some suggestion however that these figures are subject to a slow decrease in rates over time, potentially, or perhaps prematurely indicating some regression in use rates.

The rates of drug use for the WHB, as indicated above do not provide undue cause for panic, especially when compared to those of other populations. Our rates appear more comparable to the UK than to other areas of Europe or the United States. Nevertheless the alcohol use rates and frequency of drunkenness are of considerable interest. The WHB is one of the organisations which is in a pivotal position to effect what happens next as it appears that we may or may not be at the edge of a shift in drug use patterns. The potential introduction of Heroin in particular would be particularly difficult to combat at an individual level. It will be necessary to continue to monitor the situation for both legal and illegal substance rates and both large scale epidemiological information and small scale data collection for at risk populations will be required.

¹ Data for Flemish speaking Belgium only

² nr = not reported

4. Prevention policies in Ireland and abroad

Methods

The purpose of this part of the research was to collect policy documents and other literature concerning the prevention of drug and alcohol misuse from appropriate organisations both within Ireland and abroad. Relevant bodies in Ireland and abroad were identified through a number of sources: the Department of Health Promotion's existing contact lists, the published literature on drug and alcohol prevention, and the IPA's *Administration Yearbook*. These organisations were in turn asked to identify other important agencies involved in prevention of substance misuse. An Internet search was also carried out. For practical purposes, the search abroad was confined to Europe and other English-speaking countries.

A total of 76 organisations and agencies were identified by these means, representing the following sectors: Statutory bodies (principally Health Boards), educational organisations, social & political organisations, trade & professional associations, and foreign agencies & organisations. All were subsequently contacted and asked to supply information about their drug and alcohol strategies or policies. Table 12 shows the response rates for the various sectors. See Appendix I for an alphabetical list of all such organisations contacted.

TABLE 12: Organisations contacted for information on drug and alcohol misuse.

Sectors	No. contacted	Response (%)	How contacted
Statutory bodies	10	7 (70%)	L, T
Educational organisations	11	5 (45%)	L, T
Social & Political organisations	20	14 (70%)	L, T, F
Trade & Professional associations	14	7 (50%)	L, T
Foreign agencies & organisations	21	11 (52%)	L, T, F, E, I
TOTAL	76	44 (58%)	

Note: L = Letter; T = Telephone; F = Fax; E = E-Mail; I = Internet

International Policy Considerations

It is generally agreed by all the various strategic plans/policy documents reviewed, that drug misuse is a complex psychosocial problem that requires a multifaceted response. There is no single or simple solution and there is a need to regularly review and modify responses to problems, in the aim to achieve efficient and cost effective services. Responses need to be tailored to local circumstances. On the other hand, Inter and Supranational policies have strongly influenced the development of both National and subsequent regional policies. They are effected primarily by the United Nations Conventions as well Council of Europe and European Union policy. Both the United Nations International Drug Control Programme (UNDCP) and the 1988 UN Drugs Convention play a major role and are supported internationally. The Second European Action Plan on Drugs was adopted in 1995, and emphasises coherence and coordination of demand and supply reduction policies in EU member states. The Pompidou Group of the European Commission is the primary forum for developing wider cooperation on drug issues in Europe and the newer European Monitoring Centre for Drugs and Drug Addiction is charged with the compilation of information regarding the epidemiology of drug use across Europe and appropriate responses to it. The European Commission has produced a new proposal on action within the field of public health to combat drug dependence and the adoption of a common position on this proposal is likely in 1998. National and International documents are regularly short on specifics and tend to make broad statements concerning the issues or problems in hand, targets concerning reduction in consumption or associated problems, the identification of responsible agencies and resources to be allocated and less frequently approaches to be favoured.

European Drugs Policy

All European countries prohibit possession of illegal substances but their position on use differs. Less than half of the members of the E.U. prohibit use directly. All states also attempt to balance their efforts between what are called attempts to control the supply of illegal substances and efforts to reduce the demand for such substances. While international agreements on control (e.g. Europol) are explicit, there is little agreement across countries and even within countries as to what demand reduction responses to the drugs issue actually means in practice (ISDD, 1996). The more decentralised a country the more variability there is in the implementation and adoption of various policies and the balance between controlling supply and reducing demand. European nations have been characterised as preferring to treat 'addicts' as patients in need of help rather than as offenders to be punished (EMCDDA, 1996). The fundamental task for all countries and

regions has been to set up the inter-disciplinary and cross sectoral structures required to address this issue in a comprehensive fashion. In many countries non-governmental organisations have been charged with degrees of responsibility most particularly in relation to the demand reduction aspects of strategy.

United Kingdom Drugs Policy

The British Government published its white paper 'Tackling Drugs Together' in 1995, and sets out a three year strategy for England focusing on crime, young people and public health. Central to this strategy is the setting up of collaboration and co-ordination between various Government Departments and local organisations, in particular the local Drug Action Teams, who are charged with a local remit. The policy also emphasises policing and legal responses, primary and to a lesser degree secondary prevention. The major country wide activities undertaken as a result of this policy have been a National Anti-drug and solvent publicity campaign and the setting up of a National Drugs Helpline. The Health Education Authority has been charged with managing publicity campaigns and prevention initiatives. The Scottish, Welsh and Northern Irish Offices are all charged with developing strategy for their own regions, and the White Paper describes these as 'wholly congruent but retaining flexibility to build on local strengths and areas of concern'.

U.K. policy has been widely discussed and critically examined (e.g. Blackman, 1996). In particular the relative influences of those involved in policy making has been examined and the lack of homogeneity in approaches from various sectors is perceived as weakening preventative measures. Government policy emphasises primary prevention and punitive measures to control supply, and has also supported the creation of community drug teams (Strang et al., 1992) to provide a multidisciplinary, community led consultancy role. Many agencies, particularly those who are community based, recognise a need for more flexible approaches when working with young people and adopting a harm minimisation approach (Franey et al., 1993), one which Campbell (1994) argues appears to be both officially advocated and denied simultaneously. Indeed the official position on harm minimisation does not appear to support the wealth of activity being conducted in that area.

Wheeler (1997) described the drugs situation in the North of Ireland as unique and described the policy approach taken to address it. Earlier approaches to the Drugs issue in

Northern Ireland were seen as appropriately 'low-key', as the prevalence data did not support widespread intervention (Northern Ireland Committee of Drug Abuse, 1996). While there is still little evidence of injecting drug use. Heroin or Cocaine the prevalence of other drugs is increasing. The prevention aspects of the Northern Ireland Drugs Campaign has six key elements. A public information campaign, drugs education training for schools, drugs education materials development, the provision of specialist information, on-going support for research initiatives and an emphasis on local coordination networks. This co-ordinated approach is a clear example of how the issue can be addressed in one area of the UK while acting within National Government guidelines.

At a more local level, UK policy has been translated into strategy and one example of such is provided by the Greater Glasgow Health Board (1995). They consider alcohol in conjunction with drugs and provide clear rationale and objectives for their strategic approaches in each area of activity. Within the context of their perspective on equity, community participation and collaboration, the Board believe that on-going training, research and evaluation of their work will strengthen initiatives in both the short and long term. In relation to primary drugs prevention they outline a number of specific interventions to be conducted which include; the provision of training for relevant professionals, promoting the use of alternatives to drugs, the provision of appropriate information to young people and parents and the support of drugs policy implementation in key settings. In relation to secondary prevention or harm minimisation, they intend to support the Glasgow needle exchange network, provide information to recreational drug users and attempt to minimise risk associated with rave/club environments through the provision of information and advice.

