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Newsletter of the Drug Misuse Research Division

Directory of courses and training programmes on drug misuse 2006

New directory compiled by the NDC – see page 27.

Your views on *Drugnet Ireland*

– results of readers survey on page 26.

ROSIE study shows positive impact of treatment

On 11 September 2006, Noel Ahern TD, Minister of State with responsibility for drugs strategy, launched the report of findings from the Research Outcomes Study in Ireland (ROSIE).[1] A team at the National University of Ireland, Maynooth, completed the study on behalf of the National Advisory Committee on Drugs (NACD). This report focuses on outcomes for adult opiate users at one year following entry to treatment. Minister Ahern welcomed 'this timely research which provides much needed information on how well people do when they go for drug treatment'. Dr Des Corrigan, chairperson of the NACD, reiterated the report's main conclusion – 'that investment in opiate treatment services leads to benefits to the individual drug user, to their family and to the rest of the community and that this investment must be continued'.

Dr Catherine Comiskey, Principal Investigator, presenting the first findings from ROSIE. (Photo: Lar Boland)

At baseline, the study recruited 404 opiate users aged 18 years or over entering treatment at inpatient facilities (hospitals, residential programmes and prisons) or outpatient settings (community-based clinics, health board clinics and general practitioners). The opiate users selected were entering treatment for the first time, or were returning to treatment after a period of absence, at any one of 54 services nationwide. The interview schedule collected data on:

- drug use in the 90 days preceding the interview, specifically, type, frequency, quantity and cost;
- measures of harmful practices and consequences;
- health status, using a self-rated physical and psychosocial health assessment;
- social functioning, including accommodation, employment, and involvement in crime;
- mortality, using information obtained from the participants' contacts and the General Mortality Register.

The participants were interviewed at intake (baseline), at six months following entry to treatment (not presented) and again at one year after intake. The baseline data were collected between September 2003 and July 2004. Of the 404 opiate users interviewed at intake, 373 (92%) were traced one year later, of whom 305 were interviewed. Of the other 68 who were traced, 66 did not wish to participate in the follow-up interview and two had died. The characteristics of the 99 individuals who were not interviewed one year after intake did not differ from those of the interviewees. The data presented in this article compares the experience at intake to that at one year for the 305 participants interviewed at both time-points.

contents

ROSIE study *(continued)*

Mr Noel Ahern TD, Minister of State with responsibility for drugs strategy, speaking at the launch of the ROSIE findings. (Photo: Lar Boland)

There was a reduction in the proportion of participants who reported using heroin in the 90 days preceding data collection, from 81% at intake to 48% at one year. The average frequency of heroin use by participants in a 90-day period reduced from 43 out of 90 days at intake to 16 out of 90 days at one year. The average quantity of heroin consumed each day over a 90-day period decreased from 0.9 grams at intake to 0.3 grams at one year. There was a corresponding reduction in the average amount spent on heroin on a typical day, from €75 at intake to €24 at follow-up.

There were large reductions in the proportions of participants who reported use of non-prescribed methadone, cocaine powder, crack cocaine and non-prescribed benzodiazepines at one year compared to the baseline interview. There were smaller reductions in cannabis and alcohol use over the same time period.

The proportion of participants reporting use of more than one drug decreased from 78% at intake to 50% one year later.

The proportion of participants who reported injecting drug use in the 90 days preceding data collection decreased from 46% at intake to 29% at one year. The reported average number of days injecting over a 90-day period decreased from 21 out of 90 days at intake to 9 out of 90 days at one year. There was a corresponding decrease in the average number of times participants injected per day, from 1.8 at intake to 0.8 at one year. There was a small decrease in the proportion reporting an overdose, from 7% at intake to 4% at follow-up.

Between intake and one-year follow-up, there were reductions in the numbers of participants reporting 5 of 10 common symptoms of physical illness experienced by drug users; there were reductions also in the numbers of men reporting 6 of 12 selected symptoms of mental illness experienced by drug users. Women participants did not report reductions in the selected symptoms of mental illness.

The average number of visits by participants to a general practice, or to employment, educational or homeless services, had increased at the time of follow-up.

The proportion of participants reporting involvement in acquisitive crime decreased from 31% at intake to 14% at one year. In addition, the proportion reporting selling or supplying drugs reduced from 31% at intake to 11% at one year.

Of the 305 participants interviewed at both time points, 7% were not using drugs at the time of entry to treatment, while 27% were not using drugs one year later. Of the 285 participants for whom treatment status was reported, 30% completed their index treatment, 14% were transferred to another treatment site, 18% did not complete their index treatment and 38% were still in their index treatment. At the one-year follow-up interview, 82% of these 285 participants were either continuing in their index treatment or had commenced another treatment episode.

Adult opiate users reported positive changes in drug use, risk behaviour, health status, service contact and criminal behaviour at one year following entry to treatment, which indicates that treatment for these opiate users was beneficial. According to the authors, drug treatment contributed to changes in the lives of opiate users, but it is not feasible to isolate the exact contribution of the treatment, on its own, from that of other influences. *(Jean Long)*

1. Cox G, Comiskey C, Kelly P, Cronly J (2006) *ROSIE Findings 1: Summary of 1-year outcomes.* Dublin: National Advisory Committee on Drugs.

Dr Gemma Cox, ROSIE Project Manager 2003–2006, at the launch of the study's first findings. Dr Cox was recently appointed Research Officer with the National Advisory Committee on Drugs. (Photo: Lar Boland)

Cocaine-related prosecutions eclipse those for heroin

The annual report of An Garda Síochána for 2005 was published earlier this year.[1]The report is the main source of information on crime in Ireland and includes information on crimes recorded by An Garda Síochána in which criminal proceedings were taken.

The report includes a chapter on drug offences, giving the number of such offences in which proceedings were taken, by Garda division and by drug type; the number, volume and types of drug seized by the gardaí and customs officers; and the number, age and gender of persons charged, as well as the nature of the offence. The Garda annual report is primarily a reflection of the activities and effectiveness of law enforcement agencies, rather than of the prevalence of drugs or the incidence of drug-related crime. However, the Garda reports are a useful indicator of trends in drug offending over time.[2]

Figure 1 shows trends in the number of drug supply (s.15 Misuse of Drugs Act MDA 1977), possession (s.3 MDA 1977) and total drug offence prosecutions between 1995 and 2005. The majority of prosecutions are for drug possession, which increased from 5,065 in 2004 to 7,432 in 2005, an increase of almost 50% (46.7%).

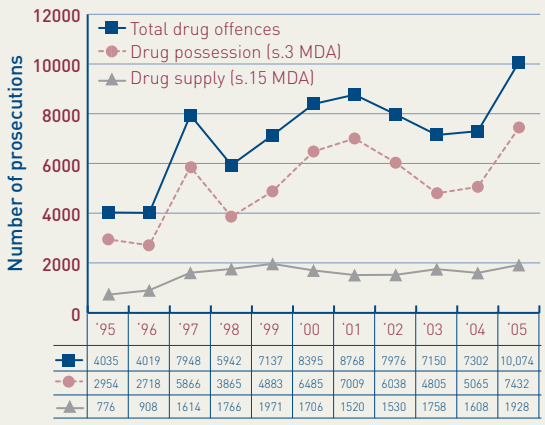


Figure 1 Trends in possession (s.3 MDA), supply (s.15 MDA) and total drug offence prosecutions, 1995–2005

Source: Annual reports of An Garda Síochána 1995–2005

Figure 2 compares trends in possession offences with the number of cannabis-related offences prosecuted from 1995 to 2005. It can be seen that most of the prosecutions which take place for drug possession are cannabis-related.

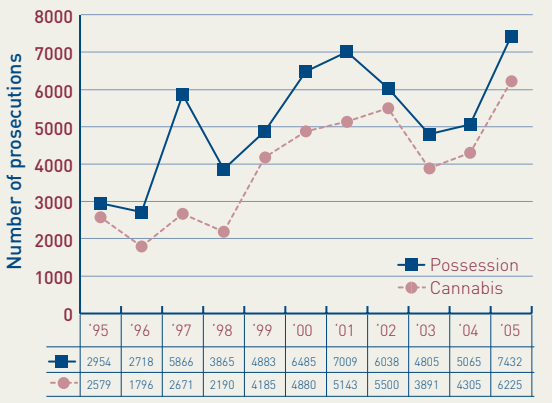


Figure 2 Trends in cannabis-related prosecutions and prosecutions for simple possession (s.3 MDA), 1995–2005

Source: Annual reports of An Garda Síochána 1995–2005

Figure 3 compares cocaine-related prosecutions with those for heroin. The growing concern with the increase in the scale of the cocaine market in recent years in Ireland is reflected in the fact that, for the first time, cocaine-related prosecutions have eclipsed those for heroin.

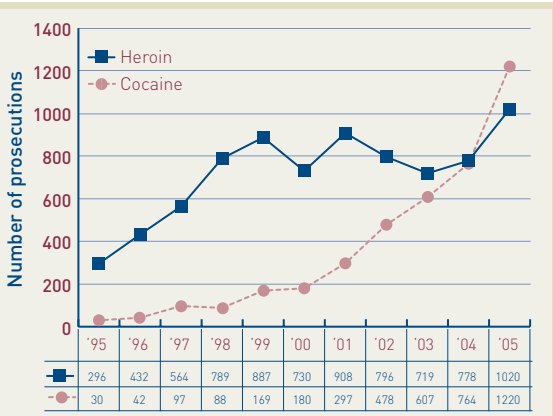


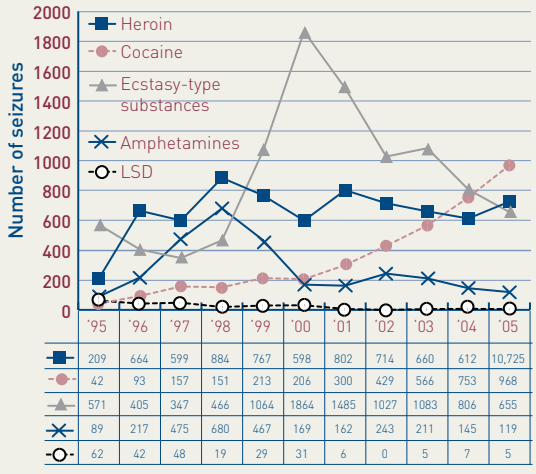
Figure 3 Drug offence prosecutions by drug type, 1995–2005

Source: Annual reports of An Garda Siochána 1995–2005

The Garda annual report also includes Information on drug seizures carried out by the Garda Síochána and the Customs Service.[3] Drug seizure figures provide information about drug availability and supply and the impact of law enforcement efforts. Although the number of drug seizures in any given period can be affected by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of traffickers to law enforcement activities, drug seizures are considered as indirect indicators of the supply and availability of drugs.[4] Cannabis seizures account for the vast majority of all drugs seized. In 2005, of the 6046

Cocaine eclipses heroine *(continued)*

reported drug seizures, 3417 (56.5%) were cannabis-related. Figure 4 shows trends in seizures of a number of selected drugs, excluding cannabis, between 1995 and 2005. We can see a steady rise in cocaine seizures over the last two decades, with heroin seizures remaining stable and ecstasy seizures continuing to decline since 2000.

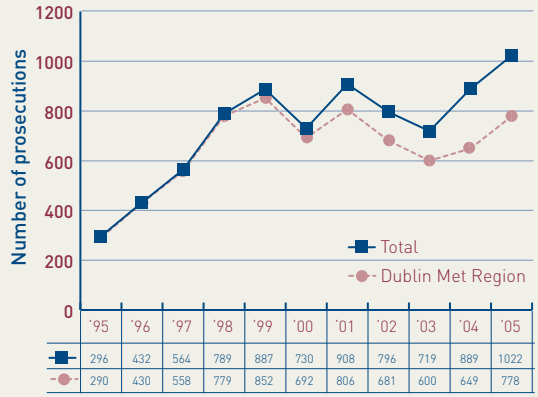


	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05
Heroin	209	664	599	884	767	598	802	714	660	612	10,725
Cocaine	42	93	157	151	213	206	300	429	566	753	968
Ecstasy-type substances	571	405	347	466	1064	1864	1485	1027	1083	806	655
Amphetamines	89	217	475	680	467	169	162	243	211	145	119
LSD	62	42	48	19	29	31	6	0	5	7	5

Figure 4 Trends in the number of seizures of selected drugs, excluding cannabis, 1995–2005

Source: Annual reports of An Garda Síochána 1995–2005

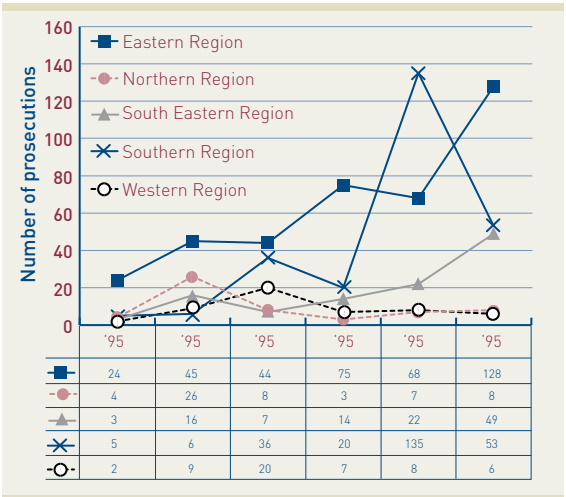
Figure 5 and Figure 6 look at trends in heroin-related prosecutions by Garda region.



	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05
Total	296	432	564	789	887	730	908	796	719	889	1022
Dublin Met Region	290	430	558	779	852	692	806	681	600	649	778

Figure 5 Trends in total heroin-related prosecutions and those in the Dublin Metropolitan Region, 1995–2005

Source: Annual reports of An Garda Síochána 1995–2005



	'95	'95	'95	'95	'95	'95
Eastern Region	24	45	44	75	68	128
Northern Region	4	26	8	3	7	8
South Eastern Region	3	16	7	14	22	49
Southern Region	5	6	36	20	135	53
Western Region	2	9	20	7	8	6

Figure 6 Trends in heroin-related prosecutions by Garda region outside the Dublin Metropolitan Region, 2000–2005

Source: Annual reports of An Garda Síochána 2000–2005

Figure 5 shows the trends in heroin-related prosecutions in the Dublin Metropolitan Region as a percentage of all such prosecutions. It can be seen that the vast majority of heroin-related prosecutions occur in Dublin. However, as shown in Figure 6, since 2000 there has been a steady increase in heroin-related prosecutions in the Eastern Region (Carlow/Kildare, Laois/Offaly, Longford/Westmeath, Louth/Meath), from 24 prosecutions in 2000 to 128 in 2005, and to a lesser extent in the South Eastern region (Tipperary, Waterford/Kilkenny, Wexford/Wicklow). It is clear that although heroin remains predominantly a Dublin-based phenomenon it is no longer confined exclusively to the capital. Further research would be required to determine whether this represents a shift or displacement in the heroin market outside the capital city. *(Johnny Connolly)*

1. The Annual Report of An Garda Síochána for 2005 is available on the Garda website at www.garda.ie
2. For a discussion about the data issues which arise in relation to the annual Garda reports see Connolly J (2006) *Drugs and crime in Ireland.* Overview 3. Dublin: Health Research Board.
3. A detailed breakdown of this information is provided by the Customs Service on the Revenue Commissioners' website at http://www.revenue.ie/services/customs/cndt2000.htm
4. For a fuller discussion of these issues see Connolly J (2005) *The illicit drug market in Ireland.* Overview 2. Dublin: Health Research Board.

Driving while over the legal limit for alcohol or under the influence of drugs

The Medical Bureau of Road Safety (MBRS) recently published its annual report for 2004.[1] The Bureau is an independent forensic body responsible under the Road Traffic Acts for the chemical testing of intoxicants in driving in Ireland. The Bureau analyses specimens of blood and urine from people suspected by the gardaí of driving offences to determine their alcohol content. The Bureau also supplies the equipment used by the gardaí for indicating the presence and concentration of alcohol in breath specimens taken in Garda stations (Evidential Breath Testing). The legal limit for alcohol varies depending on the type of specimen taken (Table 1).

Table 1 Legal limit for alcohol in blood, urine and breath

Specimen	Legal limit for alcohol
Blood	0–80mg per 100ml of blood
Urine	0–107mg per 100ml of urine
Breath	0–35µg per 100ml of breath*

* µg = microgram. A microgram is one millionth of a gram, a milligram (mg) is one thousandth of a gram.

The Bureau issues certificates indicating the alcohol level in the blood and urine specimens it receives and in the breath specimens taken by the equipment it supplies. In a small number of cases, certificates cannot be issued because of some defect in the specimen or in the documentation accompanying it. Table 2 shows the number of certified blood, urine and breath specimens over the five-year period 2000 to 2004 and the proportion over the legal limit for alcohol.

The drop in the number of blood and urine specimens certified over the period 2000 to 2004 is due to a decrease in the number of specimens received, which in turn is due to the implementation and extension of the Evidential Breath Testing programme since 2000. The proportion of certified specimens over the legal limit for alcohol, while high, shows a gradual decline over the five years. The reason for this decrease is unclear; it may be due to an increasing number of specimens from drivers whose impairment could be due to the presence of a drug or drugs other than alcohol.

On 21 July 2006 a number of key initiatives set out in the Road Traffic Act 2006 came into effect. One of these gives the gardaí the power to carry out random breath testing (mandatory alcohol testing). A recent nationwide survey of adults (18 years or over) by Alcohol Action Ireland found that a majority (87%) of respondents favoured the introduction of random breath testing to detect drink-drivers.[2]

The MBRS also analyses blood and urine specimens for the presence of seven different drugs or drug classes, namely: amphetamines, metamphetamines, benzodiazepines, cannabinoids, cocaine, opiates and methadone. For the five-year period 2000 to 2004, specimens testing positive for one or more drugs were forwarded to the State Laboratory or the UK Laboratory of the Government Chemist for confirmatory analysis. Prior to 2002, the Bureau tested specimens for the presence of drugs only at the request of the gardaí. However, since 2002 all specimens that are under the legal limit for alcohol are routinely tested for the presence of drugs. The numbers of specimens tested, screened positive and confirmed positive over the period 2000 to 2004 are shown in Table 3.

Since 2002 all specimens that are under the legal limit for alcohol are routinely tested for the presence of drugs.