United States Drugs Policy

Newcomb (1992) discusses the situation in the US and both illuminates and criticises the rationale behind their policies which emphasise punishment, restriction and 'social warfare'. Indeed any drug use among adolescents is perceived as problematic (Peele, 1986). This is a relatively recent development in US policy and certainly contrasts with the European approach which is rooted in public health considerations. While there have been considerable efforts in the area of primary prevention (e.g. DARE - Koch, 1994), and the US has taken somewhat of a lead in the evaluation of such interventions (e.g. Hansen, 1992; Tobler. 1992) the balance of policy is weighed in favour of controlling supply and maintaining a 'zero tolerance' approach. US policy is clear in its rejection of risk reduction activities for using addicts (Office of National Drug Control Policy, 1990).

This approach is under attack from within the health services (e.g. Schmoke, 1995), but policy has yet to follow.

The comparison in approaches between Europe (and the Netherlands in particular) and the United States is clearly explicated by Marlatt & Tappert (1993) who discuss the issue of reducing risks in substance use. The US refer to this approach as risk reduction, the British as harm minimisation and other European countries tend to refer to harm reduction. The major differences in policy occur in four main areas; the low-threshold approach to services favoured by the Dutch as compared to high-threshold services in the US. This refers to the relative ease with which health and social services can be accessed by Dutch drug users. Second, the US favours a criminal justice approach to addiction while the Netherlands operates under a public health oriented system. Third, the Dutch tolerate the use of so called 'soft' drugs, while there are strict penalties for any drug use in the US. In the US any use equals abuse. Finally, the US attempts to render users alien to society in an effort to denormalise use, while the Dutch attempt to normalise use and avoid increasing the potential appeal of a deviant lifestyle. These differing approaches can be seen as separate ends of the spectrum along which any policy can lie. With the possible exception of the Dutch position on the tolerance of 'soft' drugs, most other European countries tend towards the position of the Netherlands.

Domestic Policy

Irish policy related to drugs was initiated as far back as 1966 with the report of the Commission of Inquiry on Mental Illness, but was dealt with more explicitly in the 1971 report of the Working Party on Drug Abuse. This 1971 report recommended drug education as an integral part of the school curriculum, an aspiration which has never been achieved at a National level. In 1983, a Special Governmental Task Force on Drug Abuse reported. This Task Force was set up in response to reports of a growing Heroin problem in Dublin city and led to the establishment in 1985 of the National Co-ordinating Committee of Drug Abuse, later to be disbanded and reconstituted in 1989. Butler (1991) reviews Irish drug policies in the light of drug problems and argues that the two roles of controlling supply and reducing demand have not been either conceptually or practically distinct. While the various strands in drug policy have not been approached in an integrated fashion, the clear advantage of doing so has been discussed by many authors (e.g. Greenwood, 1995; Pentz, 1993; Plant, 1990). Nevertheless that level of integration is not the focus here. In the following section, policies, strategies and proposed initiatives

related only to the demand reduction aspects of current approaches are teased out and in keeping with the objectives of this document the emphasis is on prevention.

Irish National Policy is informed by two major documents; The Government Strategy to Prevent Drug Misuse (1991) and the Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). The 1991 strategy concerned both supply and demand reduction and made a number of specific recommendations regarding prevention. It charged regional Health Boards with the setting up of Community Drug Teams, primarily to assist liaison between sectors concerned with treatment, but also to assist local educational services in developing primary prevention programmes and to identify the extent of the drug misuse problem in their areas. Health Boards were also to identify Health Education Officers who would ‘assist and support measures being taken in formal and informal educational settings relating to drug misuse’.

At a National level, preventative strategies included; Inservice training for teachers both primary and post-primary, the development of a drugs education programme for schools, teacher training centres and Universities and encouraging schools to allocate time to drugs education, preferably with the designation of a specific teacher as health education co-ordinator. The Department of Education, through voluntary youth councils within the VEC’s were to ensure that adequate leisure facilities were available for young people and that drugs education be included within informal youth and sports programmes. Harm minimisation was recognised in a more minor way with a proposal to expand the outreach programmes for drug users within the Eastern Health Board area.

The National Health Strategy ‘Shaping a Healthier Future’ (1994) and the more specific Health Promotion Strategy (1995) both contribute to the National picture. Neither document specifically targets the drug user but both provide a framework for action in the field and make relevant recommendations. Three key principles underpin the National Health Strategies; equity, quality and accountability. They also emphasise participation of both communities and the voluntary sector in the planning, development and provision of services, including preventative services. The inclusion of primary prevention in schools and for key target groups is proposed to be the joint responsibility of the Departments of Health and Education. This is entirely congruent with the current Educational Policy ‘Education for a Changing World’ (1993), which views the role of education as pivotal in the promotion of Health and Wellbeing.

The Ministerial Task Force was appointed to focus on reducing the demand for drugs and chose to concentrate on the drug with most negative consequences for most people in the areas where its use was widespread, that is Heroin within the Eastern Health Board area. Nevertheless its report makes numerous references to other areas of the country and the role of Health Boards in particular. In addition it makes a number of relevant points concerning drug misuse prevention. Some of the recommendations mirror those of the earlier Government Strategy, for example the setting up of regional co-ordinating committees in each Health Board, support of on-going research and both formal and informal educational initiatives. However it does contain more specific recommendations at both local and National level. Although some of the following recommendations were made in the context of the specific 'priority' areas identified by the Task Force (none of which are within the WHB), the underlying principles are easily adapted.

In terms of education the expansion and dissemination of the substance abuse prevention programmes (Morgan et al., 1996) at both primary and post-primary level is advocated, as is increasing the emphasis on pre and inservice teacher training. Family support services also receive attention with the endorsement of early intervention programmes for children and out of school youth and support for the home-school liaison service and teacher counsellors. A list of initiatives already available or recommended by the task force is contained in Appendix 11. This is not an exhaustive list of programmes or initiatives available in State but reflects those the Minister felt most appropriate to the prevention of Drugs Misuse. Further information on available resources is readily available within the Health Promotion Unit of the Department of Health.

The ongoing role of the regional health boards is emphasised in the Task Force report, particularly in relation to the co-ordination of activities and consultation. They are charged with;

- Establishing regional drug coordinating committees
- Information collection and dissemination
- Cooperation with educational services
- Organising locally based outreach and low threshold access services
- The provision of services for users with particular attention to young users
- Strengthening family support services (in conjunction with voluntary agencies)

Clear guidelines are also given for the development of any information campaigns, which should be; developed in consultation with community and voluntary sectors, use positive

role models, use former addicts and be delivered in a style which is easily understood by the target audiences.

Many of the National organisations contacted did not have an explicit policy or strategy document on drugs. Some included drugs related issues in their general policy documents, objectives or statements of intent. These generally recorded a perceived increase in drug related problems and concern for 'young people', drug users and society in general. Some others tended to agree with the Government Strategy and implicitly or explicitly supported it or worked within it, while others disagreed and suggested some alternative methodologies. Almost all recognised the need for an integrated planned strategy and placed its delivery and the issue of collaboration, consultation or participation to the fore. What follows is a list of recommendations not noted in official Government documentation. Note that measures directed at the Heroin problem in the EHB area are not included here except when more broadly relevant. Very few of these actually fall outside the scope of current National Government Policy or Law.

Strategies and policies proposed by non governmental National Organisation

Information/Media

Negotiating with the NUJ on media guidelines to avoid sensationalising the issue. The creation of one stop centres for the provision of all information related to drugs. Increasing Harm Reduction literature to be available in all places young people gather. The declaration of an 'official drugs emergency' and accompanying high profile media campaign.

Education

Adult education courses/Fas training on drugs.

Special initiatives to keep young people within the formal education sector as long as possible.

The introduction of early intervention or secondary prevention to post-primary schools.

Producing interactive multimedia drugs education resources for all schools.

The creation of posts of responsibility within schools explicitly linked to drug education.

Drugs education in schools to be compulsory.

Peer education projects for young people as well as parents.

Involvement in the 'Health Promoting Universities' network/Introducing primary and secondary prevention efforts for students at third level institutions.

Promoting the role of Pharmacists as educators on drug issues, through the provision of specialist training to them and exploiting their professional status and community locations for the provision of information to the public.

Other

Decriminalising possession and use and/or nationalising the drugs market.

The provision of drug testing facilities, so that users can confirm the purity of their substances.

Placing an emphasis on the children of drug using parents.

A requirement that harm reduction activities will be undertaken as a prerequisite for licensing dance clubs and raves.

A more comprehensive list of recommendations/strategies recommended throughout the various International, National and local policies reviewed is contained in Appendix III.

Regional Policies in Ireland

There is a considerable degree of convergence on the direction and emphasis of Irish Drug Policy. Broad agreement exists on the relative importance of controlling supply and reducing demand and the importance and potential of educational initiatives. Administrative structures are increasingly vital and they should be multisectoral. Participation, consultation and co-operation with all partners is central and therein lie the challenges ahead. The National co-ordinating committee on Drug Use has been establishing the regional co-ordinating committees in each board area comprised of various interested and relevant parties. These committees have local responsibilities and are charged with addressing local issues with methods considered most appropriate to the local situation. The Committee on the prevention and treatment of alcohol and drug misuse in the Southern Health Board produced a regional strategy for 1995-1998 (SHB, 1994) and the Drug Misuse Prevention Group of the North-Western Board reported in 1996 (NWHB, 1996). Other Health Boards are in the process of constructing documents, strategies and policies, most of which are due to be available before Summer 1997. A number of other relevant reports were made available by various Health Boards. These included a discussion document of use and abuse of alcohol from the Mid-Western Health Board (MWHB, 1994), the report of the working group on drug misuse and medicine control from the Western Health Board (WHB, 1996) and a series of reports on the Drugs Service of the Eastern Health Board (EHB 1996; 1997).

Western Health Board

In 1996 the working group on drug misuse/medicine control of the Western Health Board reported and made a number of recommendations regarding prevention. This was one group convened in response to the National Health Strategy and covered drugs, alcohol and prescribed medicines. The report provides a useful overview of services provided by the board in relation to all three areas. The Western Health Board already has a policy in place in relation to drug and sex education in schools. This policy clearly identifies the commitment of the Health Education Unit to effective and research based interventions, and provides guidelines for educational provisions that are very much in line with what is known about best practice in school settings. In the 1996 working group report, they also recommend targeting four groups perceived to be specifically at risk; adolescents with learning disabilities, patients who attend casualty with alcohol related injuries, early school leavers and teenage girls and women contemplating pregnancy. A succinct review of effective primary prevention programmes is given and support indicated for the adoption of the Substance Abuse Prevention Programme (On my own two feet).

More specific recommendations in the report include; the organising of a specific committee within the board similar to that in the SHB, the appointment of a dedicated officer to work in this field, an annual drink/drugs awareness day, the provision of a telephone hotline, training for professionals within the board as well as community and youth workers, media campaigns and the development of an agreed protocol for the referral and management of alcohol and drug problems. There is also the recognition that the bulk of the 'problem' exists in Galway city and that along with the third level students and significant tourist trade there, any project should be based in the city. The report confirms the commitment of the Board to monitoring and evaluating initiatives while continuing to base its interventions on best practice.

Mid-Western Health Board

The 1994 Mid Western Health Board discussion document on use and abuse of alcohol is not as relevant here. It does however cover some basic ground on prevention and early intervention. It refers to the educational principles laid down by the former Health Education Bureau (HEB) in relation to teenagers. Scare tactics which exaggerate risk should not be employed. Factual information should be presented in a form which effects

the emotions of the drinker. Alcohol education should form only part of a wider curriculum on healthy lifestyles. Finally, the focus should be on fostering mature and balanced choice within an understanding of social and cultural influences.

Eastern Health Board

The activities of the Eastern Health Board as reported focus on the treatment of drug users and the management of treatment and rehabilitation services. As such they concentrate on harm minimisation and tertiary prevention exercises within the Boards remit. They do indicate a degree of other prevention activity spearheaded by the appointment of 5 dedicated education officers to work in conjunction with the Health Promotion and Public Health Departments of the Board. In 1996, they report on developments on parenting programmes (primarily for drug using parents), plans to commence a telephone helpline and the establishment of an information database.

The 1997 report plans to bring the total number of education officers to 10 and to implement specific media campaigns about Heroin Smoking and Ecstasy. The officers are charged with coordinating their work with those of various community and voluntary groups and plan to deliver an addiction awareness programme to parents, other health professionals, community groups and sports organisations throughout the board area. The EHB (1997) also report on a series of workshops conducted with community and voluntary organisations in January 1997. In relation to prevention and education, they advocated; targeting of initiatives, increased training for associated professionals, community leaders and the media, parenting to be part of the primary school curriculum, the encouragement of peer education projects and a range of programmes to deter early school leavers and individuals at risk. These measures are not all adopted but have been put forward for discussion.

Southern Health Board

Two of the best received documents on substance use and regionally based strategic responses to the issue are those from the SHB (1994) and the NWHB (1996). Both of these boards have taken Health Promotion and Education over the last decade (Nic Gabhainn & Kelleher, 1995) and accordingly their strategies are comprehensive. The report of the SHB is presented in the context of re-orienting the Health Services towards Health Promotion and includes measures concerned with inaugurating up a full Health

Promotion Service and setting up monitoring, evaluation and epidemiological research activities. They also recommend the establishment of community drug teams throughout the region and an increased level of training for General Practitioners, community and voluntary workers as well as other health professionals.

In relation to specific prevention activities the report recommends the rationalisation of the boards activities within schools and improved liaison in order to avoid duplicating work and wasting resources. It recognises the importance of starting prevention work in primary schools and of targeting young people in a positive manner. They also recommend a drugs and alcohol hotline be initiated, working with the Gardai to assist in educating the public and the development of outreach teams as part of the community drug teams. It should be recognised that the SHB already has a wide variety of health promotion activities in place, particularly in relation to schools and community education and that the current strategy involves building on and integrating these activities.