Table 2 Number of certified blood, urine and breath specimens and the proportion over the legal limit for alcohol, 2000 to 2004

Certified specimen	2000	2001	2002	2003	2004
Blood	3,952	3,004	2,218	2,187	2,348
% over the legal limit	93.2%	92.3%	91.2%	90.4%	89.1%
Urine	2,559	1,831	1,457	1,475	1,671
% over the legal limit	91.2%	87.9%	88.6%	87.9%	82.5%
Breath	3,075*	6,527	7,770	6,525	6,951
% over the legal limit	82.2%	81.8%	81.4%	80.8%	80.1%
Total	9,586	11,362	11,445	10,187	10,970
% over the legal limit	89.1%	85.6%	84.2%	83.9%	82.4%

Source: Medical Bureau of Road Safety annual reports 2000 to 2004.

* The Evidential Breath Testing programme commenced in late 1999; the low figure in 2000 represents a gradual introduction of testing equipment during this year.

Driving under the influence *(continued)*

Table 3 Number of blood and urine specimens tested for the presence of drugs, screened positive and confirmed positive, 2000 to 2004

Specimen	2000	2001	2002	2003	2004
Total tested	78	131	388	416	569
of which screened positive	71	115	233	266	354
of which confirmed positive	56	96	117	179	247
% of tested specimens confirmed positive	71.8%	73.3%	30.2%	43.0%	43.4%

Source: Medical Bureau of Road Safety annual reports 2000 to 2004.

Among the specimens that had minimal or zero levels of alcohol, 68% tested positive for one or more drugs.

As was expected, the proportion of tested specimens confirmed positive for drugs dropped dramatically in 2002 following the introduction of routine testing of all specimens under the legal limit for alcohol. In 2002, 24 specimens were tested for drugs at the request of the gardaí; 15 were tested on request in 2003 and 25 in 2004. The figures in Table 3 reveal that in recent years just over 40% of specimens that were under the legal limit for alcohol contained one or more drugs.

A study on driving under the influence of drugs in Ireland carried out by the MBRS in 2000 and 2001 found a strong trend of increased drug positivity with decreased level of alcohol.[3] Among the specimens that had minimal or zero levels of alcohol, 68% tested positive for one or more drugs. Of all specimens that were under the legal limit for alcohol, 33.1% tested positive for one or more drugs, compared to 14.2% for specimens over the legal limit. The fact that drug prevalence was more than twice as high in those specimens under the limit for alcohol suggests that incapacity because of drug taking may have been a reason why these drivers were stopped in the first place.

Of the specimens testing positive for the presence of drugs but under the legal limit for alcohol, 45.6% tested positive for only one drug, while 54.4% tested positive for two or more drugs. This high level of polydrug use was not observed in specimens that were over the legal limit for alcohol, of which only 17.6% tested positive for two or more drugs, not including alcohol.

The study concluded that driving under the influence of drugs was a significant problem in Ireland. The recent figures from the Bureau's Annual Report 2004 suggest that this problem is increasing. *(Hamish Sinclair)*

1. Medical Bureau of Road Safety (2006) *Report for the year ended 31st December 2004.* Dublin: Medical Bureau of Road Safety.
2. Alcohol Action Ireland (2006) *Alcohol in Ireland: time for action. A survey of Irish attitudes.* Dublin: Alcohol Action Ireland.
3. Cusack DA, Leavy CP, Daly L and Fitzpatrick P (2004) *Driving under the influence of drugs in Ireland: results of a nationwide survey 2000–2001.* Dublin: Medical Bureau of Road Safety.

Dr Vincent Dole: An obituary

Dr Vincent P Dole, whose research in the 1960s established that methadone could be used to treat heroin addiction, died on 1 August 2006, aged 93. In 1964, Dole and his research partner Dr Marie Nyswander experimented with treating people addicted to heroin with a synthetic drug known as methadone. At the time, methadone was known predominantly as a painkiller and, although it was recognised as having addictive properties, it was believed to have limited adverse effects on the human body.

In early trails during 1964 with 22 people addicted to heroin, Dole and Nyswander noted that methadone satisfied the physical cravings of addiction but did not make users high or subject them to violent mood swings. When treated with methadone and a comprehensive programme of rehabilitation, patients returned to education, obtained jobs and became reconciled with their families. Indeed, Dole and Nyswander emphasised that treating the medical needs of people addicted to heroin with methadone needed to be complemented by giving equal attention to their social-reintegration needs: 'The most important services needed during this [initial] phase of treatment were help in obtaining jobs, housing and education.'[1]

Their studies showed that people with heroin addiction could be maintained on prescribed doses of methadone; they remained physically dependent on the drug but were able to conduct otherwise normal lives. These findings sparked the creation of hundreds of methadone programmes worldwide. The studies also contributed to a shift from a primarily moral approach to the treatment of heroin users to one that treated them as medical patients. For this groundbreaking piece of work, society will remain indebted to the pioneering vision and scientific outlook of the late Dr Dole. *(Martin Keane)*

1. Dole VP and Nyswander M (1965) A medical treatment for diacetylmorphine heroin addiction: A clinical trial with methadone hydrochloride. *Journal of the American Medical Association,* 193(8).

New social partnership agreement addresses drugs and alcohol

Published in June 2006, *Towards 2016: Ten-Year Framework Social Partnership Agreement 2006–2015*[1] adopts a new lifecycle framework to address key social challenges that individuals in Irish society at different stages of life will face over the next 10 years. This means a focus on the needs of children, young adults, people of working age, older people and people with disabilities. The lifecycle framework will place these stages at the centre of policy development and delivery, assessing the risks facing individuals at these various stages and the supports available to them to address those risks. An agreed vision and key long-term goals for each stage of the lifecycle are identified in the framework Agreement, together with a programme of agreed priority actions in pursuit of each of the long-term goals.

The issues of illicit drugs and alcohol are addressed in relation to children (0–17 years) and young adults (18–29 years).

- The Agreement contains a commitment, identified as a priority action in relation to children, to monitor prevalence trends in smoking and substance use through the National Health and Lifestyle Surveys and the European School Survey Project on Alcohol and other Drugs (ESPAD) (*Towards 2016:* Section 30.2).
- A cross-departmental team chaired by the Office of the Minister for Children is developing an initiative to test models of best practice which promote integrated, locally-led, strategic planning for children's services. The initiative will focus on children who are at risk of suffering from multiple disadvantage relating to poverty and social exclusion, and on vulnerable families exposed to, among other things, risks from substance abuse (*Towards 2016:* Section 30.3).
- Young adults are recognised as having three particular health needs – combating substance misuse, reducing alcohol-related harm and the prevention of suicide. While not identifying any priority actions or innovative measures in relation to substance misuse or alcohol, the Agreement notes the establishment of a fifth, rehabilitation, pillar in the National Drugs Strategy, the potential for better co-ordination between the areas of drugs and alcohol, and the allocation of additional funding in 2006 to develop drug-related facilities and services for young people. It notes that the recommendations of the Working Group on Alcohol, established under Sustaining Progress, will be implemented. (*Towards 2016:* Section 31.3)

Under the heading of Road Safety, *Towards 2016* endorses the passing of the Road Traffic Bill 2006, which provides the necessary statutory backing for a range of specific measures set out in the Road Safety Strategy 2004–2006. The Agreement prioritises the need to introduce mandatory roadside alcohol testing. It makes no reference to drug driving or to mandatory drug testing. Subsequent to the release of the Agreement, on 19 July 2006 the Road Traffic Act 2006 came into effect. Under the Act, the gardaí have the power to carry out mandatory roadside alcohol testing. Drivers who are breathalysed and found to be over the legal limit[2] will face between three months and four years off the road. Those who refuse to give a breath test face two years off the road.

The new ten-year framework Agreement outlines the governance framework and monitoring mechanisms that will support implementation of the Agreement. The Steering Group established under *Sustaining Progress 2003–2006* will be reconvened and will assume overall responsibility for managing the implementation of this Agreement. As heretofore, there will be ongoing quarterly meetings to review, monitor and report on progress, and an annual formal meeting of all parties to the Agreement. In addition, the Agreement provides for a streamlined outcomes-focused approach to monitoring and reporting of progress on social inclusion matters under the lifecycle framework. A formal review will be conducted during 2008. Furthermore, government has committed to involving the Social Partners in the development of policy, to ensuring meaningful input by the Partners into the shaping of appropriate responses to individual policy issues and the design of implementation arrangements, and to providing the Social Partners, with sufficient notice, information and appropriate processes for engagement. *(Brigid Pike)*

1. Retrieved 26 July 2006 at www.taoiseach.gov.ie
2. See H Sinclair 'Driving while over the legal limit for alcohol or under the influence of drugs' on p.5 of this issue for a definition of the legal limit for alcohol on the breath.

The Agreement prioritises the need to introduce mandatory roadside alcohol testing.

The inclusion of alcohol in a national substance misuse strategy

It is now widely acknowledged that alcohol-related problems extend beyond a single disease category (alcoholism) and include a range of social and health issues.

The strategies which are demonstrably effective in improving public health and public order include fiscal measures to increase the price of alcoholic beverages.

In July of this year (2006), an Oireachtas committee published a report which considered the question of whether or not alcohol should be included in a national substance misuse strategy.[1] Having examined the issues, the committee was 'unequivocally of the view that alcohol should be included in the drugs strategy.'

The committee made this recommendation following a review of the prevalence and range of alcohol-related problems currently experienced in Ireland; consideration of the political and administrative impediments to the implementation of an integrated, national alcohol policy to date; and having examined the possibility of extending the mandate of the National Drugs Strategy to include alcohol.

As the report explains, it is now widely acknowledged that alcohol-related problems extend beyond a single disease category (alcoholism) and include a range of social and health issues which may be either chronic and ongoing or acute and once-off in nature. It is also necessary to consider the effects of alcohol-related problems on others (family members, friends, neighbours or work colleagues) and the financial burden on society as a whole when attempting to formulate a suitable policy response.

The two reports from the Strategic Task Force on Alcohol, 2002 and 2004, have compiled very clear evidence to document the wide range of negative effects which alcohol consumption has on Irish society. Over the past forty years, research carried out in the biomedical and social sciences has confirmed that the kinds of alcohol-related problems experienced in this country are a direct reflection of our national drinking habits and that the only effective solution is to use social measures aimed at changing these drinking habits.

The committee reported a disparity between the preventative strategies for which there was popular support and those for which there was evidence of effectiveness. The most popular strategies were education (of the general public and of school-going children); the provision of alternative (alcohol-free) recreational activities for young people; and the expansion of treatment systems for those with alcohol dependence. Evaluation research indicates that these approaches have little or no positive effect.

The strategies which are demonstrably effective in improving public health and public order include fiscal measures to increase the price of alcoholic beverages, restrictions on the numbers of retail outlets and days and hours of sale, tougher drink driving countermeasures, and bans or restrictions on alcohol advertising and promotion. There are two main reasons why these strategies are perceived to be politically difficult. Firstly, they are threatening to the drinks industry, an industry which contributes to the economic well-being of the country and has well-established links to Irish political life; and secondly, they may prove to be electorally unpopular since they are aimed at the drinking population in general (rather than at specific subgroups within this population).

It is interesting to note that criticism of this report from the Drinks Industry Group of Ireland (DIGI) focused on the amount of alcohol being consumed per person and per adult (defined as 15 years and older) in Ireland between 2001 and 2005. Since 2001 the amount of alcohol being consumed has fallen among these groups by 5.9% and 6.8% respectively. The committee reported European figures from the 1990s and DIGI attributes the peak in consumption levels during this period to the large proportion of the population aged between 18 and 25 years. The DIGI acknowledged that there are serious issues with the misuse of alcohol among sections of the population and that the industry was committed to addressing these problem areas. However, it stated 'we do not believe it is necessary, fair or wise to demonise the majority of people who enjoy a drink responsibly, simply because of problems caused by a minority'.

In response, the chairperson of the committee, Cecilia Keaveney, stressed that it was not the intention of the report to demonise drink. She said that 'in some cases alcohol had beneficial effects, but rather than picking holes in data, the various interests should be working together to resolve the problem.' Indeed, the committee noted that public support for alcohol control measures is growing, as evidenced in the recent attitudinal survey published by Alcohol Action Ireland (2006).

Researchers have long recognised that alcohol is an issue which cuts across many different sectors of government and that the different sectors do not necessarily operate from an agreed policy agenda. For over thirty years the WHO has recommended that national governments should create management structures which facilitate the drafting and implementation of integrated, national alcohol policies based upon research findings.

While the evidence-based strategies have been known in Ireland for more than twenty years and have been recommended in policy documents on several occasions, this has not led to ongoing implementation. No permanent management structures have been established to give effect to such recommendations.

The report shows how problems relating to illicit drugs, which have a much shorter history, are being managed through the National Drugs Strategy. Reform of the Irish public sector under

A national substance misuse strategy *(continued)*

the Strategic Management Initiative (SMI) in the late 1990s, which aimed to improve the management of cross-cutting issues and create 'joined-up government,' provided the model for the National Drugs Strategy. The structures set in place combine 'top-down' co-ordination with 'bottom-up' or community-level participation in the policy process.

These structures have facilitated the emergence of a policy process over the past ten years in which policy objectives are clearly stated; actions necessary for the realisation of objectives are identified; the agencies which have specific responsibility for working towards the attainment of the various objectives are identified; and key performance indicators and timeframes are established. A detailed policy framework, *Building on Experience: National Drugs Strategy 2001–2008,* was published in 2001 following a national consultation process. A mid-term review of this strategy was published in 2005. While the mid-term review offered evidence of mixed outcomes regarding the implementation of the strategy, it provided evidence that the structures have succeeded in keeping all the major stakeholders (statutory and non-statutory) involved in an on-going process of working towards agreed objectives. The committee argues that the National Drugs Strategy has brought consistency and coherence to the complex arena of Irish drug policy.

It is significant that during the public consultation process before *Building on Experience* was drafted, members of the public, particularly those outside Dublin, identified alcohol as their major source of concern. The committee argues that this concern with alcohol issues and the accompanying sense of frustration that alcohol is not part of the National Drugs Strategy continue to be reflected in the work of the regional drugs task forces. It concludes that the five-pillar model of the National Drugs Strategy (supply reduction, prevention, treatment, research, and rehabilitation) appears to offer an ideal framework for a comprehensive policy approach to alcohol issues. *(Sarah Fanagan)*

1. Houses of the Oireachtas Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs (2006) *Ninth Report: The inclusion of alcohol in a national substance misuse strategy.* Dublin: Stationery Office.

Guidelines on joint policing committees

Guidelines setting out the functions, composition and operation of joint policing committees (JPCs), established under the Garda Síochána Act 2005, were published in June.[1] The guidelines were prepared by the Minister for Justice in consultation with the Minister for the Environment and, following a recommendation by the Joint Oireachtas Committee on Justice, Equality, Defence and Women's Rights, with Mr Noel Ahern, Minister of State with responsibility for drugs strategy.[2]

JPCs, which are to be established in each of the 114 local authority administrative areas throughout the State, will bring together representatives from the local authority, gardaí, public representatives and representatives of the community and voluntary sector to discuss and make recommendations on matters affecting the policing of the area. The guidelines propose the establishment of pilot JPCs in the following areas: Fingal, Offaly and Wicklow County Councils; Dublin, Galway, Limerick and Waterford City Councils; Drogheda and Sligo Borough Councils; Athy, Arklow, Ballinasloe, Birr, Bray, Edenderry, Greystones, Leterkenny, Mallow, Tralee, Tuam, Tullamore and Wicklow Town Councils. In Dublin city, five sub-committees corresponding to the operational areas of the City Council will also be established.

From January 2007 an evaluation of the pilot phase will begin. After mid 2007, JPCs will be established in all local authorities until the next local elections in 2009. The guidelines also make provision to ensure that Garda representation on the JPCs is of appropriate rank and seniority, and highlight the importance of ensuring gender equality on the JPCs. The primary functions of the JPCs are to serve as a forum for consultation, discussion and recommendations on local policing matters and to keep under review levels of crime, disorder and anti-social behaviour, including the patterns and levels of misuse of alcohol and drugs.

The guidelines also cover such issues as the chairing of JPCs, the circumstances in which they can meet in public and in private and the procedures by which members of the public can raise issues of local concern. Section 36(2)(d) of the Act provides for the establishment of local policing fora by a JPC. Supplementary guidelines for local policing fora are to be drawn up at a later date. However, in light of Action 11 of the National Drugs Strategy, the guidelines stipulate that 'priority will be given to establishing local policing fora in all Local Drugs Task Force areas and other areas experiencing problems of drug misuse' (p.16). *(Johnny Connolly)*

1. Department of Justice, Equality and Law Reform (2006) *Garda Síochána Act 2005: Joint Policing Committee Guidelines.* Dublin: Department of Justice, Equality and Law Reform.
2. *Drugnet Ireland,* Issue 15, Autumn 2005.

'priority will be given to establishing local policing fora in all Local Drugs Task Force areas and other areas experiencing problems of drug misuse'

Peer drugs education programme in Kilkenny wins major European award

The European Prevention Prize, an accolade given by the Council of Europe, was presented to Kilkenny's 421 Peer Drugs Education Programme at a recent awards ceremony in Vilnius, Lithuania. The Pompidou Group awards this prize every two years in order to highlight good-quality drug prevention projects that have successfully involved young people in their design and implementation. The Kilkenny initiative, along with a project from Norway, was chosen from 31 entries by a panel that comprised six young people from the Russian Federation, Norway, the Netherlands, Romania, the UK and Turkey and experts in the field from the Pompidou Group. The two winners received a trophy, a diploma and prize money of €2,000.

The story of the emergence of the 421 Programme goes back to the year 2003 when a school chaplain in Kilkenny identified the need for an innovative approach to providing drug education in local schools. It was felt that the traditional adult-delivered drug education approach had its limitations, and that it could be strengthened by more active participation of young people themselves in both design and delivery. In response, two drug education workers from the HSE and the local youth service developed what is now the 421 Peer Education Programme.

It was felt that the traditional adult-delivered drug education approach had its limitations, and that it could be strengthened by more active participation of young people themselves in both design and delivery.

The overall aim of the 421 initiative is to provide meaningful education to young people on drugs and the main risks associated with their use. The main objective is to introduce peer education by training groups of students to design and deliver drug education in their schools. The 421 initiative trains fourth-year students to design and deliver drugs education to first-year students. The older students are trained over a three-day period by local youth workers and community drug workers from Ossory Youth, and the drugs education officer from the Carlow/Kilkenny HSE substance misuse team.

The training includes modules on the following: attitudes to substance misuse, drug facts, signs and symptoms, patterns of drug use, peer education skills, planning a programme and presentation skills. Schools pay a fee of €20 for the training of each student. These students then design their own six-session drugs education programme, which they deliver to the all first-year classes in their school. This is usually done in the context of Social, Personal and Health Education (SPHE) classes.