North Western Health Board

The NWHB is also building on an existing Health Promotion service and its report reflects the impact that service has had at Board level. They focus specifically on drugs and are the only Board to have taken an explicitly harm reduction approach in addition to primary prevention. The report includes central sections on research related to primary and secondary prevention and most innovatively a report on focus group research conducted with young people in the region. This research component is mirrored in the National strategy document on Health Promotion for Young People (1997), which does not deal explicitly with the drugs issue, but includes the findings from qualitative research done with school students. From these two sources the NWHB have developed recommendations for action, which while in line with those from other sources also include some innovative responses.

The NWHB report recommends approaching the drugs issue from both a community and a school focus, working with the wider youth population and targeting high risk areas for the provision of prevention, education, treatment and alternative activities and supports. A regional coordinating group and a strategy coordinator are recommended to enable multi-agency approaches to be developed and sustained. More specifically they suggest the extension of the Lifeskills programme into community and early school-leaver groups, increased supports for parents, collaboration with the media and increased training for professionals and community group leaders. An action research project

targeted at high risk areas is proposed and the report reveals a commitment to improved information collection and related research activities through the Public Health Department. The report also contains a sample schools drug policy for the North West one which could be easily adapted to other areas of the country.

There is then considerable agreement as to the most appropriate ways forward for policy and much of the policy agrees with what is known about the effectiveness of prevention activities. As policies and strategies become more localised they also become more specific and the Regional documents of the WHB (1996), SHB (1994) and the NWHB (1996) illustrate this. Decisions need to be made about the appropriate balance between demand reduction and controlling supply, while within the Health Sector decisions need to be made regarding the comparative resourcing of primary prevention, secondary prevention or harm minimisation and treatment and rehabilitation. These should be based on the needs of the area and population being served and the resources already available in terms of private treatment facilities, self-help networks, school level commitment to preventative education community integration and organisation, etc. Attention should be paid to the research literature and evaluation research in particular in order to guide decisions. The involvement of the community, individual target groups and service providers in a collaborative approach to planning is also widely advocated.

5. Substance misuse in the Western Health Board Region: Perceptions, programmes and proposals

Methods

The purpose of this section of the research was to garner information and opinions from a wide range of interested parties in the Western Health Board region regarding the perceived extent of drug and alcohol misuse, the nature of current prevention programmes, and proposals for improving the situation.

The list of organisations contacted was derived from a number of sources, including the IPA's *Administration Yearbook*, the *Directory of Alcohol, Drugs and Related Services in Ireland*, the *Directory of Community Health & Voluntary Services* for each of the Western Health Board's Community Care areas, the *Golden Pages*, and the *Directory of Services in Galway City*. Where possible, organisations were also asked for the names of others with a potential interest or involvement in the prevention of drug and alcohol misuse. Ultimately, a total of 96 organisations and agencies were contacted (see Appendix IV), representing the following sectors: Western Health Board services, other State services & departments, voluntary health & welfare organisations, youth associations, community & social groups, and educational organisations. Table 13 shows the response rates for the various sectors.

Individuals in organisations with a known or likely interest or involvement in the prevention of drug and alcohol misuse were interviewed by telephone using a semi-structured interview schedule (see Appendix V). In some cases, if a more formal approach was required or if it proved impracticable to make contact by telephone, a letter (see Appendix VI) was sent instead. Unstructured telephone interviews were also conducted with individual members of the Community Addiction Team itself.

TABLE 13: Organisations contacted for information on drug and alcohol misuse.

Sectors	No. contacted	Response	How contacted
Western Health Board services	15	9 (60%)	T, L, F
Other State services & departments	6	3 (50%)	T, L
Voluntary health & welfare organisations	19	11(58%)	T, L, F
Youth associations	16	12 (75%)	T, L, F
Community & Social groups	32	15 (47%)	T, L
Educational organisations	8	5 (62%)	T, L
TOTAL	96	55 (57%)	

Note: T = Telephone; L = Letter; F = Fax

Perceptions of the problem

There is broad agreement among the various sectors as to the nature and extent of substance abuse in the Western Health Board region. Alcohol is widely recognised as by far the most significant problem, in terms of availability, patterns of abuse, and impact on health and social support services. Drug use is also regarded as a ubiquitous phenomenon but its effects are generally perceived as being either less serious or less conspicuous currently.

Almost all respondents were of the opinion that alcohol misuse is very common in the Western Health Board region, and that the situation is deteriorating. While alcohol problems exist across generations, the greatest concern expressed was for teenagers and young adults. Virtually every person interviewed observed that underage drinking is a very common and serious problem, and is on the increase. Young people, it is reported, are starting to drink in greater numbers, at an earlier age, in larger quantities, and to a more advanced state of intoxication. They are reported as having no difficulty in obtaining alcohol, whether in pubs, off-licences or discos. According to some respondents, publicans and retailers who do not serve alcohol to juveniles may be in a small minority in some areas. There is also a perception that girls are drinking more in an attempt to equal the boys (despite sex differences in ability to metabolise alcohol) now that the “taboo [on girls’ drinking] has gone.”

Health professionals are already noticing an impact on services. While underage drinking is most acutely evident at times such as Christmas, examination and graduations, addiction counsellors say that the onset of “problem drinking” is now occurring at a younger age, and that the average age of patients in treatment is dropping. However, across all age groups and social strata, alcohol abuse continues to be endemic. It is still identified as a major factor in a range of social problems, including homelessness, domestic violence, criminal behaviour and delinquency, and is associated with a significant proportion of psychiatric and emergency admissions as well as GP call-outs.

A number of reasons for this state of affairs were suggested. Alcohol is “not taken seriously enough” and most of the talk about tackling the problem “is merely lip service”. Parents are not practising what they preach, may be too liberal or “afraid to say no”, and may even be “accomplices in the habit”. Older people may be “in denial”. Societal acceptance of alcohol in general and, more recently, the aggressive marketing of branded alcoholic beverages are also seen as important factors. Complacency and non-enforcement of the licensing laws means that alcohol is freely available. Among young people, particularly disadvantaged youth, “a desire for kicks”, boredom, “detachment and social isolation”, poor self-esteem and “lack of a role in society” are perceived as leading to a high risk for alcohol and drug abuse.

Most respondents stated that drug misuse is also a widespread and growing phenomenon, and is “following in the wake” of alcohol misuse. While no-one claimed to know the precise nature and extent of the problem in the Western Health Board region, there was general agreement that all drugs are available to some extent and that all areas are affected to some degree. A number of respondents emphasised that drug misuse also occurs in the smaller towns, not just in-Galway, and “should not be underestimated or ignored”.

Cannabis is by far the most commonly used drug, and is universally available. Ecstasy is believed to be readily available also. Its price is dropping, with figures as low as £3 - 4 per tablet being reported. According to the Gardai “a significant E subculture” has developed. LSD is still very prevalent, but opinions vary as to whether it is more or less widely used than Ecstasy. Respondents working with adolescents and young offenders identified solvent abuse as a significant problem, mainly in poorer urban areas. There is sporadic evidence of intravenous drug use, and there are also anecdotal accounts of heroin being smoked by some drug users in Galway city. However, heroin is not regarded

as a major problem currently, the reported number of known users being less than a dozen, all living in Galway city. Several respondents reported that misuse of prescription drugs is frequently seen, particularly among women. Breaches by GPs of Medical Council guidelines, concerning the prescription of controlled drugs, are known to occur. It is also suggested that a few pharmacies will supply controlled drugs directly to customers without a prescription. In the counselling services, addiction to prescription drugs is the second most common problem seen, with cross-addiction being frequently observed. The psychiatric services report occasional admissions for cannabis-induced psychosis or depression, mainly in long-term, heavy users. From time to time, an Ecstasy-related case may present to Casualty. Overall, drug misuse of all kinds is reported as having a relatively small impact (compared to alcohol) on health and social services.

A variety of reasons for the drug problem were identified by respondents. As in the case of alcohol, youthful “thrill-seeking”, boredom and disaffection were seen as important factors in drug abuse. Social malaise is seen as a worrying problem in many housing estates (mainly in disadvantaged areas, although more affluent areas such as Knocknacarra are also seen as potential trouble spots), where a large proportion of the population is under sixteen years of age. For example, there is anecdotal evidence that youths in these areas are being used as “runners” for local distribution of drugs. Lack of care and foresight in urban planning and development is blamed for much of the trouble in housing estates. The arrival every summer of large numbers of visitors to Galway, and the city’s general attractiveness to all kinds of people, are also cited as important factors. Some respondents expressed a concern that Galway’s popularity could lead to an influx of hard drug users, mainly from Dublin, however none report any evidence of this actually occurring. In rural areas, the perception is that drugs are brought in by students returning from colleges in Galway, Athlone and Dublin.

Prevention programmes

Respondents generally perceived that current efforts to prevent drug and alcohol misuse are insufficient. Primary prevention programmes in the community, when they occur, are mainly carried out by interested parties working in isolation or with minimal help, and most often consist of health education and awareness raising. Addiction counsellors, Gardai, youth leaders and voluntary workers reported a steady demand from schools, parents and community groups for information and seminars on substance misuse. However, some respondents reported that parents feel there is not enough being done in schools. Some youth groups are addressing some of the underlying causes by providing

personal development programmes aimed at building self-esteem and personal skills. A number of community groups are attempting to prevent juveniles accessing alcohol by introducing a local ID card system. Other agencies, such as the Probation & Welfare Service and Juvenile Liaison Officers, are involved in secondary prevention, i.e. seeking to divert high-risk youth away from substance misuse and possible criminal activity. Substance misuse is often revealed when other problems are being investigated. However, it is reported that monitoring for alcohol problems is not carried out routinely by health service personnel in the course of their work, and so opportunities for early identification of those at risk or for secondary prevention in these circumstances are often being missed.

Three sections of the statutory services do see themselves as specifically targeting the issue of drug use as part of their work. The first are the adolescent services'. This covers two Neighbourhood-Youth Projects (NYP) in Galway City, a forthcoming NYP in Castlebar as well as the adolescent outreach service and family support services. They report using a variety of interventions directly with young people, including decision making, the enhancement of resilience, self-esteem and self-efficacy in the context of many issues but including drug and other substance use. The second is the Health Promotion Service. In addition to services and courses for members of the public, the Health Promotion Service provides continuous training to Board staff around issues of Health Promotion and Education. Services to the public specifically related to drug issues include the provision of information and funding for community efforts that are consistent with models of good practice, summer schools for teachers and group skills courses for those interested in teaching lifeskills, parenting and family communication courses and workshops for adults interested in taking community action on drug misuse. Services providing these preventative services do perceive themselves to be under resourced and not in a position to work with all those requesting service provision.

Notwithstanding the above, most of the statutory and voluntary agencies are primarily engaged in coping with the consequences of substance misuse ("picking up the pieces"), rather than in primary or secondary prevention. The third service specifically targeting drug use within the board is that of treatment and rehabilitation. A description of the treatment and rehabilitation services within the board was compiled for the 1996 Health Strategy Review document 'Report of the Working Party on Drug Misuse/Medicine Control'. The relevant sections from that report can be found in appendix VII. Addiction counsellors and treatment services in the Western Health Board also feel that they are under-resourced. The Alcoholism Counselling Service in Galway, which caters for a huge

catchment area, seems to be particularly overstretched. The Psychiatric services in general are perceived as not being able to deal with the current caseload of patients referred for alcohol 'detox' treatment. Patients stay only a few days in detox and resume drinking on discharge (this is described as the "spin dry effect"). Some respondents described the existing services as being too centralised and inaccessible to rural dwellers. Medical card holders' lack of access to treatment facilities is also seen as a particular problem.

There is some concern that the perceived inadequacy of current prevention and treatment efforts could lead to a worsening of the situation. For example, a representative of one community group in Galway expressed a fear that, unless appropriate measures are taken, communities "will not be able to break the cycle of drug abuse and that the use of any drug ... will inevitably lead to a problem with intravenous drugs." Another respondent said that "increasing hard drug use in Galway is inevitable", and that there is a need for greater awareness in this area. However, while acknowledging the potential for a worsening of the drug problem, most respondents indicated that tackling the alcohol problem was of more immediate concern.

Proposals for action

There was strong support from respondents for a prevention strategy. It was stressed that this should be a properly constituted, multi-faceted, coherent health promotion programme, backed by realistic resources. A multisectoral approach, involving schools, families, youth groups, community organisations, voluntary bodies and the statutory services, is favoured. Networking, co-ordination of efforts and common short and long term goals are seen as crucial aspects of such a strategy.

Integrated health promotion programmes, including lifeskills and personal development, are recommended for both primary and secondary schools (the Department of Education being the appropriate body to implement these). Several respondents warned against reliance on drug awareness talks and scare tactics (such as visits by reformed addicts to schools). There was general agreement among respondents that both the development and implementation of the strategy should involve appropriately qualified personnel: addiction counsellors, psychiatrists, GPs, public health specialists, health promotion professionals and other suitably trained persons. Youth groups recommended that the idea of training young people as "peer educators" should be examined. Community

groups stressed the need for capacity building and local development measures aimed at improving quality of life and diverting youth away from risky behaviours. A number of respondents suggested that the Western Health Board should take a more prominent, communicative and innovative role in local development and prevention initiatives. Concerning long term goals, it was proposed that the Board, in particular its Department of Public Health, should take a leading role in local planning and development. Were Healthy Cities principles to be followed from the outset, holding actions to cope with social problems might not be necessary later. The Galway Health Project, one of the current activities supported by the Board is based upon the Health Cities principles and may provide a fruitful avenue for future developments.

Information on the prevalence of substance abuse is regarded as lacking currently, but it is felt that a dearth of precise data should not unduly hinder prevention efforts. Specific measures recommended for immediate implementation include establishment and enforcement of an official identity card scheme, pressure on alcohol retailers, and greater penalties on premises where drug use and underage drinking occurs. It was also recommended that health professionals should “give due regard” to possible alcohol problems in every encounter with clients. Respondents also urged that alcohol counselling and treatment services be upgraded. The weight of opinion appears to be strongly against the establishment of a dedicated drug rehabilitation service, in particular a Methadone programme. The idea is rejected on the grounds that there is no significant hard drug problem in the region, and that providing such a service could well prove to be counter-productive: users and dealers might simply be attracted from other areas. There is also general agreement that alcohol and drug programmes should be kept separate, although they will have elements in common, in case that mixed messages might prove detrimental to prevention efforts.