The 421 Programme has been in existence since 2004. To date (summer 2006) the programme has trained 92 fourth-year students from four schools in Co Kilkenny. These young people have gone on to provide drugs education to approximately 880 first-year students. The initiative relies extensively on internal evaluations to make changes and respond to issues arising. The whole programme is due to undergo an external evaluation soon. Funds for the evaluation have been secured and an external evaluator is in discussion with the programme team.

At the prize-giving ceremony in Vilnius, from left: Mel Bay, Kilkenny City Drugs Initiative; Marion Hearne, Loreto Secondary School, Kilkenny; Susan Barnes, HSE Substance Misuse Team Carlow/Kilkenny; Rachel Walsh, 421 Peer Educator, Loreto Secondary School.

An article in issue 18 of *Drugnet Ireland,* 'Inequality and the stereotyping of young people', highlighted two recent pieces of research among young people in Ireland. Devlin[1] reported that young people perceived and experienced levels of inequality and disrespect from certain adult groups in society including the gardaí and school teachers, and Lalor and Baird[2] highlighted the crucial role that peers play in the everyday lives of young people, particularly as providers of 'new information'.

The article in issue 18 suggests that perhaps it would be wise for adult groups that deliver drug education to young people to reflect on their methods of engagement and give serious thought to training young people themselves in the design and delivery of peer education. The 421 initiative is an excellent example of how this approach can be developed. It will be interesting to assess the effectiveness of this intervention and to see how it is received by its target audience; these questions will receive some attention in the forthcoming external evaluation. Finally, a special word of thanks to Mr Mel Bay from Ossory Youth for providing information on the history and operation of the 421 initiative. *(Martin Keane)*

1. Devlin M (2006) *Inequality and the stereotyping of young people.* Dublin: The Equality Authority.
2. Lalor K and Baird K (2006) *Our views – Anybody listening? Researching the views and needs of young people in Co Kildare.* Kildare: Kildare Youth Services.

Identifying new drugs and new drug trends with the help of drug helplines

In July 2006 the European Foundation of Drug Helplines (FESAT) published the results from its eleventh monitoring project.[1] Since the beginning of 2001 FESAT has been collecting information every six months on the types of person contacting helplines throughout Europe, the content of these calls and how this has changed compared to the previous six months. The main objective of this monitoring is to identify the emergence of new drugs and new drug trends as early as possible.

During the second half of 2005 six helplines received calls about drugs that had not been reported to them before. Helplines in Cyprus and Italy reported calls about Ketamine, an anaesthetic that has hallucinogenic effects. The Cypriot helpline also reported questions about LSA, a naturally occurring psychedelic found in some plants. In Austria, calls were received about mCPP, a piperazine-derived designer drug commonly sold as ecstasy. One Belgian helpline reported receiving 15 calls about *Efedrine* (Ephedrine), a stimulant that suppresses appetite. In Finland, calls were received about GBL, which when ingested turns into GHB, producing effects such as relaxation, mild euphoria and drowsiness. Lastly, in Norway, two new drugs were reported by one helpline: Vallergan, an antihistamine with sedative effects reportedly used by drug users to relieve sleeping problems, and DMT, a hallucinogenic drug similar to LSD.

The FESAT report also notes a continuation of the increasing trend in the number of calls about cocaine and about alcohol; whether these were used in combination is not stated.

Unpublished data from the Drugs/HIV Helpline in Ireland show that the number of calls about the combined use of alcohol and cocaine as a proportion of all calls concerning alcohol or cocaine increased threefold over the period 2002 to 2006 (Table 1). However, trends based on helpline calls should always be interpreted with care. Aileen Dooley, Drugs/HIV Helpline manager, stresses that helpline staff record only what is revealed during calls, and a caller might not always mention a second drug (Aileen Dooley, personal communication). In addition, helpline staff are increasingly aware of the need to record mention of alcohol. So the observed increase may be due, in part, to better recording practices.

In July 2005, the Health Promotion Unit of the Department of Health and Children launched the third phase of the National Drugs Awareness Campaign, which was aimed at raising awareness of the dangers of mixing cocaine with other drugs, especially alcohol.[2] When cocaine and alcohol are taken together they combine in the body to form another drug, Cocaethylene, which is more toxic than either drug alone. Cocaethylene can seriously affect the normal functioning of the heart. This recent phase of the drug awareness campaign specifically targeted recreational settings, such as pubs and clubs. Anecdotal reports suggest that cocaine is increasingly available in Irish pubs, which tends to link the drug with alcohol, giving it an 'acceptability' that needs to be addressed.[3] *(Hamish Sinclair)*

1. Hibell B (2006) *FESAT Monitoring Project – Changes during the second half of 2005*. FESAT (The European Foundation of Drug Helplines). www.fesat.org
2. Keane M (2005) National Drugs Awareness Campaign. *Drugnet Ireland,* Issue 15: 7.
3. Sinclair H, Long J (2006) Health Service Executive facilitates workshop on cocaine. *Drugnet Ireland,* Issue 18: 11.

More information about FESAT can be found on the website of the European Foundation of Drug Helplines at www.fesat.org

The Drugs/HIV Helpline in Ireland is a confidential, freephone, active listening service offering non-directive support, information, guidance and referral to anyone with a question related to substance use or HIV and sexual health. Set up in July 1997, the service is funded and managed by the Health Service Executive South Western Area on behalf of the HSE South Western, East Coast and Northern Areas. The freephone number is 1800 459 459. The Helpline manager is Aileen Dooley.

The main objective of this monitoring is to identify the emergence of new drugs and new drug trends as early as possible.

Table 1 Number of calls to the Drugs/HIV Helpline about the combined use of alcohol and cocaine as a proportion of all calls concerning alcohol or cocaine in the first five months of the year, 2002–2006.

	Number of calls in the first five months of the year				
	2002	2003	2004	2005	2006
All calls about either cocaine or alcohol	178	246	309	277	403
Calls about the combined use of cocaine and alcohol	8	17	41	30	60
Proportion of calls about the combined use of cocaine and alcohol	4.5%	6.9%	13.3%	10.8%	14.9%

Source: Aileen Dooley, Drugs/HIV Helpline

Southern Regional Drugs Task Force: Strategic Plan 2005–2008

Drug and alcohol use had increased across all types of drugs in the region between 1996 and 2004.

The Southern Regional Drugs Task Force (SRDTF) was established in 2003 by the National Drugs Strategy Team.

The SRDTF recently published its Strategic Plan[1] to address drug and alcohol misuse in Cork and Kerry. The Plan is the result of extensive research and consultation with a range of individuals and organisations to determine the nature and extent of the problem of drug and alcohol misuse in Cork and Kerry.

The background research carried out in the preparation of this Plan included a detailed profile of the SRDTF. Current drug- and alcohol-related services, the uptake of services and gaps in service provision were highlighted. A study by Dr Tim Jackson, *Smoking Alcohol and Drug Use in Cork and Kerry* (2004), the repeat of a 1999 study, was used for comparative purposes.

The research and consultation process revealed that:

- Drug and alcohol use had increased across all types of drugs in the region between 1996 and 2004.
- Cannabis use had significantly increased and was the most popular illicit drug of choice.
- The increase in illicit drug use was most pronounced in the 15–19 and 20–24-year age groups.
- Societal tolerance of high alcohol and illicit drug use had significantly increased.
- Addiction was a feature for many prisoners and ex-prisoners, as well as for their immediate families.
- There was a specific illicit drug trade aimed directly at non-nationals.
- The number of people accessing treatment for both drug and alcohol misuse had increased by 300% since 1999.
- The key/link worker approach was identified as offering flexibility in treatment and rehabilitation, but no such resource exists in the region.

There was a specific illicit drug trade aimed directly at non-nationals.

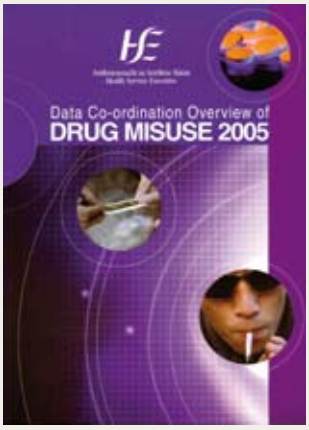
Some of the key recommendations of the Strategic Plan are:

- The development of partnership between state and voluntary sectors in the provision of treatment for drug and alcohol misuse.
- The development of the role of key/link worker which will ensure continuity between each phase of treatment. These workers can play a significant role in ensuring that the pathway to rehabilitation is made accessible to all clients.
- That the needs of families affected by drug and alcohol misuse must be addressed in order that rehabilitation can take place within the family unit.
- The level of treatment service provision should reflect the level of drug and alcohol misuse.
- Recognition of the roles of alternative treatment methods rather than relying solely on drug-based treatments.

The Strategic Plan was submitted to the National Drugs Strategy Team for consideration and funding has been approved for the implementation of a detailed Action Plan over the three-year period 2005–2008. *(Siobhán Reynolds)*

1. Southern Regional Drugs Task Force (2005) *Strategic Plan 2005–2008.* Cork: SRDTF.

Substance misuse in the HSE South Eastern Area



The Health Service Executive (HSE) South Eastern Area published its annual report entitled *Data co-ordination overview of drug misuse 2005*[1] in June 2006. The report comprises three sections: treatment services, education and prevention, and supply and control.

The section on treatment services analyses data collected from statutory and voluntary drug and alcohol treatment agencies, acute general hospitals and psychiatric hospitals in the HSE South Eastern Area based in HSE South. The data from the drug and alcohol treatment services are returned to the National Drug Treatment Reporting System.

The total number of contacts with treatment services in 2005 was 2,786. This is an increase of 237 clients compared to the 2004 figure. As the report notes, this may be a true increase or may be the result of improved reporting from the participating services. Contacts with treatment services include those by clients continuing in treatment from the previous year, clients who were assessed but not treated, clients who were treated, and concerned persons. Some 142 concerned persons, the majority (76%) of them female, contacted treatment services in the south-east in 2005.

Substance misuse in the HSE South Eastern Area *(continued)*

The combined total of new referrals who were treated and clients who returned to treatment after an absence was 1,944. Of these:

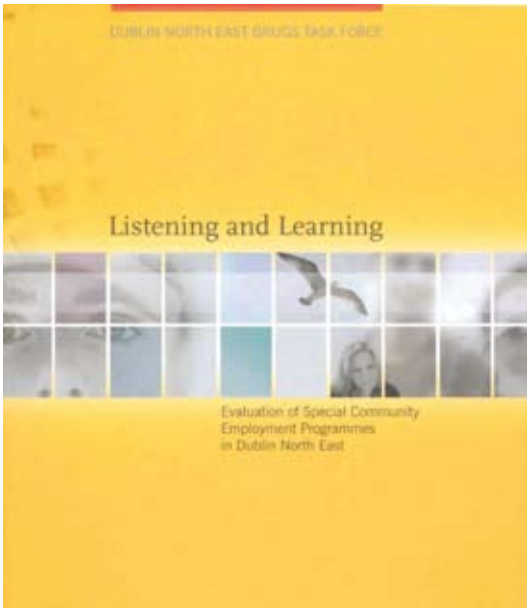
- 75 per cent were male and 25 per cent female;
- 7.5 per cent were under the age of 18 years, and 43 per cent were aged between 20 and 34 years;
- Alcohol (66%) was the most common main problem substance for which treatment was sought, followed by cannabis (16.5%) and heroin (8%);
- The number of clients whose main problem substance was cocaine increased considerably, from 25 cases in 2004 to 85 cases in 2005;
- Of the clients who had used a drug, 41 per cent reported that cannabis was the first drug they had ever used;
- 39 per cent of clients reported using a secondary substance, the main ones being cannabis (16%), alcohol (7%) and ecstasy (6%);
- 63 per cent of clients treated for alcohol and 69 per cent treated for a drug as their main problem substance were treated for the first time.

Of all clients treated in the south-east in 2005 (including clients continuing in treatment from the previous year), 152 (6%) had injected a substance. Of those who had injected, 66 (43%) had shared injecting equipment at least once. *(Sarah Fanagan)*

1. Kidd M (2005) *Data co-ordination overview of drug misuse 2005*. Waterford: HSE South Eastern Area.

The number of clients whose main problem substance was cocaine increased considerably, from 25 cases in 2004 to 85 cases in 2005.

The role of vocational training in Dublin North East Drugs Task Force projects



The Dublin North East Drugs Task Force recently published a review of FÁS Special Community Employment (CE) programmes in the area.[1] FÁS Special CE was designated the main vehicle through which vocational and employment skills training would be delivered in local drugs task force (LDTF) areas.[2] The review by Lawless[1] reflects the views of staff and participants engaged in CE and includes a number of key learning points that merit attention from policy makers, service providers and other relevant stakeholders engaged in responding to the needs of drug users.

How is FÁS CE perceived: Rehabilitative or vocational?

The primary aim of FÁS Special CE projects in LDTFs is to provide vocational and employment skills training to improve the chances of clients finding employment. Yet, Lawless reported that the majority of respondents in the Dublin North East area continued to view CE as the main mechanism for delivering drug rehabilitation, with therapeutic functions as the primary role. Education and training were viewed as the least important role. An overall review by Bruce[3] of FÁS CE in LDTF areas reported a similar finding, with project staff and participants expressing the view that CE was being used to provide personal development and relapse-prevention skills, with little attempt to provide vocational training options.

Critique of health services as part of inter-agency approach

Lawless reported that all respondents cited the lack of inter-agency work as one of the main barriers to the full effectiveness of CE. The majority of respondents expressed the view that the Health Service Executive (HSE), which they felt should be responsible for drug rehabilitation work, had abdicated its responsibility and transferred this work to FÁS, which was not equipped for the task. Many felt that, without the strategic involvement of the HSE, local community groups were out of their depth in trying to do the work they were involved in. The review by Bruce identifies a similar experience among project staff, who expressed their frustration at the lack of HSE involvement in their work with clients.

The role of methadone, dosage reduction and detoxification

Lawless reported that staff and participants had strong views on the role of methadone in the overall context of FÁS CE. Methadone was viewed as a key part of the initial stages of stabilisation; however, it was felt that, more often than not, it

FÁS Special CE was designated the main vehicle through which vocational and employment skills training would be delivered in local drugs task force (LDTF) areas.

The role of vocational training *(continued)*

had become the sole and final solution. The criticism was not of methadone treatment but of the lack of options available to clients. This 'one size fits all' approach was heavily criticised and, indeed, runs counter to the central premise of the National Drugs Strategy 2001–2008, which holds that drug misuse is the result of a complex interplay of factors and will not be alleviated by any one approach, but requires an array of options. Some respondents to the research survey by Lawless viewed the methadone programme 'as a form of social control' and 'an abdication of the state's responsibility' (p.68) to provide a properly funded and structured treatment programme of options and pathways to rehabilitation.

Additionally, clients reported that when they tried to take some responsibility for their own treatment, they very often got an adverse response from medical staff. Across the four special CE projects in the Dublin North East Task Force area, clients spoke of themselves or others being treated with disrespect by the medical staff, of not being involved in their own treatment plans and of feeling frustrated in their attempts to reduce their dosage or to detox from prescribed medication.

The option of threatened sanctions as favoured by clients as a demand reduction tool

Lawless reported that clients favoured the option of urine samples being taken for testing twice or three times a week, despite the sanctions that a failed test would entail. Clients expressed the view that they could 'get round' having one test per week and continue to dabble in drugs if they wished, but having to submit to two or three tests would prove more difficult and so reduce the likelihood of their using illicit drugs. Clients felt that this would strengthen their motivation to stay off drugs. Research by Ginexi *et al.*[4] found that by far the greatest barrier to labour force participation and employment for persons in treatment for drug use over a three-year period was continued use of illicit drugs.

The need for more intensive vocational input to enable client progression

Clients expressed the view that participation in the CE programme had enabled them to further their personal development, but were frustrated at how little progress they had made in terms of education and training and how few move-on options were open to them. Most of all, they wanted to leave the project with more formal qualifications. They wanted to see more work placement and work experience built into the programme and felt that structured move-on options were essential. Research by Lidz *et al.*[5] reported that where a relaxed rather than an intensive approach is taken to vocation training, the results can be quite discouraging for clients.

An alternative approach to CE, based on the findings of the evaluation

Taking the three components of dosage reduction, use of sanctions and intensive vocational inputs that have been requested by clients, service providers can use an approach that is showing promise in improving employment opportunities for clients on methadone. Research by Kidorf *et al.*[6] suggests that reducing methadone dosage, the threat of sanctions and the application of intensive vocational training support can be effectively combined to help clients in methadone treatment progress to employment. The Motivated Stepped Care (MSC) approach requires all patients who complete one year of treatment to secure work, with continued methadone treatment contingent upon securing employment. The approach includes a highly intensive Job Seekers Skills Training group where specialists motivate clients to tackle the personal barriers between them and employment, with the objective of developing the self-efficacy of the client so that he or she can take responsibility for their job seeking behaviour. Based on preliminary evaluation of this approach, Magura *et al.*[7] suggested that it is one of the few in the vocational training field to demonstrate promise when applied to people in methadone treatment. The adoption of this approach in LDTF areas is a feasible option and should at least be piloted to test its applicability in an Irish context. However, such an approach will require the development of inter-agency co-operation and much greater involvement of clients in the design and management of a structured care plan, with buy-in from all relevant stakeholders. As we approach the final stages of the current National Drugs Strategy, it is incumbent on both policy makers and service providers to invest in the progression needs of clients who have been maintained on methadone for some time. *(Martin Keane)*

[Clients] wanted to see more work placement and work experience built into the programme and felt that structured move-on options were essential.

1. Lawless K (2006) *Listening and learning: evaluation of Special Community Employment programmes in Dublin North East.* Dublin: Dublin North East Drugs Task Force.
2. Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996) *First report of the ministerial task force on measures to reduce the demand for drugs.* Dublin: Stationery Office
3. Bruce A (2004) FÁS Community Employment schemes in local drug task forces: a review. (Unpublished).
4. Ginexi EM, Foss MA and Scott CK (2003) Transitions from treatment to work: employment patterns following publicly funded substance abuse treatment. *Journal Of Drug Issues,* 33(2): 497–518.
5. Lidz V, Sorrentino DM, Robinson L and Bunce S (2004) Learning from disappointing outcomes: an evaluation of prevocational interventions for methadone maintained patients. *Substance Use and Misuse,* 39(13–14): 2287–2308.
6. Kidorf M, Neufeld K and Brooner RK (2004) Combining stepped care approaches with behavioural reinforcement to motivate employment in opiod-dependent outpatients. *Substance Use and Misuse,* 39(13–14): 2215–2238.
7. Magura S, Staines GL, Blankertz L and Madison EM (2004) The effectiveness of vocational services for substance users in treatment. *Substance Use and Misuse,* 39(13–14): 2165–2213.