In conclusion the main points made by participants in this exercise are as follows;

What is the nature of the problem?

- Alcohol misuse is the biggest problem, and has a significant impact on services
- Underage drinking is common, and alcohol problems are said to be occurring earlier
- Use of illegal drugs, especially cannabis. Ecstasy and LSD, is reported to be widespread
- Complacency, inaction and “the drink culture” are blamed for continuing alcohol problems
- Treatment services are seen as over-stretched, under resourced and often ineffective
- Boredom and social alienation among youth are perceived as major risk factors for substance abuse

What is being done?

- Current prevention programmes are widely regarded as uncoordinated and inadequate
- Health education and awareness raising are the mainstay of existing prevention efforts
- There is some concern that prevention shortcomings will lead to increasing drug use

What should be done?

- A multisectoral, co-ordinated, properly financed health promotion strategy is required
- Personal skills, community development and proper training are seen as essential
- Direct action should be taken, in a number of settings, to deal with substance misuse
- Alcohol services should be upgraded but drug treatment facilities are not a priority
- The WHB should take a leading role in planning and development at all levels in the community.

6. Policy responses to the issue of drug use in the Western Health Board

Based on earlier drafts of this report, members of the community addiction team were encouraged to make recommendations for policy and strategic responses for the consideration of the Board. What follows are recommendations made on that basis. These fall into a number of categories; Organisation and Management, Policy, Research, Training, Environmental Interventions, Primary Prevention, Focused Interventions, Treatment and Evaluation. These are not totally separate and the implementation of any one objective will have an impact on others. Nevertheless, for ease of interpretation they are dealt with sequentially below.

Organisation and Management

The organisation of all drug misuse prevention work within the Board should take a multidisciplinary approach, incorporating the skills of the wide variety of existing health professionals. These should be combined with relevant external agencies, both community based and voluntary in order to provide a multi-agency approach. This will assist in both planning and in management and should help to avoid duplication of services as well as encouraging the provision of a consistent approach to the issue of drug misuse.

Localised teams should be constructed. These would consist of those working in the field and operate as active working groups in order to share information and improve communication, rather than management or policy groups. These would be chaired by the drug co-ordinator and involve those employees and external agencies directly working in the field.

The drug co-ordinator of the Board is to act as a liaison and resource person for all those involved with drug misuse prevention in the WHB region. The co-ordinator should be centrally involved in planning activities throughout the Board. In order to assist this, all those who intend to conduct any interventions related to drug misuse should use the co-ordinator as a central focal point for information and resources.

Policy

A full policy statement on the provision of information to the public should be produced by the Board. This should include policy on the provision of speakers to community groups. Responses to requests for assistance can be dealt with in a uniform way and the limitations of such activities must be considered.

Various sections of the Board already provide drug misuse prevention services and consider it a pan of their on-going responsibility. In order to render the approach as cohesive as possible, it is proposed that the activities and policies adhered to within the various sections of the Board be collated and updated by the drug co-ordinator. Where policies do not exist it is proposed that such policies be developed by services in the context of their own work in collaboration with the drugs co-ordinator. These should indicate methods of best practice.

Western Health Board drug policy will be updated and revised regularly. Evidence based activities that have proven to be of use should be documented within the board and the communities it serves in order to assist these on-going developments. A monitoring and evaluation system should be constructed to document Board wide activities in relation to drug misuse prevention and treatment. This should include information on rationale, specific activities, personnel and services involved, budgets, target groups and evaluations. Such a system would also provide valuable information to those interested in conducting further interventions as well acting as a resource for planning and policy development.

Research

Up to date information and accurate knowledge bases are key factors which will impact on the quality of the drug misuse prevention activities within the region. Resources should be allocated to assist in updating the library provision for this field and the Board should subscribe to current journals and information networks in the field. This could be done in conjunction with University College Galway or the Regional Technical Colleges in Galway or Castlebar.

The Board should support the setting up of a national database of drug misuse treatment contacts. This would be done in conjunction with other Health Boards under National and International requirements and will render the data collected as comparable as possible to other areas of the country and other areas of Europe. It may be possible to customise such a data base to include issues of specific interest to the Western Health Board.

It is proposed that an early identification system be constructed within the Board. The objective of such a system would be the rapid identification of any new drugs being misused within the region as well as the identification of any new patterns of drug use emerging. This system would comprise the constructed drug misuse database, the information being collected by the members of the localised teams as well as the informal network cultivated by the drugs co-ordinator.

Training

In order to draw on the wealth of existing expertise within the Board, an inservice training programme should be developed. This should incorporate the principles of both primary and secondary prevention and include; early identification of potential problem drug users, risk assessment and supportive interventions. The scale of such training will be considered within the context of the Health Promotion and Education brief of the Board. It will be possible to explore issues of accreditation with the Adult Office of U.C.G. or another appropriate organisation.

Such training would commence with those working in Primary Health Care settings (including General Practitioners and Pharmacists). Training will be tailored to the needs of other Board staff, Community Groups, Voluntary Organisations and other Health Care Professionals, and will subsequently be offered to other multi-agency and multidisciplinary groups.

It is proposed that specific training on media issues also be provided. This would include dealing with the media and implementing the policies of the Board in relation to the provision of information to the public. Training for members of the media in drug related issues and responsible reporting should also be considered.

Environmental Interventions

The physical and social environments in which people live exert influences over their ability to choose healthy lifestyles and also influence other determinants of health. With due regard to the existing statutory regulations and the role of the Community Care services (including Environmental Health), the Board should find ways of working in collaboration with local authorities, advising on the health implications of various planning options, with an emphasis on minimising the environmental risk factors of drug misuse.

The Western Health Board's Health Education service is already working with a wide variety of groups on ways to make their communities healthy places to live. The World Health Organisation Network of Healthy Cities and Healthy Communities may also provide a useful model for further action in this area. These Networks promote the adoption of multi-agency cross-sectoral approaches to health promotion and disease prevention throughout whole communities. Numerous organisations within geographical areas work together with unified health related objectives. Sligo Healthy Cities Project is one such example. The Galway Health Project, a voluntary grouping with input from Croi, the VEC, Business & Enterprise, and the Lyons Club is a similar Network and the co-ordinator had been closely involved with the Healthy Cities organisation. The actual content of such an intervention is intended to address local concerns and be the result of an on-going process reflecting the various sectors, disciplines and groups involved. It is therefore proposed that the models of cooperation and consultation forwarded by these Networks be further explored and costed by the Board.

Primary Prevention

The 1996 report of the Western Health Board Health Strategy Review group on drug misuse and medicine control recommended the adoption of the Substance Abuse Prevention Programme 'On my own two feet' for the regions post-primary schools. This programme draws on a number of models of prevention intervention including the knowledge-attitudes, decision making and social competence models, attempting to draw the best from each approach. Training of youth workers and teachers in the region has commenced. This should be continued and within the context of on-going monitoring and evaluation of the initiative be expanded within the Board.

As the board continues to support this initiative a decision needs to be made regarding the adoption of the primary school version of the Substance Abuse Prevention Programme. The primary school initiative is currently undergoing a pilot throughout the country. When this phase is complete, teacher training will be made available through the Department of Education which should be supported by the Board.

It is proposed that parental involvement in Primary Prevention through schools and youth groups continues to be supported by the Board. It should be possible to reorient some of the school home support and parenting programmes already provided towards the specific issue of drug misuse. It is also proposed that a programme to support parents of children at risk of drug misuse be initiated through the co-ordinator of adolescent services within the Board. This could take the form of peer support from other parents who would have first hand knowledge of the local situation and the parenting issues involved.

Focused Interventions

The board has also already indicated support for interventions with those perceived to be at high risk of drug use or misuse. The four groups identified are; adolescents with learning disabilities, patients who attend casualty with alcohol related injuries, early school leavers and teenage girls particularly those contemplating pregnancy. It may be considered desirable to widen this net to include other risk groups or individuals with other risk factors as discussed earlier in the report. The nature and organisation of specific interventions with these groups also needs to be considered in more detail.

On-going services being provided to those at risk and young users will continue to be monitored and supported by the Board. This includes the Neighbourhood Youth Projects in Ballybane and Westside areas of Galway City, the Family Support Services in East Galway and the Adolescent Outreach Services. The activities of other groups funded by the Board which target these groups should also be considered here.

A group of young people at risk by virtue of their truancy and suspected drug use have already been identified in one Galway city school in conjunction the

Neighbourhood Youth Project in Ballybane. It is suggested that a dedicated position be created or made available to work with this group within the school setting.

Since 1994 a Community Arts worker has been supported jointly by the Board and the Arts Council. This worker has been primarily involved with children and adolescents and currently operates within a broad health focus. This position may become a more central aspect of the services provided for adolescents and within a community arts model it could involve a clearer focus on drug use and misuse.

Treatment

In order to further support the treatment and counselling services for drug misusers provided by the Board, it is proposed that an appropriate needs assessment be conducted. This should include the organisational location of drug treatment services within the Board and clear identification of resource implications for service expansion. Within this context at least one dedicated worker should be appointed to work in this area and further training in drug use for addiction services personnel should be supported by the Board.

Evaluation

All of the recommendations listed above require on-going documentation, monitoring and evaluation. This will be necessary to justify the investment of the Board as well as to provide local information as to the effectiveness and efficiency of various approaches. All activities undertaken that are designed to reduce drug experimentation, drug misuse or harm associated with drug use should be fully evaluated as a routine either within or external to the Board. These evaluations should consist of both process and summative considerations and as far as possible include cost-benefit and cost-effectiveness analyses. This need not necessarily be complex as other services within the Board and within the Community Care Programme (e.g. The Health Promotion Service, The Community Nutrition Service) already take this approach.

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Appendix I:

Alphabetical list of organisations contacted outside the Western Health Board region

Action Group on Irish Youth	Irish Pharmaceutical Union
Alcohol Advisory Council of New Zealand	Irish Rural Link
Association of Community & Comprehensive Schools	Irish Society of Medical Officers of Health
Centre for Research on Drugs and Health Behaviour, UK	Irish Vocational Education Association
Chambers of Commerce of Ireland	King's Fund Centre, UK
Community Response, Dublin	Labour Party
Democratic Left	London Irish Women's Centre
Dept. of Justice	Mid-Western Health Board
Drinks Industry Group	Midland Health Board
Drug Abuse Research, Education & Advisory Committee, Australia	Ministry of Health Library & Information Services, UK
Drug Policy Department, Ministry of Health, London	Ministry of Health, New Zealand
Drugs Strategy Secretariat, Canada	National Addiction Centre, UK
Dublin City Centre Business Association	National Centre for Guidance in Education
Dublin City University	National Council for Curriculum & Assessment
Dublin Inner City Partnership	National Economic & Social Council
Dublin Institute of Technology	National Parents' Council
Eastern Health Board	NIFAST
Federation of Community Centres	North-Eastern Health Board
Fianna Fail	North-Western Health Board
Fine Gael	Pharmaceutical Society of Ireland
GAA, Dublin	Progressive Democrats
Garda Siochana	Revenue Commissioners
Green Party	Rialto Community Drugs Team
GROW	RTC Cork
Health Education Board for Scotland	RTC Letterkenny
Health Promotion Agency for Northern Ireland	RTC Sligo
Health Promotion Wales	Sinn Fein
Home & Health Department, The Scottish Office	SIPTO
IBEC	South-Eastern Health Board
Inner City Organisations Network, Dublin	Southern Health Board
Institute for the Study of Drug Dependence, UK	Standing Council On Drug Addiction, UK
Institute of Community Health Nursing	TACADE, UK
Institute of Guidance Counsellors	UK Department of Health
Irish Association of Social Workers	United States Information Agency
Irish College of General Practitioners	University College Cork
Irish Countrywomen's Association	University of Limerick
Irish Medical Organisation	Waterford Drug Co-ordination & Advisory Group
	Welsh Drug & Alcohol Unit
	Workers' Party

Appendix II:

Programmes/Initiatives Discussed in the Report on the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996)

Education

The substance abuse prevention programme for primary schools - in a pilot phase of development

On my own two feet - substance abuse prevention programme for post-primary schools - currently being disseminated throughout the country

Health Promoting School Project - developing from 10 to 40 schools throughout the country

Home School Liaison personnel and School Counsellors

Public Health and Community

Drugs education video - available from the Health Promotion Unit, Department of Health

Parent Education Programme on Alcohol, Drugs and Family Communication - available in the SHB with wider dissemination planned

Parenting for Prevention programme - available from Community Awareness on Drugs

Drug Questions - Local Answers, a community based training programme - available from the Health Promotion Unit, Department of Health

Solvent Abuse resource materials- available from the Health Promotion Unit, Department of Health

Leadership Training Programme for the Primary Prevention of Drug Misuse - A Crosscare initiative

The Juvenile Diversion Programme - the Gardai and the Probation and Welfare Service

The Drugs Awareness Programme, The Garda Schools Programme and The Garda Mobile Anti-Drugs Unit- the Gardai

Youth and Sport

Sport for all - supported by the Vocational Educational Committees

Outdoor Education Projects - supported by the Vocational Educational Committees

Out of school projects for youth - administered by the Youth Affairs Section

The National Youth Health Programme - Departments of Health and Education and the National Youth Council of Ireland

Variety of Projects funded by the Department of Education to provide local sports and community recreational facilities

Appendix III:

Summary of Recommendations

The following is a summary of the main recommendations of the strategic plans/policy documents reviewed.