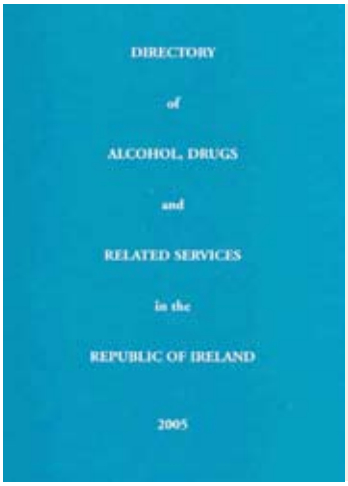
'Working Together Works'

Dublin North East Task Force hosts Open Day

Noel Ahern TD, Minister of State with responsibility for drugs strategy, launched the open day hosted by Dublin North East Drugs Task Force at their offices in Donnycarney on 29 June. 'Working Together Works' was both educational and fun, with guest speakers, information stands and entertainment throughout the day. Picture shows, from left: Tom O'Brien, Task Force Coordinator; Councillor Deirdre Heaney; Minister Ahern; and George Ryan, Task Force chairperson.

Johnny Connolly of the DMRD speaking at 'Working Together Works' in June.

New Life Choir was among the many bands, choirs and youth groups providing entertainment to the large attendance.



The Directory of Alcohol, Drugs and Related Services in the Republic of Ireland 2005 was published by the Health Promotion Unit, Department of Health and Children, in May 2006.

Health Promotion Unit contact details: Tel: 01 6354372;

Email: healthpromotionunit@health.irlgov.ie

Website: www.healthpromotion.ie

Politicians and the drugs debate

Starting in some 18 months' time, UN members, including Ireland, will be reporting on their actions in pursuit of the goals and targets set for the year 2008 in the UN Political Declaration on drugs.

In May 2006 some 25 members of Dáil Éireann (including eight Independents) debated a private member's motion on Ireland's drugs policy.[1] Both the motion and the contributing speakers endorsed the National Drugs Strategy (NDS)[2] and its strategic objective, 'to significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research' (NDS: Section 6.7). The motion called for increased resources and an intensification of efforts to support the full implementation of the NDS (see Table 1). The opportunity was not taken, however, to debate the larger strategic question of whether or to what extent Ireland's policy objectives in relation to illicit drugs were still appropriate.

It might have been an opportune time to initiate such a debate because, starting in some 18 months' time, UN members, including Ireland, will be reporting on their actions in pursuit of the goals and targets set for the year 2008 in the UN Political Declaration on drugs[3] and debating the next steps. In addition, the EU Drugs Action Plan 2005–2008[4] and Ireland's National Drugs Strategy 2001–2008[2] will both be expiring. At UN level, the Commission on Narcotic Drugs, the UN's central policy-making body dealing with drug-related matters, has already begun to prepare for the evaluation of the UN action plan.[5] International, European and Irish non-governmental organisations (NGOs) have also begun to debate the alternatives to the approach favoured by the UN.[6]

In Ireland, the Review Group that drew up the NDS in 2000/1[2] considered alternative strategic approaches, including broadening the harm-reduction approach to include heroin on prescription and/or injecting rooms (NDS: Section 4.13.2). It also noted the debate regarding the decriminalisation of certain controlled substances (NDS: Section 5.2.5). The Review Group concluded, however, that these harm-reduction options were not appropriate but should be kept under review.

Reporting in 2005, the Mid-Term Review (MTR) of the NDS[7] reported that the current aims and objectives of the NDS were 'fundamentally sound' (MTR: Section 8.2). In relation to harm reduction, the MTR expressed the view that, 'in light of the increase in the incidence of hepatitis C and the ongoing prevalence of HIV, higher priority should be given to the relevant actions in the Strategy [Actions 62 and 63 relating to needle exchange and other injecting paraphernalia]' (MTR: Section 5.23). The MTR did not, however, review the wider range of harm-reduction options considered by the Review Group in 2000/1.

Given that the Steering Group that undertook the mid-term review did not present any evidence to support its conclusions regarding the fundamental soundness of the aims and objectives of the NDS, and given that there was a general consensus among contributors to the Dáil debate in May that both the supply of and demand for illicit drugs in Ireland had increased dramatically in the five

Table 1 Summary of measures included in Private Member's Motion, Dáil Éireann, May 2006[1]

Supply reduction	• Target major drug traffickers • Ring-fence seized funds related to the drugs trade for development in communities worst affected by 'drug scourge' • Appropriate sanctions, including sentences, for those involved in drugs trade • Increased resources for drug-related Garda activities
Prisons	• Ensure access for prisoners to health and prevention policies and services, including harm-reduction strategies, equivalent to those available in the wider community
Cocaine	• Formulate, resource and implement an action plan to address cocaine use
Treatment	• Increase funding to ensure waiting lists are eliminated • Encourage the HSE to return to 'real partnership' with community and voluntary groups in addressing problematic drug use • Expand spectrum of services • Ensure access to counselling and other medical services, without discrimination
Prevention	• Ensure take-up of widespread and well-resourced education programmes and campaigns
Grandparents	• Increase orphan-guardian allowance for grandparents looking after children of their drug-addicted offspring, in line with provision for foster parents
Socio-economic factors	• Address poverty and inequality, including educational disadvantage
All-Ireland approach	• Work on an all-Ireland basis to ensure application of strategic objectives in National Drugs Strategy
Strategic leadership	• Appoint a Minister of State with sole responsibility for the drugs issue

Politicians and the drugs debate *(continued)*

years since the NDS was published, it might have been expected that the Dáil deputies would review the strategic aims and objectives of the NDS and consider whether the approach being followed was still both appropriate and sufficient.

Arguably, the Minister of State with responsibility for drugs strategy, Noel Ahern TD, invited such debate when he stated, 'The key drivers of the [illicit drugs] market include both economic factors and the attitude of societies towards illicit drug consumption.'[8] While the minister elaborated on the economic factors, he did not explore the links between social attitudes and the drugs situation and the implications for drugs policy, and no other speaker took his cue.

Researchers in the area of Irish drugs policy suggest that there has long been a reluctance on the part of Irish politicians to address the wider strategic questions with regard to illicit drugs. It has been argued that, ideologically, there has been a cross-party consensus that 'drugs' not only are a social problem in and of themselves but also exacerbate the crime problem in Ireland, and are evil and to be prohibited.[9] It has also been argued that, sociologically, political leaders have generally not encouraged or participated in explicit public debate on the concept of harm reduction in relation to illicit drugs, in order to contain sensitive and potentially divisive national social issues.[10]

A structural factor that may also inhibit politicians' engagement with the strategic aspects of the drugs issue is the availability and accessibility of research-based evidence to support their analysis and deliberations. In reviewing the Research pillar of the NDS, the MTR reported that 'substantial progress' had been made in filling information gaps but urged agencies to make their information more readily available (MTR: Section 6.13). The MTR did not consider the associated question of whether and how information and research findings were translated into policy and practice. To what extent do researchers understand and work within the 'real' world of policy and practice, and to what extent do policy makers, including politicians, understand the value and methods of research and how to apply the lessons of research in formulating policy?[11]

To enhance the translation process, a series of possible initiatives has been identified,[12] including investment in *long-term research strategies* linked to national and EU policy concerns; establishment of *centres of excellence* to co-ordinate and/or carry out research; the establishment of *think tanks* alongside the research centres, comprising academics, policy makers and practitioners, to offer detached reflection and cultural questioning on what the research means in a wider context, and alternative approaches and questions; and promotion of a *stakeholder partnership* comprising three-way collaboration between government, science and the market for the exchange of knowledge and the development of policy. *(Brigid Pike)*

1. Private Member's Business. Drug Abuse: Motion (23–24 May 2006) *Parliamentary Debates Dáil Éireann Official Report: Unrevised.* Vol. 620, No 1, cols. 54–85 and Vol. 620, No 2, cols. 493–528. See www.oireachtas.ie
2. Department of Tourism, Sport and Recreation (2001) *Building on experience: National drugs strategy 2001–2008.* Dublin: Stationery Office.
3. UN Political Declaration. 9th plenary meeting of the UN General Assembly (UNGASS), 10 June 1998. A/RES/S-20/2.
4. EU Drugs Action Plan 2005–2008. 2005/C 168/01.
5. Commission on Narcotic Drugs (2006) Report on the forty-ninth session (8 December 2005 and 13-17 March 2006). E/2006/28, E/CN.7/2006/10.
6. At international level, see, for example, the websites of the Senlis Council at www.senliscouncil.org and the International Drug Policy Consortium at www.idpc.info In Europe, on 6–7 November 2006, ENCOD (European Coalition for Just and Effective Drug Policies) will be hosting a conference in collaboration with the GUE and Green Party factions of the European Parliament on 'European Alternatives on Drug Policies – the Road to Vienna 2008'; see www.encod.org for further information. In Ireland, on 28 August 2006, three NGOs – the Irish Penal Reform Trust (IPRT), Merchants Quay Ireland (MQI) and the Union for Improved Services, Communication and Education (UISCE) – held a public forum entitled 'Rethinking the War on Drugs'; see www.iprt.ie for further information.
7. Steering group for the mid-term review of the National Drugs Strategy (2005) *Mid-term review of the national drugs strategy 2001–2008.* Dublin: Department of Community, Rural and Gaeltacht Affairs.
8. Ahern N (23 May 2006) *Parliamentary Debates Dáil Éireann Official Report:* Unrevised. Vol. 620, No 1, col. 69.
9. Murphy T (2002) Drugs, crime and prohibitionist ideology. In O'Mahony P (ed.) *Criminal Justice in Ireland.* Dublin: Institute of Public Administration.
10. Butler S and Mayock P (2005) "An Irish solution to an Irish problem": Harm reduction and ambiguity in the drug policy of the Republic of Ireland. *International Journal of Drug Policy,* 16(6): 415–422.
11. For a case study of how research has translated into policy and practice in Ireland, see McGarry K (2004) 'An evidence-based policy in a moral panic: Linking local drugs task forces to drug treatment data'. MSc thesis, Trinity College, Dublin.
12. See R Hartnoll (2004) *Drugs and drug dependence: linking research, policy and practice – lessons learned, challenges ahead.* Background paper for the Pompidou Group's Strategic Conference on connecting research, policy and practice, Strasbourg, 6–7 April 2004. Strasbourg: Council of Europe Publishing Group, and Pompidou Group (2004) *Connecting research, policy and practice: lessons learned, challenges ahead.* Proceedings of Strategic Conference on connecting research, policy and practice, Strasbourg, 6–7 April 2004. Strasbourg: Council of Europe Publishing Group.

Researchers in the area of Irish drugs policy suggest that there has long been a reluctance on the part of Irish politicians to address the wider strategic questions with regard to illicit drugs.

To what extent do researchers understand and work within the 'real' world of policy and practice, and to what extent do policy makers, including politicians, understand the value and methods of research?

Emerging drug trends in Europe: a case study of hallucinogenic mushrooms

To mark International Day against drug abuse and illicit trafficking (26 June), the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published a thematic paper entitled *'Hallucinogenic mushrooms: an emerging trend case study'.*[1] This paper is the first in a series of reports to be published under a new EMCDDA pilot project to explore the capacity in EU member states and the EMCDDA to detect, track and understand emerging drug trends in Europe. The project is called European Perspectives on Drugs, or E-POD for short.

The detection and tracking of emerging drug trends demand a different approach to that of the traditional key epidemiological indicators[2] used for monitoring the main types of drug use. While the key indicators developed by the EMCDDA since the mid-1990s provide reliable and comparable European drug data, they are not sensitive enough to detect emerging drug trends in a timely manner. The approach adopted by the EMCDDA in its E-POD pilot project was to collect and analyse information on hallucinogenic mushrooms in Europe from a range of sources (some non-conventional) and within a limited timeframe (between July and October 2005). The work of detecting and monitoring emerging trends relies largely on locally based information sources that are close to the target drug-using groups. The sources used included:

The work of detecting and monitoring emerging trends relies largely on locally based information sources that are close to the target drug-using groups.

- Targeted surveys conducted in club or dance music settings
- Telephone helplines, including the European Foundation of Drug Helplines (FESAT)
- Information from retail outlets (e.g. 'smartshops', 'headshops' and 'grow shops')
- Information from national focal points
- Published reports and scientific articles
- Newspaper and magazine articles
- Non-published (grey) literature
- Internet websites and discussion groups
- Personal communication with key informants.

The thematic paper highlights the growth in the marketing of hallugincogenic mushrooms by smartshops, internet shops and market stalls across Europe. This increase in availability has fuelled interest in such mushrooms and has led to an increase in their use.

In Ireland, the estimated lifetime prevalance of hallucinogenic mushroom use is 5.5%.

Surveys in 12 EU member states indicate that, among young people aged 15 to 24 years, lifetime use of hallucinogenic mushrooms ranges from less than 1% to 8%. In Ireland, the estimated lifetime prevalance of hallucinogenic mushroom use is 5.5%. However, the 95% confidence interval around this estimate ranges from 4.2% to 6.9%, indicating that the prevalence could be as low as 4.2% or as high as 6.9%.[3]

The third European School Survey on Drugs and Alcohol (ESPAD) conducted in 2003 introduced a question about the use of hallucinogenic mushrooms. Across Europe, lifetime use of hallucinogenic mushrooms by schoolchildren (aged 15–16 years) ranged from 0% to 8%. In Ireland, the estimated lifetime prevalence was 4%.[4] No confidence intervals were provided for this ESPAD estimate.

As might be expected, clubbing surveys in Europe show higher levels of hallucinogenic mushroom use among clubbers than among the general population of the same age. No clubbing surveys have been carried out in Ireland.

The thematic paper notes that, since 2001, six EU countries have tightened their legislation on hallucinogenic mushrooms, apparently in response to their increasing availability and use. In Ireland, legislation was introduced in January 2006 to ban the possession and sale of hallucinogenic mushrooms in their natural state.[5] Heretofore, only possession and sale of such mushrooms in their dried or prepared state was unlawful. In the UK, tighter legislation introduced in July 2005 appears to have had an immediate impact on both the availability of hallucinogenic mushrooms and on the general volume of internet sales.

The EMCDDA points to a number of additional factors which may help limit the diffusion of this emerging trend. Unlike ecstasy, which is easy to take at a party or dance scene, mushrooms must be chewed or brewed in hot water. This cumbersome route of consumption is likely to serve as a barrier to widespread or frequent recreational use of mushrooms; it may also reduce the likelihood of young people witnessing others using mushrooms and possibly copying their behaviour. In addition, the unpredictable potency and negative effects, such as nausea and panic attacks, or the lack of sociable effects, may contribute to limiting recreational use of hallucinogenic mushrooms.

The E-POD pilot project contributes to the implementation of objective 41 of the EU Action Plan on Drugs (2005–2008) which calls for the development of 'clear information on emerging trends and patterns of drug use and drug markets'. The EMCDDA thematic paper provides an important snapshot of the current status of hallucinogenic mushroom use, its consequences and the responses in Europe, using available data sources. In order to monitor trends, it will be necessary to repeat the data- collection and analysis exercise on a regular basis in the future. *(Hamish Sinclair)*

1. Hillebrand J, Olszewski D and Sedefov R (2006) *EMCDDA Thematic Papers – hallucinogenic mushrooms: an emerging trend case study.* Lisbon: European Monitoring Centre for Drugs and Drug Addiction.
2. The five key epidemiological indicators of drug use are (1) prevelance of drug use in the general population, (2) prevalence of problem drug use, (3) drug-related infectious diseases, (4) drug-related deaths, and (5) the demand for drug treatment. Objective 39 of the EU Action Plan on Drugs (2005–

Emerging trends: hallucinogenic mushrooms *(continued)*

2008) calls for 'reliable and comparable data on key epidemiological indicators' and places responsibility on all member states to fully implement the five key epidemiological indicators.
3. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2006) *Drug use in Ireland and Northern Ireland. 2002/2003 drug prevalence survey: first results (revised) from the 2002/2003 drug prevalence survey – Bulletin 1. Confidence Intervals.* Dublin: National Advisory Committee on Drugs.
4. Hibell B et al. (2004) *The ESPAD Report 2003: Alcohol and other drug use among students in 35 European countries.* Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN), Council of Europe, Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group).
5. Connolly J (2006) Government bans sale of 'magic' mushrooms. *Drugnet Ireland,* Issue 17: 9.

Civil society to have role in EU drugs policy

The European Commission is currently seeking to establish a clear role for civil society in relation to drugs policy in the EU. It has defined what it means by 'civil society' and why it should be involved in drugs policy. How it should be involved is the question posed in the recent consultative document *Green Paper on the role of civil society in drugs policy in the European Union.*[1]

The Green Paper defines 'civil society' as 'the associational life operating in the space between the state and market, including individual participation, and the activities of non-governmental, voluntary and community organisations' (p. 5). Associational life includes non-governmental, voluntary and community organisations that represent service providers, the interests of professionals working in the drugs field, drug users or their families, and others who, while not working directly or primarily with drug policy, still have a valuable contribution to make, for example in relation to HIV/AIDS. The Green Paper also explicitly includes 'individual citizens who clearly make a significant commitment or contribution' and 'those affected by public policies, who might otherwise not be heard' (p. 5).

The three reasons given for involving civil society in drugs policy are consistent with the types of actors included in the definition of civil society – service providers and users: 'to support policy formulation and implementation through practical advice, to ensure an effective two-way information flow, and to stimulate networking among civil society organisations' (p. 5).

The Green Paper outlines two possible mechanisms for engaging civil society in drugs policy:

- a Civil Society Forum on Drugs, which would be a platform for regular structured dialogue between the European Commission and civil society, mainly on themes occurring in the EU Action Plan on Drugs; and
- creating co-operation between civil society organisations by linking networks under common themes as an informal, light and cost-effective way of structuring information flows and enabling a more effective consultation.

Feedback is invited on the perceived benefits, added value or weaknesses of these two options, on whether the options are mutually exclusive, or could be combined, and on whether there are other possible mechanisms not mentioned in the Green Paper. Whatever mechanism is finally chosen, it may be anticipated that it will not be the last word on how the European Commission engages with civil society. The brevity of the Green Paper and the narrow focus of the issues presented therein belie the complexity of the topic. What civil society is and how it should engage in public policy development are being fervently debated at both United Nations (UN) and European Union (EU) level and views and understandings are evolving rapidly.