It is recommended that:

- * the long-term strategy be to develop an integrated alcohol and drug service, with emphasis being placed on community based primary care services, in conjunction with specialist backup services involved in ongoing development in approaches to the treatment of addiction problems;
- * because of the multi-agency nature of drug and alcohol services, good co-ordination, liaison and consultation mechanisms are essential;
- * multidisciplinary community drug teams be established, and a co-ordinator appointed to lead and co-ordinate local efforts to tackle drug misuse;
- * outreach services be established as part of the community drug teams;
- * a system of monitoring and evaluation of services be developed if long-term activity is to be justified on cost grounds;
- * a regional drug misuse database be established (to collect data from voluntary and statutory treatment centres);
- * a survey be undertaken to obtain epidemiological data on alcohol and drug misuse within the region; (school surveys would not only identify trends but also identify protective factors against drug use, assisting in the planning and development of drug prevention measures in schools);
- * a regional free-phone alcohol and drugs misuse helpline be established;
- * an early warning system be developed to alert the appropriate authorities to new types of drugs coming onto the market;
- * media campaigns be developed which are relevant to local circumstances and aimed at specific target groups;
- * there be provision for parental education and support (more creative approaches than the provision of talks be adopted). This is considered an essential element in tackling the problem;
- * parenting programmes for drug using parents be established;
- * there be particular emphasis on early childhood intervention;
- * drugs prevention education be integrated into school curricula, with particular attention being given to schools in priority areas (i.e. areas where young people because of their environment or other factors are particularly vulnerable to drug misuse);
- * pre and inservice training be provided for teachers
- * educational programmes be co-ordinated e.g. through a programme of health promotion and through Health Education Officers in the Health Board assisting and

supporting measures being taken in formal and informal educational settings relating to alcohol and drug misuse;

- * Health Education Officers assist the Gardai in meeting the increased demand to educate the public in relation to alcohol and drug misuse;

- * there be development of preventive work targeted at groups of young people who because of their environment or other factors are particularly vulnerable to drug misuse pressures (e.g. pilot community drug action teams. These pilot schemes could pursue the development of alternative activities which seek to engage young people at a time in their lives when they are attracted by excitement and risk);

- * guidelines for treatment and referral be developed, particularly for GPs and A&E staff involved in providing emergency treatment;

- * those who are dependent/addicted as a result of alcohol and drug abuse be treated on an outpatient basis initially;

- * training be offered to a wide range of health professionals in relation to drug and alcohol misuse;

- * training be offered to voluntary workers attached to community based groups;

- * training be offered to GPs who wish to become involved in the diagnosis and treatment of alcohol and drug misuse;

- * the importance of specific prescription writing requirements for Controlled Drugs be emphasised so that forgeries are made more difficult;

- * the Department of Health be requested to set up a National Register of CD 2* drugs;

- * the establishment of a Statutory Drugs Advisory Board (e.g. from the National Coordinating Committee);

- * an annual Drink/Drugs awareness day be established;

- * a Teenage/Adolescent Drug and Alcohol Misuse Programme be established as pan of treatment services;

It is acknowledged that the heroin problem is principally confined to Dublin and North Cork City. Consideration should be given to methadone prescribing and dispensing, and to needle and syringe exchange services, to control intravenous drug abuse and the associated incidence of HIV/AIDS. Consideration should also be given to an education campaign on the dangers of heroin smoking.

- * CD 2 drugs = Controlled Drugs, category 2 (e.g. morphine, pethedine)

Appendix IV:

Alphabetical list of organisations contacted in the Western Health Board Region

Accord Marriage Counselling Services, Ballina
Accord Marriage Counselling Services, Ballinasloe
Accord Marriage Counselling Services, Castlebar
Accord Marriage Counselling Services,
Charlestown
Accord Marriage Counselling Services, Galway
ACOA
Addiction Counselling Service, Castlebar
Addiction Counselling Service, Loughrea
Addiction Counselling Service, Mountbellew
Addiction Counselling Service, Roscommon
Addiction Counselling Service, Tuam
AIDS Help West
Al-Anon & Alateen
Alcoholism Counselling Service, Merlin Park
Hospital
Army Personnel Officer, Galway
Ballinfoyle Area Youth Project
Ballybane Youth Project
Bohermore Community Project
Bohermore Youth Club
Clareview Park Neighbourhood Watch
Clifden Community Council
Coiste Pobail, An Spideal
Coiste Pobail, Cama
Coiste Pobail, Indreabhan
Comhar Oiris Leader Teo.
Community Care, Galway
Community Care, Mayo
Community Care, Roscommon
Community Workers Co-Op
Council for the West
Cuan Mhuire
Fairgreen Hostel
Family Life Centre, Castlebar
Family Life Centre, Boyle
Feroige Castlebar
Fordige Galway
FORUM, Connemara
Galway City Partnership
Galway Combined Residents Association
Galway Community Development
Galway Diocesan Youth Services
Galway Rural Development
Galway Simon Community
Galway Voluntary Youth Council
Galway Youth Federation
Galway Youth Federation, Tuam
GP Unit, Merlin Park
Home Management Advisory Service, Merlin Park
Hope House, Foxford
Horizon House, Galway
IRD Kiltimagh
Irish Countrywomen's Association
Juvenile Liaison Officer, Ballina
Juvenile Liaison Officer, Galway
Juvenile Liaison Officer, Roscommon
Knocknacarra Combined Residents Association
Knocknacarra Community Development Group
Le Cheile
Macra na Feirme
Meitheal Forbartha na Gaeltachta
Meitheal Mhaigh Eo
Moy Valley Resources
Muintearas na nOilean
Muinrir na Tire
Narcotics Anonymous
National Parents' Council
Neighbourhood Youth Project
North Connacht Youth & Community Services
Pioneer Total Abstinence Association
Probation & Welfare Service, Castlebar
Probation & Welfare Service, Galway
Psychiatric Unit, Roscommon
Psychiatric Unit, UCHG
Renmore Community Development Association
Roscommon Partnership
Roscommon Regional Youth Service
RTC Athlone
RTC Galway
RTC Sligo
Sallhill Tourist & Development Association
South West Mayo Leader
St. Brigid's Hospital, Ballinasloe
St. Christopher's Youth Club, Tuam
St Mary's Hospital, Castlebar
Teachers' Centre, Castlebar
Teachers' Centre, Galway
Teachers' Centre, Tuam
Tuam Travellers' Education & Development Group
Tuam Youth Services
University College Galway
VEC, Galway
Vita House, Roscommon
Westside Resource Centre
Youth Links
Youthreach, Letlerfrack

Appendix V:

Interview Schedule adopted with relevant groups within the Western Health Board Region

INTERVIEW SCHEDULE

Information was sought under the following headings:

- Name of organisation/group
- Contact person(s)
- Telephone number(s)
- Address for correspondence
- Fax number
- Nature of organisation/group
- When founded
- Aims & objectives
- Target/Client group
- Activities/services
 - Frequency
 - Scope
 - Documentation
 - Evaluation)
- Prevention category
- Primary (educational/environmental)
- Secondary (high risk)
- Tertiary (treatment)
- Sources of funding
- Links/affiliations
- Meetings
- Publications
- Resources
 - Equipment
 - Premises
 - Educational material
- Skills available to/within group
- Needs
- Skills/resources on offer
- Future intentions
- Perception of problem
- What should be done

Appendix VI:

Letter sent to relevant bodies within the Western Health Board Region

A chara,

Re: Prevention of drug and alcohol abuse

The Western Health Board's *Community Addiction Team* is currently preparing a strategy document on the prevention of drug and alcohol abuse. As pan of this process, the *CAT* have asked us to contact relevant individuals and organisations in the region, in order to record any service responses to the problem and to canvass opinion on the content of the proposed strategy. The main questions being asked are:

- What is the nature and extent of the drug and alcohol problem in the WHB region?
- What is being done about it, by whom, and with what objectives?
- What should be done?

If you or your organisation have an interest or involvement in the topic, we would be very pleased to hear from you.

Yours sincerely,

Appendix VII:

**The Treatment and Rehabilitation Services
of the Western Health Board**

from

The Health Strategy Review

Report of the Working Group on Drug Misuse and Medicine Control

July 1996