EU and civil society

In Europe civil society has had a formal voice since the establishment of the European Economic and Social Council (EESC) under the 1957 Treaty of Rome.[2] In 1994, under the EU Treaty, a Committee of the Regions (CoR) was established to give a voice to regional and local authorities.[3] In 2001, in preparation for EU enlargement, the European Commission launched a white paper on European governance, seeking to enhance democracy and increase the legitimacy of the EU institutions.[4] This white paper identified a number of ways of strengthening the role of civil society in relation to the work of the European Commission, including establishing minimum standards for consultation,[5] setting up a database accessible to the public which lists the civil society organisations (CSOs) involved in consultations,[6] and using the Internet to collect and analyse reactions in the market place for use in the EU's policy-making process.[7] In 2006 the European Commission launched an open public consultation on a new initiative on European transparency, seeking, among other things, feedback on the Commission's minimum standards for consultation.[8]

These initiatives highlight a number of questions relevant to the involvement of civil society in EU drugs policy.[9] For example:

- *Representivity:* How are CSOs to be chosen and what contribution can they make? Who should act as the gatekeeper and how? Acknowledging the diversity of views and approaches among CSOs in the drugs field, the Green Paper states that the European Commission will 'select members for the Forum on the basis of an open call, after it has received and analysed reactions to the Green Paper' (p. 8). The Paper states that representation of different stakeholders and different policy options should be balanced and that membership of the Forum should be for a fixed term, and proposes some preliminary selection criteria, including credibility and representativeness.

The Green Paper also explicitly includes 'individual citizens who clearly make a significant commitment or contribution' and 'those affected by public policies, who might otherwise not be heard'.

Civil society and EU drugs policy *(continued)*

In recent years the UN has embarked on an extensive programme of organisational reform, including reviewing the role of civil society.

- *Democratic Legitimacy:* How will the European Commission balance policy input from civil society against input from the democratically-elected governments of member states or from other democratic sources such as regional or local authorities? The Green Paper states that the 'consultations with civil society should not replace or duplicate the existing debate between civil society and national or local governments. The focus should be on European added value' (p. 8, underlining in original).
- *EU Decision-Making Procedures:* The Green Paper does not address the question of whether and how civil society might interact with other EU institutions involved in making drug-related policy, e.g. the European Council and the European Parliament. For example, in the area of supply reduction, including drug trafficking and organised crime, it is the European Council, rather than the European Commission, that makes policy decisions.

UN and civil society

Article 71 of the 1945 UN Charter mandates a consultative role for civil society in relation to the UN's Economic and Social Council (ESC).[10] In turn, the UN Office for Drugs and Crime (UNODC), which is accountable to the ESC, promotes strong partnerships with CSOs in countering the global drug abuse and crime problem.[11] In recent years the UN has embarked on an extensive programme of organisational reform, including reviewing the role of civil society.[12] The review of the role of civil society in relation to the UN addresses many of the same issues as the EU. Two additional areas relevant to the role of civil society in relation to EU drugs policy are:

The power of civil society is a soft one. It is their capacity to argue, to propose, to experiment, to denounce, to be exemplary. It is not the power to decide.

- *Operational Systems and Procedures:* How are CSOs which participate in policy making to be resourced and supported in their Commission-related work? What mechanisms are needed to support the CSOs and co-ordinate their work with that of the European Commission? What protocols need to be developed to govern access to the Commission and ensure appropriate interactions and information flows between Commission personnel and CSOs? While not addressed in the Green Paper, these matters have been considered as part of the UN reform process.[13]
- *Governance:* Perhaps the most contentious question about the role of civil society in relation to policy making is that of its role in respect of decision making – what responsibilities will be assigned to CSOs, and to whom shall they be accountable? The European Commission's Green Paper indicates that CSOs will 'support' policy formulation and implementation, provide practical advice, inform and network, but not decide. The chair of the UN Panel of Eminent Persons, Fernando Henrique Cardoso, put the case as follows: 'The legitimacy of civil society organizations derives from what they do and not from whom they represent or from any kind of external mandate. In the final analysis, they are what they do. The power of civil society is a soft one. It is their capacity to argue, to propose, to experiment, to denounce, to be exemplary. It is not the power to decide.'[14] *(Brigid Pike)*

1. Released on 26 June 2006 the Green Paper on the role of civil society in drugs policy in the European Union (COM (2006) 316 final) seeks responses by 30 September 2006 to a number of questions set out on page 9 of the document. Submissions should be sent to: European Commission, Directorate General for Justice, Freedom and Security, Unit C2 – Anti-Drugs Policy Co-ordination Unit, LX 46 1/88 – 1049 Brussels, Belgium. Email: JLS-drugspolicy@ec.europa.eu . Fax: 00 322 295 32 05.
2. See www.eesc.europa.eu/
3. See www.cor.europa.eu/
4. See 'European governance' COM (2001) 428 final. Retrieved 28 July 2006 at www.ec.europa.eu/governance/
5. See 'Towards a reinforced culture of consultation and dialogue – General principles and minimum standards for consultation of interested parties by the Commission' COM (2002) 704 final. Retrieved 28 July 2006 at www.ec.europa.eu/civil_society/
6. See CONNECS at www.ec.europa.eu/civil_society/
7. See 'Interactive policy making' COM (2001) 1014 final, and also www.ec.europa.eu/yourvoice/
8. See 'European transparency initiative' COM (2006) 194 final. Retrieved 28 July 2006 at www.ec.europa.eu/transparency/
9. J Almer and M Rotkirch (2004) *European Governance – An overview of the Commission's agenda for reform* (Stockholm: Swedish Institute for European Policy Studies) provide a useful account and assessment of the issues arising out of the implementation of the 2001 White Paper on European governance in relation to civil society. Retrieved 28 July 2006 at www.sieps.se
10. See www.un.org/issues/civilsociety/
11. See www.unodc.org/unodc/en/ngos_and_civil_society.html
12. In June 2004 a Panel of Eminent Persons, appointed by the UN to assess and draw lessons from UN interaction with civil society with a view to enhancing interaction between them, released its 83-page report, 'We the peoples: civil society, the United Nations and global governance' (A/58/817). The following September the UN Secretary General, Kofi Annan, published his response, 'Report of the Secretary General in response to the report of the panel of eminent persons on United Nations–Civil society relations' (A/59/354). Documents retrieved 28 July 2006 at www.un.org/reform/civil-society.html
13. See J Clark and Z Aydin (2003) 'UN system and civil society – An inventory and analysis of practices'. Background paper for the Secretary-General's panel of eminent persons on United Nations relations with civil society. Retrieved 28 July 2006 at www.un.org/reform/civil-society.html
14. See F H Cardoso (2003) 'Civil society and global governance.' Contextual paper prepared by the Chairman of the high-level panel on UN–civil society. Section 4.2. Retrieved 28 July 2006 at www.un.org/reform/civil-society.html

Northwest Regional Drugs Task Force Strategic Plan 2005–2008

The first strategic plan of the Northwest Regional Drugs Task Force (NWRDTF), entitled *Co-ordinating action around drug and youth alcohol problems,* was published in June 2005.[1]

The NWRDTF was established in 2003 and covers counties Donegal, Sligo and Leitrim and the north western portion of county Cavan. Development of the plan involved extensive consultation with stakeholders which included one-to-one interviews, a series of group workshops and review sessions. Background research was also carried out on existing services, drug prevalence and the population distribution of the North West.

The strategic aim of the plan is: 'to reduce the negative impact of drug misuse and underage drinking upon the individual and society in the region through co-ordinated and targeted actions at regional and local levels.' The strategic objectives of the plan are grouped under the following headings: awareness; co-ordination; communication; direct actions; and advocacy.

The NWRDTF identified actions based upon the agreement that all actions should be tailored to meet the specific needs of the North West. These needs are:

- The population distribution of the region and the need to restructure the group to accommodate the geographical spread.
- The need to maintain or reduce the low level of drug prevalence in the region.
- The impact of Northern Ireland (particularly Derry) on the drug culture in the North West.
- The level of polydrug use among drug users.
- The level of underage drinking, which has been identified as a significant problem throughout the region.
- The degree to which the drug culture and underage drinking have become intertwined in recent years.

The action plan drawn up by the NWRDTF is organised according to the four pillars of the National Drugs Strategy and also includes a section on operational actions. The actions are described in detail, allocated high, medium or low priority and the stakeholders responsible for implementing them are listed. The table below provides a summary of the high-priority actions.

Operational actions

- Recruit NWRDTF Co-ordinator, Development Worker and Administration Support.
- Take account of operating costs (for example, rent, insurance, and financial and legal fees).
- Expand membership of NWRDTF and sub-committees to encourage knowledge-based representation.
- Source external providers with experience in community-based organisations to provide on-going training and support to the NWRDTF and its sub-committees to ensure they operate in an effective manner.
- Establish and operate county-based and interest-based sub-committees of the NWRDTF.
- Promote the NWRDTF as the regional body for co-ordinating all illicit drug and underage drinking initiatives and as the central contact point in the region.
- Review NWRDTF structures and validate initiatives and programmes.

Supply reduction

- Establish a sub-committee with the authority to initiate actions aimed at supply reduction.
- Support the development of a referral scheme between the Garda Síochána and service providers for underage drinking and drug-related offenders.

Education

- Provide public training and information sessions for community groups to assist in developing appropriate responses to local problems.
- Work closely with communities to identify their concerns and issues relating to illicit drug use and underage drinking and to assist in finding solutions.
- Establish protocols to co-ordinate inter-agency activities (interventions in schools and communities).
- Undertake a publicity campaign informing the public and community groups of the role and functions of the NWRDTF.
- Design and maintain a single website for the NWRDTF, including sub-committees and special interest groups.
- Initiate a film programme, aimed at transition year students, inviting submissions of films dealing with illicit drug use and underage drinking.

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NWRDTF Strategic Plan 2005-2008 *(continued)*

- Develop programmes aimed at pubs and night clubs to address the intertwined nature of illicit drug use and underage drinking.
- Identify effective methods of communication for individuals and communities responding to illicit drug use and underage drinking at the local level.
- Develop and publish regionally relevant, local information on illicit drug use and underage drinking.

Treatment and rehabilitation

- Publish a North West Region handbook for those affected by illicit drug use and underage drinking, providing:
  - A step-by-step guide to accessing help locally;
  - Contact and service information at local/ county level.
- Help secure funding for programmes aimed at the reduction of illicit drug use and underage drinking.
- Establish:
  - A small-grant fund to provide funding to evidence-based community and voluntary projects relating to illicit drug use and underage drinking;
  - A Youth Alcohol and Drug Service in Leitrim on a pilot basis;
  - A relapse-prevention programme to equip participants with a range of skills, including assertiveness, problem solving and creativity.
- Support:
  - The establishment of a urine analysis protocol between the Probation and Welfare Service and HSE NW;
  - An increase in the number of support workers and level of resources available to those working with young people at risk and/or outside mainstream education;
  - Initiatives in the region that will impact on awareness, transmission, treatment and management of blood-borne viruses;
  - The provision of drug and alcohol counsellors to the Courts Service, in partnership with Probation and Welfare;
  - The development of residential and in-patient services (for example, an under-18s alcohol and drug detoxification and treatment facility);
  - The HSE NW in developing a Court Alcohol and Drug Programme in the region dedicated to under-18s.

Research

- Conduct research into levels of misuse in the North West and provide access to up-to-date information.
- Work with other agencies to identify more effective means of extracting and recording data on levels of misuse in the North West (for example the Coroners Court and HIPE).

(Sarah Fanagan)

1. Northwest Regional Drugs Task Force (2005) *Co-ordinating action around drug and youth alcohol problems: Strategic Plan 2005–2008.* Ballyshannon: Northwest Regional Drugs Task Force.

Overview of blood-borne viral infections among injecting drug users in Ireland, 1995 to 2005

In October 2006 the Health Research Board will publish Overview 4, which describes what is known about blood-borne viral infections among drug users in Ireland.[1] The data pertaining to injecting drug users are presented where possible, and where the data are not analysed by injecting status or where injecting status is not ascertained, the data on all drug users are presented.

The analysis presented in this Overview is based on disease notifications reported to the Health Protection Surveillance Centre (formerly known as the National Disease Surveillance Centre) during the period 1995 to 2005 and on ad hoc research studies.

The main observations and their implications are:

The number of newly diagnosed cases of HIV among injecting drug users increased in 1999 and to date has remained at a higher level than in the early nineties, while the number of new AIDS cases diagnosed decreased. Around one-tenth of injecting drug users in drug treatment are HIV positive. Age, injecting practices and sexual practices are associated with HIV status. The increase in HIV infections over the last five years requires investigation. HIV treatment is available to injecting drug users through genito-urinary medical units and infectious disease clinics in Ireland. In 2003, a study reported that a number of stable

Overview of blood-borne viral infections *(continued)*

injecting drug users were suitable for treatment, but were not receiving treatment at the time of the study. Two studies demonstrated that decentralised treatment at drug treatment centre level achieved high uptake and compliance with HIV treatment.

Just under one-fifth of injecting drug users in treatment have ever been infected with hepatitis B and approximately 2% are chronic cases. Age, injecting practices and sexual practices are linked to hepatitis B status. The uptake and completion rates of hepatitis B vaccination are much higher in the HSE South Western Area (56%) and in Drug Treatment Centre Board (86%) cohorts for the period 2001 to 2003 than those reported in prisoners or at general practice in Ireland between 1998 and 2001. This possibly indicates an increase in hepatitis B vaccine coverage in recent years. There are no published data on the coverage of hepatitis B vaccine among injecting drug users outside the HSE Eastern Region. It is important to ensure that hepatitis B vaccine is administered as early as possible in a drug user's career; therefore, needle exchange and low-threshold methadone services require facilities to deliver this intervention on a daily basis.

Around 70% of injecting drug users attending drug treatment tested positive for antibodies to the hepatitis C virus. Injecting practices and prison history are associated with hepatitis C status. There are seven specialist hepatology centres for adults and one for children in Ireland. A number of studies demonstrated low rates of access to and uptake of treatment for hepatitis C among injecting drug users. Two small studies demonstrated that a decentralised approach to initial assessment at general practice level and hepatitis C treatment at drug treatment centres achieved higher uptake and compliance rates than the current centralised approach.

Little has been published in Ireland on the prevalence of co-infection with HIV and/or hepatitis B and/or hepatitis C. The two national prison surveys in the late nineties presented data on co-infection among prisoners. These data indicated that approximately one-fifth of prisoners testing positive for hepatitis C were also infected with either hepatitis B or HIV. Up-to-date information is required.

Both HIV co-infection and, independently, high rates of alcohol consumption among those infected with hepatitis C are associated with more rapid disease progression and higher death rates.

The principles of expanded and accessible harm reduction measures are documented in both the AIDS Strategy 2000 and the Mid-Term Review of the National Drugs Strategy and will lead to synergistic actions to stem the current increase in new HIV cases among injecting drug users. The publication of the HSE Eastern Region's hepatitis C strategy is awaited.

Newly diagnosed HIV cases are reported directly to the Health Protection Surveillance Centre (HPSC) through a case-based, extended surveillance system and staff at the HPSC collate these data on a six-monthly basis. Up to 2005, information on risk factors was not included in the data recorded on newly diagnosed cases of hepatitis B and hepatitis C, which makes it difficult to monitor the number of newly diagnosed cases of these infectious diseases among injecting drug users. It also means that Ireland has been unable to provide data to the European Monitoring Centre for Drugs and Drug Addiction on the incidence of hepatitis B and hepatitis C among injecting drug users. Action 39 of the European Union Drugs Action Plan requires member states to comply with the requirements of the key indicators to measure the drug situation. The incidence and prevalence of HIV, hepatitis B and hepatitis C among injecting drug users is one of the five key indicators. In recent years, the HPSC has improved the reporting of newly diagnosed cases of hepatitis B and hepatitis C. In 2006, hepatitis B data by risk factor status will be published.

There are a number of areas where further research is required. The data presented in this Overview indicate the need to record the risk factor status of newly diagnosed cases of hepatitis C. There is a need to set up a register to quantify the incidence and prevalence of hepatitis C among all heroin and cocaine users, including those who are in harm reduction and treatment services. The register should also permit the assessment of main risk factors, treatment uptake and outcomes. Strategies to increase uptake of and compliance with HIV and hepatitis C therapy in both prison and community settings need to be implemented and monitored. The medical consequences of and interventions required to deal with hepatitis C among injecting drug users need to be estimated. A system to monitor the national hepatitis B vaccine uptake is required to estimate coverage among prisoners, injecting drug users and sex workers. The effectiveness of needle exchange, opiate detoxification and opiate maintenance programmes in stabilising and reducing the incidence of hepatitis C needs to be quantified. *(Jean Long)*

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There is a need to set up a register to quantify the incidence and prevalence of hepatitis C among all heroin and cocaine users, including those who are in harm reduction and treatment services.

1. Long J (2006) *Blood-borne viral infections among injecting drug users in Ireland 1995 to 2005.* Overview 4. Dublin: Health Research Board.

New data on the incidence of HIV

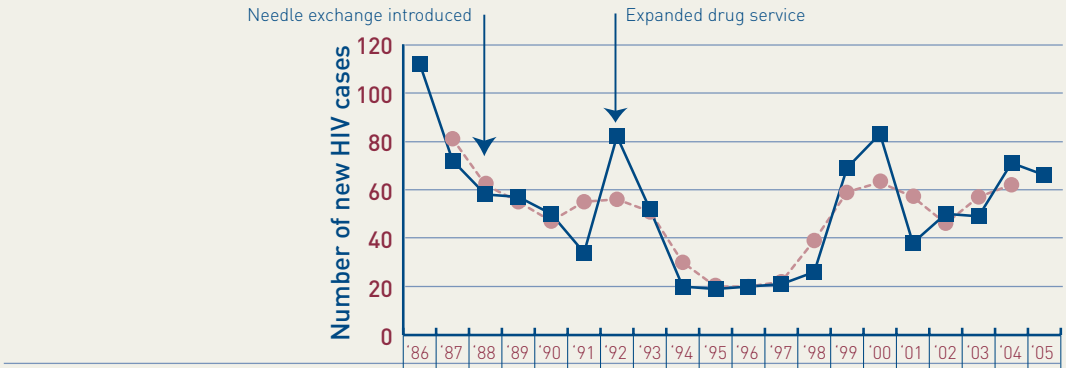
HIV (subsequently known as HIV1) was identified in 1981 and HIV2 was identified in 1986. The virus attaches itself to the CD4 particle of the T-lymphocytes. These T-lymphocytes co-ordinate the body's immune response. HIV may lead to a condition known as acquired immunodeficiency syndrome (AIDS). This condition generally occurs when the CD4 count is below 200 per millilitre and is characterised by the appearance of opportunistic infections. Such infections take advantage of a weakened immune system. The HIV virus is found in all body fluids and is transmitted via sexual intercourse (both heterosexual and homosexual), mother to foetus and baby, infected blood and blood products and procedures with unsterile needles, syringes and skin-piercing instruments. Best evidence available to date indicates that once an individual is infected he or she remains infected for life.

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1985. By the end of 2005, there were 4,082 diagnosed HIV cases in Ireland, of which 1,270 (31%) were probably infected through injecting drug use.[1]

Figure 1 presents the number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland; data from 1982 to 1985 were excluded from the figure as these four years were combined in the source records. The data presented in Figure 1 are based on data reported to the Department of Health and Children,[2] the National Disease Surveillance Centre[3] and the Health Protection Surveillance Centre.[1, 4] Kelly and Clarke[5] reported a fall in the number of HIV cases among injecting drug users between 1994 and 1998, with about 20 cases per year compared to about 50 cases each year in the preceding six years. In 1999, there was a sharp increase in the number of cases among injecting drug users, which continued into 2000, with 69 and 83 new cases respectively.[6] Between 2001 and 2003 there was a decline in the number of new injector cases (38, 50 and 49 respectively) when compared to 2000 but the number was higher than in 1998. In 2004, once again there was an increase (to 71 cases) in the number infected through injecting drug use compared to the preceding three years. In 2005 there were 66 cases infected through injecting drug use. It was difficult to interpret the trend due to the relatively small numbers diagnosed each year, so a smoother curve (red line in Figure 1) was calculated using a rolling centred three-year average. This curve presents an increase in the annual number of HIV cases in 1999; this higher number of cases was sustained between 2000 and 2004. This indicates a true increase in the number of cases.

Of the 66 new HIV cases among injecting drug users reported to the Health Protection Surveillance Centre in 2005, 37 were male and 29 were female and the average age was 30.5 years. Of the 60 cases for whom place of residence was known, 55 lived in the HSE Eastern Region. The authors of the report on the 2004 data highlighted the need to continue to promote the use of harm reduction measures among injecting drug users. *(Jean Long)*

1. Health Protection Surveillance Centre (2005) *Newly diagnosed HIV infections in Ireland: quarters 3 & 4 2004, and 2004 annual summary.* Dublin: Health Service Executive.
2. O'Donnell K, Cronin M and Igoe D (2000) *Review of the epidemiology of AIDS in Ireland 1983–1999.* Dublin: National Disease Surveillance Centre.
3. National Disease Surveillance Centre (2004) *Newly diagnosed HIV infections in Ireland. quarters 3 & 4 2003, & 2003 annual summary.* Dublin: National Disease Surveillance Centre.
4. Health Protection Surveillance Centre (2006) *Newly diagnosed HIV infections in Ireland: quarters 3 & 4 2005, and 2005 annual summary.* Dublin: Health Protection Surveillance Centre.
5. Kelly GE and Clarke SM (2000) Has there been a turning point in the numbers of AIDS and HIV antibody positive cases in Ireland? *Irish Journal of Medical Science,* 169(3): 183–186.
6. National Disease Surveillance Centre (2001) *HIV and AIDS: updated 2000 figures.* Dublin: National Disease Surveillance Centre.



	'86	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05
Actual number	112	72	58	57	50	34	82	52	20	19	20	21	26	69	83	38	50	49	71	66
Rolling centred three year average number		82	62	55	47	55	56	51	30	20	20	22	39	59	63	57	46	57	62	

Figure 1 Actual number and rolling average number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland, 1986 to 2005

Adapted from data reported to the Health Protection Surveillance Centre

Special initiative: working together to reduce the harms caused by alcohol misuse

Sustaining Progress, the agreement between Government and the social partners, set out ten special initiatives to be progressed in its lifetime; these were issues that required 'mobilisation of a range of resources across sectors, organisations, and individuals, and at different levels of government'. One of the issues selected was alcohol and drug misuse.

To progress this special initiative, the Working Group on Alcohol Misuse was established in July 2005. The Group was chaired by Peter Cassells and included representatives from six government departments, the Irish Congress of Trade Unions, IBEC, the Health Service Executive, An Garda Síochána and a number of youth groups. The Group also consulted with relevant stakeholders not directly represented. The aim of the Group was to agree on a programme of actions to deliver targeted results in relation to the three specific areas of underage drinking, harmful (binge) drinking and drink driving. It concentrated on the potential for effectively mobilising State and other organisations and the social partners around a programme of actions that would contribute to a reduction in alcohol misuse.

While the Group considered the three specific areas, its final report[1] sets out a single strategy containing 29 actions under 11 headings, as follows:

Local community responses

- Establish at least four community mobilisation projects[2] by the end of 2006.

Treatment intervention services

- Set up one pilot screening and brief intervention project in each of the community mobilisation project areas by the end of 2006.
- Develop a national screening and brief intervention protocol for appropriate healthcare settings by the end of 2007.
- Prepare an extended early intervention plan for the existing juvenile liaison scheme by the end of 2006.
- Examine the benefits and potential of mandatory alcohol awareness and rehabilitation programmes for those convicted of drink-driving offences; the plan will be prepared by the end of 2006.
- Examine the feasibility of developing counselling services for those affected by drink-driving accidents by the end of 2007.

Awareness and education interventions

- Continue the roll-out and development of the Social, Personal and Health Education curriculum in schools, with special emphasis on the community mobilisation project areas.
- Develop appropriate education initiatives in out-of-school settings.
- Increase parents' awareness of alcohol use among children through the provision of appropriate information, such as the booklet *Straight Talking,* during 2006.
- Train community and youth workers on alcohol issues, using the Code of Ethics which will be published in 2006 by the National Youth Work Advisory Committee. The training will be implemented in 2007.
- Enhance local road safety initiatives in co-operation with local communities during 2006 and 2007.
- Increase public awareness within communities on the harms associated with alcohol use through media campaigns from 2006 to 2010.

Alternative facilities

- Develop and promote at least one alcohol-free recreation facility in each of the community mobilisation project areas by early 2007.
- Involve young people in the management structure and day-to-day management of the facilities by early 2007.
- Promote responsible approaches to alcohol by sporting organisations at local level from 2006 onwards.

Compliance and enforcement

- Support more visible enforcement and compliance with liquor licensing legislation in each of the community mobilisation project areas in 2006 and 2007.
- Promote responsible serving and trading programmes in each of the community mobilisation project areas in 2006 and 2007.
- Improve the security details for the Garda National Age Card by 2007 in order to reduce forgery.

Workplace

- Develop guidelines to facilitate the development of alcohol misuse policies for the workplace in 2006.

Below-cost selling

- Prohibit below-cost selling of alcohol by March 2006.

Off-trade

- Develop a code of practice with the off-trade sector and legislation to address specific areas of concern by the end of 2007

Alcohol advertising

- Propose additional representation from the social partners on the monitoring body for the Voluntary Code on Advertising. The proposal will be considered in 2006.

Drink driving

- Introduce random breath testing.
- Reduce the blood alcohol level from 0.8mg% to 0.5mg%.
- Keep under review the question of setting lower blood alcohol level for provisional drivers.
- Promote high visibility enforcement of traffic laws.
- Introduce administrative alternative to court (though disqualification should remain a deterrent).
- Restructure provisions to ensure that the period of disqualification for a drink-driving offence cannot be reduced on appeal.

Labelling

- Establish a group to consider the information to be included on the labels of non-draft alcohol products in 2006.

This report does not give details of budget provision for the implementation of any of these actions and, while it suggests some possible sources of support and mentions monitoring arrangements, it makes no clear commitment to ensuring that the actions are completed. *(Jean Long)*

The new social partnership agreement, *Towards 2016,* is discussed on p. 7.

1. *Sustaining Progress Special Initiative: working together to reduce the harms caused by alcohol misuse* (2006) http://www.dohc.ie/publications
2. The authors describe community mobilisation projects (CMPs) as a comprehensive response involving a wide range of individuals, agencies and organisations which come together when an issue is too big for one sector to tackle alone.

Drugnet Ireland survey results

The areas in which people had the most interest, and would like covered in more depth, were: social consequences, treatment, health consequences and problem alcohol use.

We asked you, our readers, to tell us a little about yourselves and what you think about *Drugnet Ireland.* We sent out 1,780 short survey forms and freepost reply envelopes with the Spring issue. The response rate was lower than we had hoped – we received 227 (13%) completed forms. Thank you to all of you who took the time to complete and return the questionnaire. What we learned from your replies will influence our decisions about the content and development of *Drugnet Ireland.*

Key survey findings

We received forms from respondents working in a wide variety of occupations and settings. Seventeen categories of workplace were represented; the highest number of responses came from local drugs projects or community-based services (25%), followed by drug treatment centres (19%).

We explored readers' preferences. The areas in which people had the most interest, and would like covered in more depth, were: social consequences, treatment, health consequences and problem alcohol use. One new topic suggested by a small number of readers was 'user involvement'. In previous issues of *Drugnet Ireland,* we have summarised research conducted by user groups and will continue to do so in the future.

We ascertained the readers' experience of *Drugnet Ireland* (see Figures 1–3):

- 93% reported that *Drugnet Ireland* was an important source of information on the drugs situation in Ireland.
- 91% found that the content was relevant to their work.
- 34% often discussed the contents with their colleagues, while more than half (57%) occasionally discussed the contents.
- 46% reported that the detail of articles was adequate, although 45% reported that articles can be too detailed.
- Almost all respondents (99%) reported that the presentation of articles was clear.
- 88% found the use of graphics and tables was helpful; however, 10% found them confusing at times.

We also asked how often regular features in *Drugnet Ireland* were read and whether information from these features was used in work. There were many missing answers for the latter question (over 40%) but both sets of answers followed a similar pattern. The items 'In brief', 'New publications' and 'Upcoming events' were read 'often' by over 65% of readers. Around two-fifths of respondents said that they used the information in these features in the course of their work.

Finally, we asked how respondents would prefer to receive the newsletter.[1]

- 54% of respondents are aware that an electronic version of *Drugnet Ireland* exists.
- 4% read the electronic version.
- 32% of respondents would prefer the electronic version to the print one. *(Mary Dunne)*

1. An electronic version of *Drugnet Ireland* is available on the National Documentation Centre on Drug Use website, www.hrb.ie/ndc. A PDF version is on the Health Research Board site www.hrb.ie.

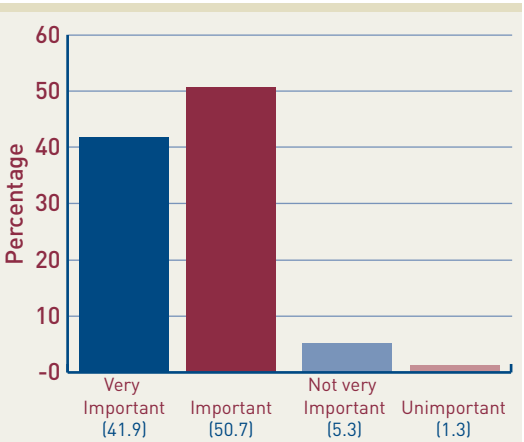


Figure 1 *Drugnet Ireland* is important as a source of information (225 respondents)

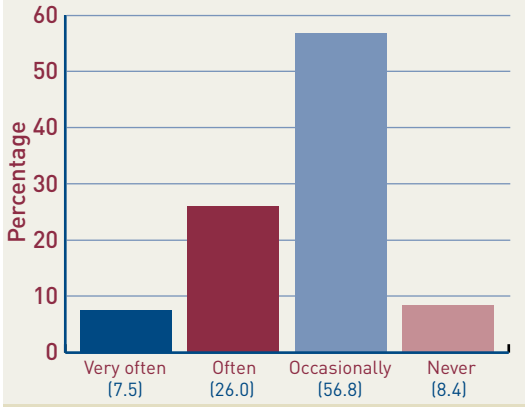


Figure 2 *Drugnet Ireland* is discussed with colleagues (224 respondents)

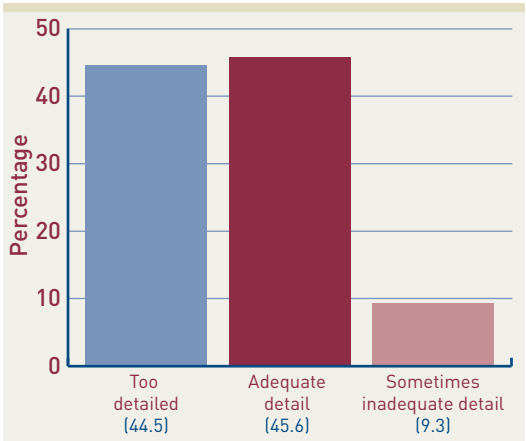
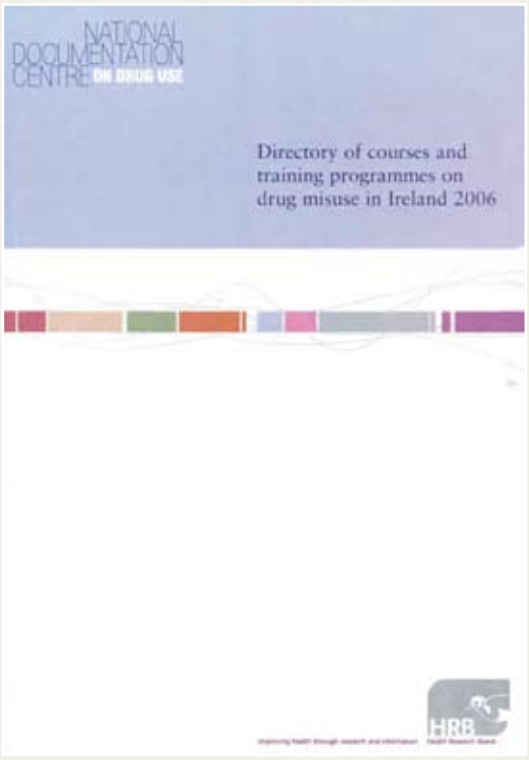


Figure 3 *Drugnet Ireland* contains adequate detail in articles (226 respondents)

The National Documentation Centre on Drug Use



New Directory of training courses

The National Documentation Centre on Drug Use has published a new Directory of courses and training programmes on drug misuse in Ireland for individuals and agencies interested in developing their knowledge, skills and capacity in this field. The only other resource of this kind was produced by the Department of Tourism, Sport and Recreation in 1999. Course details are primarily based on responses to a request for information from course co-ordinators in *Drugnet Ireland,* issue 16. We also contacted many training institutes and organisations directly.

The Directory lists a range of training available, from single sessions to courses lasting up to two years. Obviously, the depth of coverage of the issues varies considerably according to the length of the course and the level at which it is aimed. There are also variations in the training methods and in the underlying principles and approaches to issues in drug misuse.

Different courses are aimed at different target groups. Some courses are open to anyone in the community who is interested in the issue; others are aimed at those whose work brings them into contact with drug-related issues; and some are aimed at specific groups. The majority of courses listed in the Directory do not stipulate formal educational attainments as entry requirements, although a number of more advanced courses do require participants to have some previous knowledge and understanding of relevant issues.

The Directory does not assess or provide information about the quality or relevance of any of the courses listed. Instead, we present information as supplied by the course co-ordinators on course length, assessment, qualifications and accreditation.

Twenty-eight providers sent us information about 69 courses and we divided these into five sections:

A Short courses (less than 20 hours of course time) providing basic information and/or raising awareness of drug misuse among a general target audience, or developing skills of those working in the field of drug misuse – 37 entries

B Longer courses providing information, raising awareness and developing skills among those whose paid or voluntary work brings them into contact with drug misuse – 16 entries

C Courses leading to a professional or academic qualification (at diploma level or higher) in the field of drug misuse – 9 entries

D Courses in drug misuse for young people – 3 entries

E In-service training for professionals and other vocational groups working in the field of drug misuse or related areas – 4 entries

Most course providers are based in Dublin (68%), others are in counties Carlow, Wexford, Waterford, Tipperary, Kildare, Meath, Offaly, and Cavan. A small number of courses are offered outside these locations but, while the midlands, northeast and southeast are well represented, large parts of the country do not have or did not submit courses. One online course, suitable for home-learning, is included.

The information was gathered over a short period of time. Inevitably, some agencies providing courses and training in drug misuse were overlooked, while others were unable to respond in time. New courses are continually being developed. We hope, therefore, to update this directory at least annually. Please consult our website, www.hrb.ie/ndc, for the most up-to-date edition. *(Mary Dunne)*

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

The Directory lists a range of training available, from single sessions to courses lasting up to two years.

We present information as supplied by the course co-ordinators on course length, assessment, qualifications and accreditation.

The EDDRA column

There is a move within the EMCDDA for a more targeted focus on identifying and disseminating information on science-based practice in the field.

The Exchange on Drug Demand Reduction Action (EDDRA) column has appeared in the past 15 issues of *Drugnet Ireland*. The purpose of this column is to inform readers about the EDDRA database as a knowledge resource on good practice in the field of drug demand reduction and to highlight examples of good practice. This present column is taking a slightly different approach, in that its purpose is to highlight the upcoming revision of the EDDRA database being co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). This revision will inevitably mean changes in reporting practices to the EDDRA database, as the main aim of the revision is to further develop EDDRA as a tool for collecting, storing and disseminating examples of science-based practice in the field. Science-based practice will include interventions that are theoretically based and have been evaluated for effectiveness, meaning that the evaluation has identified what works, for whom and under what conditions. In some cases, these evaluations are referred to as outcome or impact evaluations.

EDDRA was established in 1996 to collect, store and disseminate information on good practice in demand reduction throughout the EU, with the aim of promoting the role of evidence-based practice and an evaluation culture within the field. Ten years on, and with a renewed focus on what constitutes evidence-based practice within the EU and the role of the EMCDDA in disseminating this information, a decision has been taken to review the current structure and operation of EDDRA.

From the outset, the Drug Misuse Research Division (DMRD), as the Irish Focal Point for EMCDDA activities, has been one of the main providers of information to EDDRA, with data on over fifty interventions submitted for inclusion on the database. This information is presented in a standardised format that includes aims and objectives, evaluation indicators and evaluation results. The interventions are judged to be well designed and have been evaluated and thus satisfy the main criteria for inclusion. However, like most of the interventions in EDDRA, there are questions regarding the quality of the evaluations and whether they can be referred to as science based.

For example, the majority of interventions have not been evaluated to determine their effectiveness in producing an intended or expected result. Instead, evaluations have tended to examine how the intervention is being implemented and whether the target group is being successfully reached. The usual methods employed are semi-structured interviews with staff, and in some cases with participants. There is nothing wrong with this type of evaluation, indeed it is necessary to establish the status of interventions that have been running for at least one year. We know little about the effectiveness of interventions that are seeking to reduce the demand for drugs in Ireland. Even where evaluations have reported on positive outcomes, such as individuals remaining drug free or progressing to education or employment, there is little evidence to show how this was achieved and under what conditions it could be replicated.

As noted earlier, there is a move within the EMCDDA for a more targeted focus on identifying and disseminating information on science-based practice in the field, and it is envisaged that the EDDRA database will be refined to play a role in these activities, which are influenced by the EU Drugs Action Plan 2005–2008. The next steps in the revision process are a technical meeting on 13 September 2006 in Lisbon and further discussion at the EDDRA managers' meeting on 3–4 October 2006. *Drugnet Ireland* will keep readers informed of these developments as they proceed.
(Martin Keane)

In brief

On 18 May 2006 the **Special Residential Services Board (SRSB)** held its annual conference on the theme of 'Stepping Out: Young People Leaving Care/ Custody'. Presentations were given on the legislative and policy context and on the work of Crosscare, Extern Ireland, Life Centre, Lilac House, the Probation and Welfare Service, the Scottish Throughcare and Aftercare Forum, and Trinity House School. www.srsb.ie

On 25 May 2006 the report ***Counted in 2005*** was launched by Noel Ahern TD, Minister of State for housing and urban renewal. The report presents the results of the third periodic assessment of homelessness in the Dublin area. Conducted every three years, the assessment shows that, among other things, the number of people sleeping rough increased from 1999 to 2002, but decreased between 2002 and 2005, with a significant overall decrease of 33% from 1999 to 2005. www.homelessagency.ie

In May 2006 the **Irish Pharmaceutical Union (IPU)** called on the Health Service Executive to develop a dedicated liaison service for pharmacies outside Dublin that participate in the Methadone Treatment Scheme. This service would provide community pharmacists with a point of contact if they encounter difficulties when dispensing methadone to patients. The IPU is also calling for more protection for pharmacies from attacks and tougher action in the Courts against individuals who raid pharmacies. www.ipu.ie

On 1 June 2006 an **Independent Evaluation of the RAPID Programme** was published. The report indicates that the RAPID programme has contributed substantially to identifying the needs

In brief *(continued)*

of disadvantaged communities, bringing forward important local projects in response to those needs and establishing structures that have been effective in facilitating local development activity. On the negative side, the evaluators identified a general weakness with regard to strategic planning in some areas, variations in the level of interaction with the local implementation of the programme by representatives of key State agencies, and difficulty in securing funding for particular types of projects, for example, education, training and employment. www.pobail.ie

On 1 June 2006 the **Criminal Law (Insanity) Act 2006** came into effect. The Act contains clear statutory rules in relation the defence of insanity and the related question of a person's fitness to be tried. For the purposes of the Act, 'mental disorder' is defined as a mental illness or handicap, dementia or any disease of the mind. Intoxication by alcohol or other substances is explicitly excluded from the scope of the definition. www.justice.ie

On 2 June 2006 **Democracy, Cities and Drugs** held its second conference, in Ghent, Belgium, on local and participative responses to the issue of drug use. Topics included how to develop municipal drug strategies and action plans; how to create and maintain a multi-agency partnership; how to increase the involvement of communities in local drug policies; and how to change conflicts into consensus. www.democitydrug.org

On 6 June 2006 the **Health Service Executive (HSE)** released its first annual report. It contains an account of an Alcohol Detox Unit for people who are homeless, established by the Primary, Community and Continuing Care (PCCC) Directorate in partnership with the Dublin Simon Community. In 2005, 156 people were admitted to the programme, of whom 80% completed the 7–10 day detox programme, and 66% completed the 21-day detox programme. Staff working on the programme have been trained in the Community Reinforcement Approach (CRA) to addiction treatment. www.hse.ie

On 26 June 2006 the **United National Office on Drugs and Crime (UNODC)** selected 'Drugs are not child's play' as the theme of its 2006 international campaign against drug abuse and illicit trafficking. The objective is to increase public awareness about the destructive power of drugs and society's responsibility to care for the well-being of children aged 4 to 10. For further information on the campaign, see www.unodc.org/unodc/event_2006-06-26_1.html

On 6 July 2006 the **Parole Board** released its 2005 annual report. In relation to drug use in prisons, the Board comments: 'The Board views with great dismay the fact that drugs are available in so many places of detention in the country. We have even seen examples of prisoners who went on drugs for the first time whilst in custody. Whilst this difficulty arises in other jurisdictions the information we have gathered reveals that it is far less prevalent than in Irish prisons and what can be done in other jurisdictions can surely be done here. The intention of the Minister and the prison service to cut out the availability of drugs in prisons must be fully supported.' www.justice.ie

On 6 July 2006 the **National Educational Welfare Board (NEWB)** released its analysis of school attendance for the school year 2004/2005. It shows that attendance has improved in many of the areas targeted specifically by NEWB, such as primary and post-primary schools in designated disadvantaged areas. In a number of these targeted areas, the mean percentage of students absent on 20 days or more has declined by over 4%, compared to 2003/2004. www.newb.ie

On 10–11 July 2006 the **Council of Europe Pompidou Group** held a seminar on 'Road Traffic and Drugs'. The seminar heard that,while alcohol is recognised as a major road safety problem, alcohol combined with cannabis considerably increases the risk of fatal accidents. Also highlighted were the lack of reliable tests to detect cannabis use, and the major differences between European countries' legislation and penalties in respect of drink and drug driving. www.coe.int/t/dg3/pompidou/

In July 2006 the **World Customs Organization (WCO)** released its definitive 2005 report on Customs and Drugs, an annual report that provides a global overview of drug trafficking. It reports trends and statistics for individual drugs, including heroin, cocaine, cannabis resin, herbal cannabis, amphetamines, MDMA (Ecstasy), methamphetamine and khat (Catha edulis). www.wcoomd.org

On 2 August 2006 the ***Guidelines for Developing a School Substance Use Policy,*** published in 2002 by the Department of Education and Science, were augmented by the publication of support materials, including a template prompt document outlining issues to consider and questions to ask when developing a substance use policy, and a sample alcohol, tobacco and drug use policy. The materials are intended to assist school authorities in developing their own policies. www.education.ie

On 31 August 2006 ***The Irish Times*** reported that the Government had deferred publication of its annual progress report on the Agreed Programme for Government, usually published in July. It is instead considering a more comprehensive pre-election account of its time in power. The Agreed Programme contains five new initiatives not contained in the National Drugs Strategy, which are intended to contribute to achieving drug-free prisons, reducing drug supply and improving information regarding the drug situation.
www.ireland.com

(Compiled by Brigid Pike)

From *Drugnet Europe*

Responses: Cigarettes, alcohol and colonisation

Cited from Peter Thomas, Drugnet Europe, *No. 55, July–September 2006*

'I have learned not to try to convince people about what to do. I consider the task of trying to convince others a lack of personal respect, an attempt at colonisation', wrote José Saramago. The reticence of the Portuguese Nobel prize-winning author provided the perfect challenge to health professionals active in the field of licit and illicit drugs attending the first EMCDDA expert meeting on 'environmental prevention strategies' held in Lisbon from 29–30 June.

This was the first EMCDDA event to focus on legal psychoactive substances, in the context of the agency's current task to examine polydrug use. Presentations were delivered on tobacco and alcohol regulation, and on the evidence base for environmental approaches to psychoactive substance use prevention. Case studies described environmental approaches to reducing smoking and drinking in Ireland, Malta, Poland and the UK.

Professionals working in the fields of both licit and illicit psychoactive substances – disciplines often kept apart – were able to debate topics such as the potential cross-substance effects of smoking bans, aggressive marketing which encourages binge drinking; and the poor impact of school education and health promotion campaigns, particularly those demonising drugs. Based on discussions at the event, evidence suggests that 'macro-environmental' measures can offer better value prevention than those focused on persuading the individual. However, regulatory measures can face obstacles, such as the political resistance to universal measures and defensive lobbying by vendors. While colonisation of the mind is rarely the agenda, what is certain is that regulation has a valuable role to play in changing cultural attitudes towards psychoactive substances, whether the laudanum or absinthe of the past, or today's alcopops, cigarettes and vertical drinking. A full follow-up report of the event will be published in the autumn.

Drugs-Lex – Europe's diverse drug-driving laws presented at Pompidou Group seminar

Cited from Brendan Hughes, Drugnet Europe, *No. 55, July–September 2006*

The latest ELDD 'Topic overview' (http://eldd.emcdda.europa.eu), describing the laws and penalties regarding drugs and driving across the EU, was presented at the Pompidou Group's 'Third seminar on road traffic and drugs' held in Strasbourg from 10–11 July. …The 'Topic overview' updates and expands on groundwork carried out in 2003 (see ELDD 'Legal reports'). The new document examines: the status of the offence (criminal/non-criminal); the substances forbidden by law; whether police may stop to test at random or only on suspicion; and whether there is zero tolerance (any trace of drugs) or whether a certain level of impairment is required before prosecution. The paper also looks at the various sanctions available by country, particularly the range of fines and prison sentences and the possible period for suspension of a driving licence. The overview shows that, although all Member States list 'drug driving' as an offence, the conditions for its prosecution and the range of possible penalties can vary massively between countries.

Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). An electronic version of _Drugnet Europe_ is available on the EMCDDA website at www.emcdda.europa.eu

If you would like to receive a hard copy of the current or future issues of _Drugnet Europe,_ please contact: Drug Misuse Research Division, Health Research Board, Knockmaun House, 42–47 Lower Mount Street, Dublin 2. Tel: 01 676 1176 ext 127; Email: dmrd@hrb.ie

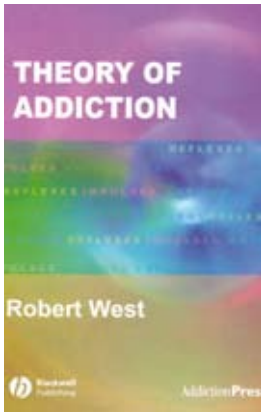
Recent publications

Books

Theory of addiction

West R, with Hardy A
Blackwell Publishing 2006, 211 pp.
ISBN-13 978 1 4051 1 1359 6

In the preface to this book, the author explains the theory of addiction as 'a theory of motivation and how the motivational system is distorted in the case of addiction'. An understanding of addiction theory is vital to the understanding addiction itself. This book aims to develop this understanding by taking a journey to the development of a synthetic theory of addiction, beginning with the simplest possible common-sense approach and exploring how the theory needs to be extended or changed to take account of the available evidence. The goal is to end up with a theory that is 'parsimonious, coherent, original, stimulating and above all useful'. West's scheme for

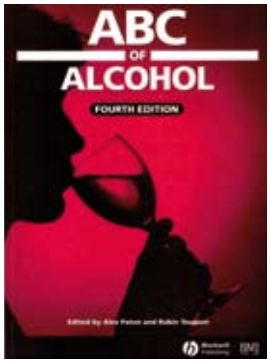


Recent publications *(continued)*

communicating the theory has five key themes: the structure of the motivational system; the moment-to-moment control of behaviour; the plasticity of the motivational system; identity; and the unstable mind.

The first six chapters cover the existing theories by working through the various approaches to understanding addiction. Chapter 7 takes the reader through the development of a comprehensive theory, starting with the simplest rational-choice model and extending it to a model that involves concepts of self-control and impulse, and then habit. Chapter 8 sets out the first draft of a synthetic theory of motivation and introduces the acronym 'p.r.i.m.e.' (plans, responses, impulses, motives and evaluations) to refer to the five levels of complexity at which the human motivational system works. The final chapter returns to the concept of addiction and examines how the p.r.i.m.e. theory of motivation helps in understanding the various manifestations of addiction.

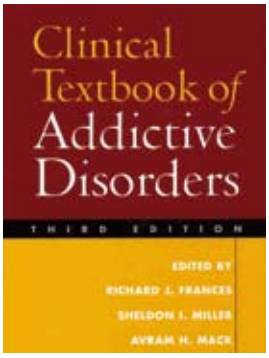
Designed to enable students, practitioners and researchers to find a starting point in the complex world of addiction theory, *Theory of Addiction* recognises the diversity of the experience of addiction, discusses factors at the level of both the individual and populations and provides key recommendations for the development of effective interventions.



ABC of alcohol (4th edition)
Paton A and Touquet R (eds)
Blackwell Publishing
2005, 57 pp.
ISBN-13 978 0 7279 1814 7

The objective of the first edition of *ABC of alcohol* in 1988 was to encourage doctors to regard alcohol misuse as a legitimate part of professional practice. The editors of this latest edition believe that this aim has not been realised fully in the intervening years, that in some quarters the feeling is still that doctors should not get involved. They suggest that this is largely because of lack of knowledge about how misuse of alcohol affects society and people, and thus a lack of confidence in tackling misuse. This book is designed to remedy this and to show that sympathetic management of people with alcohol problems, especially if they are detected early, can be a rewarding experience.

In this edition, existing chapters have been revised and important sections have been added on the impact of alcohol on accident and emergency departments and surgical practice, and on the potential dangers of alcohol's interaction with legal and illegal drugs. The editors have tried to broaden the 'doctor–patient' model to encompass alcohol workers and their clients. Designed, as a practical reference guide, this book has chapters on the wider social consequences of alcohol misuse; the physiological and pathological effects of alcohol on the body; definitions of healthy and of harmful drinking; the nature of alcohol use; detecting misuse; medical and surgical problems; management of alcohol misuse in primary care; advice and counselling; treatments; and resources.



Clinical textbook of addictive disorders (3rd edition)
Frances RJ, Miller SI and Mack AH (eds)
The Guilford Press 2005, 684 pp.
ISBN 1 59385 174 X (hardcover)

The revised and expanded third edition of this book presents the latest scientific knowledge about all aspects of addictive disorders and their treatment. Leading researchers and practitioners describe best practices in assessment and diagnosis and provide the latest tools for working with users of specific substances.

Divided into five parts, the book begins by describing the scientific foundations and historical background of addictions treatment. Current procedures for psychological evaluation and laboratory testing are then outlined. Subsequent sections provide substance-specific information and examine issues in working with particular populations, including polysubstance users, culturally diverse patients, women and older adults. Next, widely used psychological and pharmacological treatment approaches are thoroughly reviewed. Attention is given throughout to the importance of tailoring interventions to each patient's needs while delivering compassionate, evidence-based care. With expanded coverage of co-morbidity and dual diagnosis, the third edition contains entirely new chapters on the neuroscientific basis of addiction, addiction to gambling and to pain medications and substance abuse in the workplace, as well as a chapter on dialectical behaviour therapy.

This clinical textbook will be of interest to practitioners, graduate students and others in a range of disciplines, including psychiatry, clinical psychology, social work, substance abuse counselling and allied health fields. It is used as a core text for courses in addiction psychiatry and substance abuse counselling.

Recent publications *(continued)*

Evidence-based policy: a realist perspective
Pawson R
Sage Publications 2006, 196 pp.
ISBN-13 978 1 4129 1060 6 (paperback)

The author tells us that choosing a title for this book was troublesome. The problem with the term 'evidence-based policy', he says, is that there is no such thing. He tells the reader that what they are about to read is – (The best we can do by way of) evidence-based policy: a realist (in one sense of the term) perspective.

Chapter 1 identifies the main vehicle for evidence-based policy. Current hopes are pinned on rigorous 'systematic reviews', which attempt to synthesize the entirety of evidence on existing interventions. Chapter 2 introduces realist methodology, both as a philosophy of social inquiry and as a tool for dissecting the workings of social interventions. Chapter 3 is a critical interlude examining 'meta-analysis', currently the dominant model for research synthesis. Chapter 4 is the pivot of the book, introducing a new model of systematic review and setting down at length the principles and practice of 'realist synthesis'.

Chapter 5 is the first of three providing illustrations of realist synthesis. The evidence on the USA's sex offender registration and community notification programme (Megan's Law) is reviewed in order to show how and how much the success of complex interventions depends on the efficacy of each step in a long implementation chain. Chapter 6 offers a review of youth mentoring programmes, to show how realist synthesis can fine-tune understanding of the inner workings of programmes. Chapter 7 is a realist synthesis of 'naming and shaming' interventions. The aim is to compare the same initiative in action in very different policy spheres in order to demonstrate the contextual sensitivity of a key weapon of public policy. Chapter 8 asks the question: Does this dose of realism about the nature of the evidence base change expectations about its capacity to infiltrate the policy process?

Journal articles

The following abstracts are from a selection of articles relating to the drugs situation in Ireland recently published in international journals.

Booting and flushing: needle rituals and risk for bloodborne viruses
McElrath K
Journal of Substance Use 2005; 11(3): 177–189

'Booting' and 'flushing' are terms used to describe an injecting behaviour in which the plunger is pulled back and the fluid (mostly blood and perhaps blood only) is re–injected. The behaviour differs from 'registering', which occurs before the drug is injected. Booting/flushing can produce subcutaneous and venous damage, and increases the risk of the spread of blood-borne viruses when used equipment is passed on to other injectors. The purpose of the study was to explore the extent of flushing, the context of flushing and IDUs' self-reported reasons for flushing. Data were collected through semi-structured interviews with 59 IDUs in Northern Ireland, recruited by various strategies. Respondents' ages ranged from 22 to 50 years and females comprised 34% of the sample. Mean length of injecting career was 8.3 years. A total of 46% reported flushing on a regular basis during some or most of their injecting career. The results showed that flushing occurs for different reasons and is not associated solely with cocaine or speedball injection. Interventions designed to reduce the extent of flushing must take into account the various reasons for the behaviour.

Review of a community-based youth counselling service in Ireland
Lalor K, O'Dwyer S and McCrann D
Children and Youth Services Review 2005; 28(3): 325–345

The structure and operation of a community-based youth counselling service operated by the Kildare Youth Services (KYS), Ireland, are examined with a view to highlighting the preventative nature of such a service. Presenting problems are explored in the context of the wider social milieu. Particularly, recent trends in sexual behaviour, substance abuse and child sexual abuse are examined. Interviews were conducted with a sample of professionals who referred clients, patients and students to the KYS Youth Counselling Service. Interviews were also conducted with a small sample of clients of the service and with the counsellor-co-ordinator of the service. The service was viewed positively throughout the community and its role in the prevention of further distress was highlighted.

Economic and cultural correlates of cannabis use among mid-adolescents in 31 countries
ter Bogt T, Schmid H, Nic Gabhainn S, Fotiou A and Vollebergh W
Addiction 2006; 101(2): 241–251

The aim of this study was to examine cannabis use among mid-adolescents in 31 countries and associations with per-capita personal consumer expenditure (PCE), unemployment, peer factors and national rates of cannabis use in 1999. The authors used results from the Health Behaviour in School-aged Children (HBSC) study, a collaborative cross-national research study supported by WHO/Europe. The sample was nationally representative and consisted of a self-report survey of 22,223 male and 24,900 female 15-year-olds. Country

Recent publications *(continued)*

characteristics were derived from publicly available economic databases and previously conducted cross-national surveys on substance use.

Anglo-American countries (Canada, UK, US) and Switzerland and Greenland have a relatively high prevalence of lifetime cannabis use, whereas most countries from eastern and northern Europe, except Czech Republic, Hungary, Slovenia and Ukraine, have a low prevalence. Mediterranean countries, except Spain and to a lesser extent Italy and Portugal (Malta, Israel, Greece and Macedonia) also tend to have relatively low prevalence estimates. Most western European countries rank in mid-range (Belgium, Denmark, France, Germany, Ireland, the Netherlands). On the whole, boys have higher prevalence rates than girls, gender differences generally being greatest in eastern and southern European countries. Overall, lifetime prevalence and frequent use are associated with PCE, perceived availability of cannabis (peer culture) and the presence of communities of older cannabis users (drug climate).

The authors conclude that, as PCE increases, cannabis use may be expected to increase and gender differences decrease. Cross-national comparable policy measures should be developed and evaluated to examine which harm reduction strategies are most effective.

'Harry Wynne' Child and youth care practices and values: a reflection on a study of heroin misusers in Ireland

McElwee, NC
Child & Youth Care Forum 2006; 35(2):205–217

This discussion paper sets out to explore 'doing' research with a hard-to-reach population from a relational child and youth care perspective. It sets out some of the delimitations in undertaking such research and discusses some of our findings in relation to the individual and the family contexts.

Drug treatment programmes in prison: longitudinal outcome evaluation, policy development and planning interventions

Pugh J and Comiskey CM
Irish Journal of Psychological Medicine 2006 23(2): 63–67

The aim of this research is to evaluate a seven-week abstinence-based drug treatment programme and to use this to assist policy makers in the planning and provision of future programmes. Seventy-nine clients were interviewed at two stages: stage I, prior to the treatment programme: stage II, immediately after the treatment programme. A selected group of 20 clients were followed up and interviewed at stage III, up to 24 months after the treatment programme. This latter sample of 20 clients consisted of eight prisoners who had re-offended and returned to prison, three prisoners who were still in prison serving their original sentence and nine prisoners who were out of prison. These 20 also participated in a more detailed quantitative and qualitative survey. All clients were prisoners at Mountjoy Prison, Dublin Ireland.

In order to measure the prisoners' criminogenic attitudes and needs, the Crime Pics II instrument was used. This is a semantic differential scale which measures attitudes toward offending behaviour. It includes a problem checklist which can be used to measure change over time.

An 82% follow-up rate was achieved on the original group of 79 clients, and a follow-up rate of 100% for the selected group of 20 clients who were interviewed three times. Regardless of category of client, findings demonstrate an improvement over time for the outcome variables, general attitude to offending, anticipation of re-offending and perception of current life problems. However, the study failed to demonstrate any significant change for the outcome variables, victim hurt, denial and evaluation of crime.

These results were short-lived for many prisoners, who failed to sustain the gains made. Interviews with the cohort of 20 suggest that clients who did not receive continuity of treatment post programme, in terms of case management and structured treatment, did not fare as well as those who received such treatment.

Psychiatric morbidity in the male sentenced Irish prisons population

Duffy D, Linehan S and Kennedy HG
Irish Journal of Psychological Medicine 2006; 23(2): 54–62

This is the first epidemiologically representative cross-sectional study of psychiatric morbidity using research diagnostic instruments in sentenced prisoners in Ireland. The aim of the research was to estimate the prevalence of psychiatric morbidity and psychiatric service requirements. The authors interviewed 340 men serving a fixed sentence (14.6% of total) and 98 men serving a life sentence (82% of total). Prisoners were drawn from 15 different prisons using a random stratified sampling method. Mental illness and substance misuse were measured using the SADS-L, SODQ and a structured interview to generate ICD-10-DCR diagnoses. A high prevalence of mental illness was found. The six-month prevalence for psychosis (2.7%) was similar to an international meta-analysis. The authors found a significantly higher prevalence of psychosis in life-sentence prisoners (6.1%) than in fixed-sentence prisoners (1.8%). Drugs and alcohol problems were very prevalent.

Using the six-month prevalence figures found for psychosis, the authors estimate that there are

Recent publications *(continued)*

approximately 79 sentenced male prisoners with a severe mental illness who would require treatment in hospital additional to current provision. The relationship between drug availability and the prevalence of severe mental illnesses in prisons is also discussed.

Psychiatric morbidity among women prisoners newly committed

Wright B, Duffy D, Curtin K, Linehan S, Monks S and Kennedy HG
Irish Journal of Psychological Medicine 2006; 23(2): 47–53

The aim of the research was to estimate the prevalence of psychiatric morbidity, substance misuse problems and related health and social problems among women prisoners newly committed and a cross-section remanded and sentenced. In 2002 women represented 10.7% (1043) of all persons committed to the Irish prison system, and 3.3% (104) of the daily average number of persons in custody. The authors surveyed psychiatric morbidity in these two groups to assess the need for psychiatric services for women prisoners, and to compare Irish morbidity with an international average.

Ninety-four newly committed women prisoners were interviewed within 72 hours of committal, representing approximately 9% of female committals per year. The authors also interviewed a cross sectional sample of 92 women, representing approximately 90% of all women in custody. Mental illness and substance misuse were measured using the SADS-L, SODQ and a structured interview. Five (5.4%) of the committal and 5 (5.4%) of the cross-sectional sample had a psychotic illness within the previous six months; 8 (8.5%) of the committal and 15 (16.3%) of the cross-sectional sample had a major depressive disorder in the last six months. Eight (8.6%) of the committal and 14 (15.2%) of the cross-sectional sample had an anxiety disorder within the last six months. Sixty-one (65.6%) of the women interviewed at committal and 61 (65.2%) of the cross-sectional sample had a substance misuse problem in the last six months.

There is a high prevalence of mental illness and substance misuse problems among women newly committed to prison and in a cross section of those remanded or sentenced in Ireland. The authors found evidence of a cycle of deprivation and institutionalisation. These findings highlight the need for the integration of community and forensic psychiatric services, and for ongoing collaboration with drug services.

The social contexts of drinking among Irish men in London

Tilki M
Drugs: Education, Prevention & Policy 2006; 13 (3): 247–261

This article reports the alcohol-related findings of a qualitative study that examined health beliefs and behaviours among Irish people in London. The findings elicited though key informant and lay focus groups and semi-structured interviews, illuminated the social and socioeconomic background to excessive alcohol use among middle-aged Irish men who left Ireland in the 1960s and 1970s. The findings describe the economic role of the pub and alcohol for men in the construction industry as well protecting them from homesickness, isolation and alienation in an unwelcoming and hostile environment. They illustrate the use of alcohol later in life to cope with physical and psychological pain, social stress and the symptoms of mental illness. The use of alcohol as a culturally sanctioned coping strategy is considered, exploring the ambivalent culture of alcohol in Ireland and in particular the tolerance of excessive consumption among men. The article explores the possibility that tolerant attitudes to alcohol in Ireland persist on migration to Britain and are then confounded by a culture of binge drinking among young people in general. The conclusion argues for further research and for culturally sensitive healthcare and health promotion strategies that take account of cultural and structural factors impacting on young Irish men in Britain. Current NHS policies on equality, alcohol and suicide offer timely opportunities to address alcohol misuse in order to improve physical and mental health and reduce the incidence of suicide among Irish men in Britain.

(Compiled by Louise Farragher and Joan Moore)

Upcoming events

(Compiled by Louise Farragher) Email: lfarragher@hrb.ie

September 2006

18 September 2006
The Drug Treatment Centre Board 2006 Autumn Educational Seminars

Venue: Newgrange Hotel, Navan, Co Meath
Organised by / Contact: Drug Treatment Centre Board
Tel: + 353 (01) 6488600
www.addictionireland.ie/events

Information: The Drug Treatment Centre Board will present a series of seminars in Meath, Donegal and Kilkenny. With a range of speakers including Dr Brion Sweeney, Dr Bobby Smyth, Dr Joe Barry, Dr Declan Bedford and Dr Des Corrigan, the programme will address issues such as the 4-Tier Model, Development of Adolescent Services, Drugs and Alcohol and the Effects of Psychoactive Drugs.

21 September 2006
27th Annual EAP Conference & Training Institute. Managing the Performance, Safety & Health Risks of Employee Drug & Alcohol Use

Venue: Stillorgan Park Hotel, Dublin
Organised by / Contact: Miriam Tobin, Conference Administrator,
EAP Institute, 143 Barrack Street, Waterford, Ireland
Tel: +353 (0)51 855799
Fax: +353 (0)51 879626
Email: eapinstitute@eircom.net

21–23 September 2006
ESSD: European Society for Social Drug Research – 17th Annual Conference

Venue: Lisbon, Portugal
Organised by / Contact: Maria do Carmo Gomes, Researcher/Sociologist, Centre for Research and Studies in Sociology (CIESISCTE)
carmo.gomes@iscte.pt
Tel: +351 21 790 3077

Information: ESSD was founded in 1990 as an association of European social scientists working on drug issues. Its principal aim is to promote social science approaches to drug research, with special reference to the situation in Europe. The society holds annual conferences and workshops, co-ordinates research and organises joint projects.

October 2006

4 October 2006
The Drug Treatment Centre Board 2006 Autumn Educational Seminars

Venue: Mill Park Hotel, Donegal Town, Co Donegal
Organised by / Contact: Drug Treatment Centre Board
Tel: + 353 (01) 6488600
www.addictionireland.ie/events

5–7 October 2006
9th European Conference on Drugs and Infections Prevention in Prison. From the Principle of Equivalence to the Practice of Care: Bridging the Gap.

Venue: Grand Hotel Union, Ljubljana, Slovenia
Organised by / Contact: Cinzia Brentari, Rue Hotel des Monnaies 52, 1060 Brussels, Belgium.
Tel: +32 (0)2 5380171
cbrentari@cranstoun.org.uk

Information: This year's conference is structured to provide opportunities for dialogue on the development and implementation of effective drug prevention and health promotion policies and services for those who come into contact with the criminal justice system.

6–8 October 2006
EUROPAD 7 European

Venue: Radisson SAS Hotel, Bratislava
Organised by / Contact: European Opiate Addiction Treatment Association & Slovak Professional Society for Dependencies on Psychoactive Substances.
Email: maremman@med.unipi.it
www.europad.org/conf2006.asp

9–11 October 2006
9th International Symposium on Substance Abuse Treatment

Venue: National Research and Development Centre for Welfare and Health (STAKES) in Helsinki, Finland.
Organised by / Contact: Mari Miekkala, Research Assistant
Tel: +358 (0)9 3967 2004
Email: mari.miekkala@stakes.fi
www.nad.fi/sat2006/

Information: This symposium will cover the following topics:

- Characteristics and assessments of treatment systems: what clients are reached by different treatment systems and what treatment is offered to different clients?
- Brief interventions and internet-based services – theory and practice: Do these practices reach new client groups and how do they work, for instance, in case of drug problems?
- Treatment in prison settings – contexts and qualities
- Therapeutic communities – characteristics and their role in different treatment systems
- Harm reduction and treatment – new division of labour or changed ambitions?

12 October 2006
Alcohol and Drug Problems in Contemporary Ireland

Venue: Swift Lecture Theatre, Arts Building, Trinity College Dublin, Thursday evenings, 7.30pm – 9.00pm
Contact / Organised by: Application forms are available from The Executive Officer, Addiction Studies, School of Social Work and Social Policy, Arts Building, Trinity College, Dublin 2
Tel: +353 (0)1 608 1163 (mornings)
Email: addiction.studies@tcd.ie
Fee: €100 payable in advance (reduced fee for unemployed people and pensioners). Cheques to be made payable to TCD No. 1 Account.

Information: This evening course, a series of 10 lectures, will be given by lecturers and practitioners who contribute to the Diploma in Addiction Studies and the MSc in Drug & Alcohol Policy which are run in the School of Social Work. The first lecture takes place on 12 October 2006. The lecture topics and speakers are:

- Alcohol and Drug Use: Complex Problems & Simplistic Solutions (Marguerite Woods)
- Alcohol Policy in Ireland (Shane Butler)
- Drug Policy: the International Dimension (Eoghan Quigley)
- Alcohol and Drug Education as a Means of Prevention (Marguerite Woods)
- Alcohol and the Family (Shane Butler)
- The Role of 12-Step Fellowships (Tony Jordan)
- Harm Reduction in a Drug-free Culture (Shane Butler)
- Women and Drug Use (Marguerite Woods)
- Youth and Drugs (Mary Cunningham)
- Drug Problems: the Community Dimension (Barry Cullen)

Upcoming events *(continued)*

17 October 2006
The Drug Treatment Centre Board 2006 Autumn Educational Seminars

Venue: Kilkenny River Court, Kilkenny
Organised by / Contact: Drug Treatment Centre Board
Tel: + 353 (01) 6488600
www.addictionireland.ie/events

November 2006

8 November 2006
Drug & Alcohol Professionals Conference

Venue: Royal Institute of British Architects, 66 Portland Place, London
Organised by / Contact: The Federation of Drug & Alcohol Professionals (FDAP) in association with Drink & Drugs News
www.fdap.org.uk

Information: FDAP's Annual Drug & Alcohol Professionals Conference aims to support the development of front-line workers, managers and commissioners, and to give delegates the opportunity to have their say on important issues of the day. This year's event will include plenary presentations on the future of alcohol services, residential rehab and harm reduction, as well as the next steps on workforce development. Workshops and seminars will cover issues such as: services for steroid users; meeting the needs of young people; working with clients with co-occurring gambling problems; brief therapies for alcohol problems; and managing child protection issues. Delegates will have the chance to contribute to policy debates on: whether psychological therapies work with substance users; what role, if any, there should be for coercive treatment; and whether practitioners should have to be qualified to work in this field.

15 November 2006
2nd National Conference on Reducing Drug-Related Deaths

Venue: The Lowry Hotel, Manchester
Organised by / Contact: Salman Desai, Greater Manchester Ambulance Service NHS Trust, Ladyridge Hall, 399 Chorley New Road, Bolton BL1 5DD. Tel: +44 (0)1204 492419
Email: info@gmas.nhs.uk

Information: Reducing drug-related deaths (DRDs) remains a key issue for all services. This one-day conference will explore the causes, impacts and ways to reduce DRDs. Themes include the provision of Naloxone for users, blood-borne viruses, abstinence vs maintenance, and the role of prisons in reducing DRDs. The conference will be of interest to DATs; drug, mental health and ambulance services, police, prisons, probation, professionals working in primary and social care, accident and emergency staff, coroners, directors of public health, researchers and service users.

16–17 November 2006
International child psychiatry conference on the treatment of adolescent addiction

Venue: The Davenport Hotel, Merrion Square, Dublin 2
Fee: €295.00 per delegate
Organised by / Contact: Drug Treatment Centre Board (DTCB). To request a brochure, reserve a place or for queries please call +353 (0)1 648 8750
Email: seminars@dtcb.ie
www.dtcb.ie

Information: International best practice indicates that treatment of severe adolescent addiction problems should involve dedicated input by a multi-disciplinary team. The Young Persons Programme at the DTCB deals with the most complex cases of adolescent addiction and has substantial experience and real expertise within this field. There is growing awareness of the need for child and adolescent psychiatrists to become more involved in the provision of addiction treatment to teenagers with substance misuse difficulties.

The main learning objective of the DTCB's two-day conference is to equip attendees with the basic skills to conduct assessments of complex adolescent addiction cases and to develop treatment plans to tackle the problems identified. The format will involve a combination of lectures, case discussions, small-group work and workshops dealing with very specific area of treatment. Key team members from the DTCB Young Persons Programme, including Dr Gerry McCarney and Dr Bobby Smyth, will deliver this conference with special guest speaker Dr KAH Mirza.

January – March 2007

Managing the Performance, Safety and Health Risks of employee drug and alcohol use

Organised by / Contact: Anita Furlong, EAP Institute 143 Barrack Street, Waterford, Ireland
Tel: +353(51)855733
Fax: + 353(51)879626
Email: maurice@eapinstitute.com
www.eapinstitue.com

Thursday 18 January 2007
Venue: Ramada Viking Hotel, Waterford

Thursday 15 February 2007
Venue: Heritage Hotel, Portlaoise

Thursday 8 March 2007
Venue: Radisson Hotel, Galway

Information: The Safety, Health and Welfare at Work Act 2005 was signed into law in June 2005. The Act requires employees not to be under the influence of intoxicants (defined as drugs and alcohol) to the extent that they endanger their own or another person's safety at work. The purpose of this seminar is to outline the impact of drug impairment in the workforce and give practical guidance on the recognition and treatment of employees whose behaviour presents risks to themselves and others.

The Drug Misuse Research Division (DMRD) of the Health Research Board is a multi-disciplinary team of researchers and information specialists who provide objective, reliable and comparable information on the drug situation, its consequences and responses in Ireland. The DMRD maintains two national drug-related surveillance systems and is the national focal point for the European Monitoring Centre for Drugs and Drug Addiction. The division also manages the National Documentation Centre on Drug Use. The DMRD disseminates research findings, information and news through its quarterly newsletter, *Drugnet Ireland,* and other publications. Through its activities, the DMRD aims to inform policy and practice in relation to drug use.

***Drugnet Ireland* mailing list**
If you wish to have your name included on the mailing list for future issues of *Drugnet Ireland,* please send your contact details to:
Drug Misuse Research Division, Health Research Board, Knockmaun House, 42–47 Lower Mount Street, Dublin 2. Tel: 01 676 1176 ext 127; Email: dmrd@hrb.ie

Please indicate whether you would also like to be included on the mailing list for *Drugnet Europe* and *Drugs in focus.*