

Trends in cocaine and opiate use

Two new Trends Series papers launched. See p. 10.

NDC launches new website

www.drugsandalcohol.ie

- New drugs strategy summarised:
 - policy initiatives under the five pillars
 - assessment of 2001–2008 strategy
 - discussion of alcohol misuse under each pillar
- C and AG report on drug treatment
- Alcohol affordability and harm
- Alcohol and young people
- Studies of opiate users in methadone treatment
- Drug use, sex work and risk
- Review of progress on suicide
- Ana Liffey launches SMS service
- Drug helplines' role in monitoring new drug trends

Taoiseach launches new National Drugs Strategy



An Taoiseach Brian Cowen, Kathleen Stack, Assistant Secretary at the Department of Community, Rural and Gaeltacht Affairs, and Minister for Drugs John Curran at the launch of the *National Drugs Strategy (interim) 2009–2016* (Photo: Fennell Photography)

On 10 September 2009 the Irish government published its national drugs strategy 2009–2016.¹ Noting that the previous drugs strategy had been successful in tackling the heroin problem in Dublin, the Taoiseach, Brian Cowen TD, acknowledges in his foreword to the new strategy that the situation has now changed: 'problem drug use has spread to other areas and the range of drugs available has increased. The challenge involved is complicated by the fact that drug use can be linked to circumstances of social exclusion as well as to circumstances of economic prosperity.'

New announcements mark launch of drugs strategy

Speaking at the launch, Minister for Drugs John Curran TD announced:

- The extension of the 'Dial to Stop Drug Dealing' campaign. Minister Curran said he had decided to continue the scheme owing to the positive outcomes being achieved. He noted that an emphasis on the evaluation of outcomes and the allocation of resources based on evidence of real achievement would be a feature of the new Strategy.
- The allocation of capital funding of €1.1 million towards the development of treatment clinics in Limerick, Cork, Waterford, Enniscorthy, Drogheda and Dundalk. The Minister said he had been assured that some of these clinics would be in operation by the end of the year, with treatment being available in all six locations early in 2010.
- The HSE and the Irish Pharmacy Union have agreed a plan to roll out needle exchange services through community pharmacies in 65 new locations. Implementation of this initiative, which is supported by the Elton John AIDS Foundation, will commence shortly.

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New drugs strategy published

Both the Taoiseach and the Minister for Drugs, John Curran TD, emphasise that partnership both at national and local level, including the drugs task forces, will continue to form the basis of the government’s approach to tackling the problem. Minister Curran confirms that the government will retain the five pillars – supply reduction, prevention, treatment, rehabilitation and research, ‘as these have served us well and still encompass the areas that need to be addressed. This will also facilitate the dovetailing of the Strategy with the provisions of the EU Drugs Action Plan 2009–2013.’

Overall strategic objective

To continue to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation, and research.

Overall strategic aims

- To create a safer society through the reduction of the supply and availability of drugs for illicit use;
- To minimise problem drug use throughout society;
- To provide appropriate and timely substance treatment and rehabilitation services (including harm reduction services) tailored to individual needs;
- To ensure the availability of accurate, timely, relevant and comparable data on the extent and nature of problem substance use in Ireland; and
- To have in place an efficient and effective framework for implementing the National Substance Misuse Strategy 2009–2016.

The new strategy uses the same framework as before, constructed around a hierarchy of aims, objectives, key performance indicators and actions (Figure 1). The pillar construction is accompanied by a co-ordination ‘pillar’, with its own objectives, KPIs and actions. The expectation appears to be that the high-level aspirations will provide an over-arching logic uniting the whole, while, simultaneously, the underpinning actions will drive the new strategy forward.

While the overall strategic approach and framework are the same as before, the contents of the pillars in the NDS 2009–2016 reveal some shifts in emphasis – reflecting either the changing nature of the situation and the problem being faced, the experience gained through implementing the previous drugs strategy, or the insights acquired through the new research and information accumulated during the past seven years. While the overall strategic objective remains broadly the same, there has been a change in the active verb – ‘to significantly reduce the harm’ in the previous strategy has been replaced by ‘to continue to tackle the harm’.

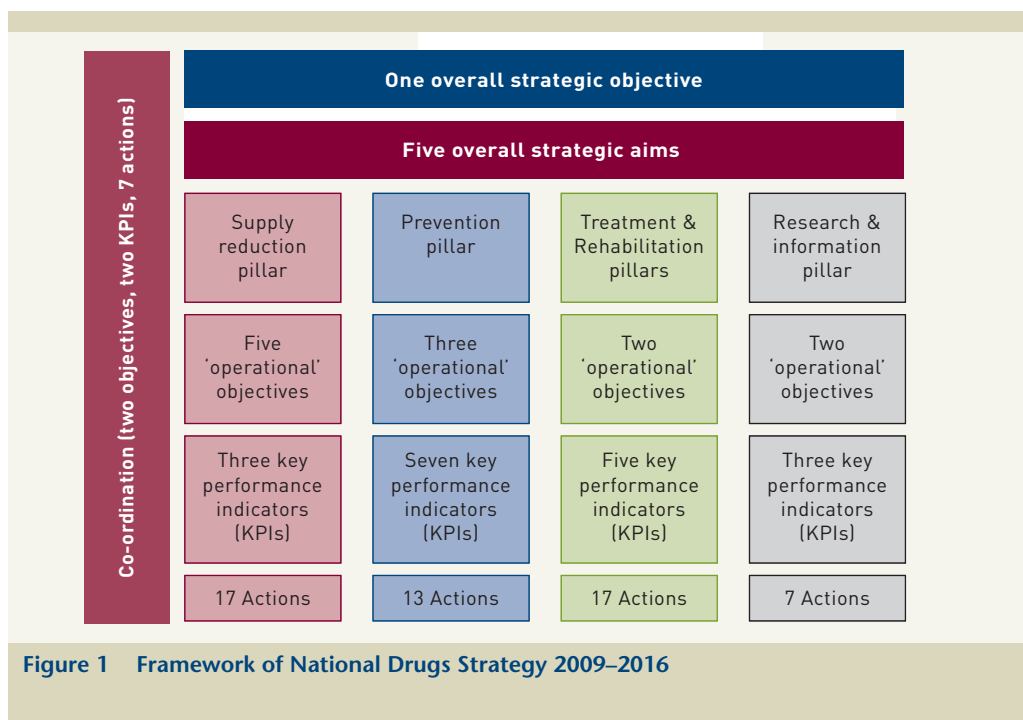


Figure 1 Framework of National Drugs Strategy 2009–2016

New drugs strategy published *(continued)*

More details on policy initiatives under each of the pillars may be found in the sections below.

Although there was no final evaluation of the previous drugs strategy, the Steering Group that drew up the new strategy assessed progress under each of the pillars. A summary of this

assessment is provided on page 8. Furthermore, aware that a combined substance misuse strategy, including both alcohol and illicit drugs, was to be developed over the next 18 months to two years, the Steering Group initiated discussion of alcohol misuse under each of the pillars in the new 'interim' strategy. This discussion is summarised on page 9.

Supply reduction pillar

Under the supply reduction pillar, the primary aim of reducing the availability of drugs remains. However, there is a greater note of realism evident in the NDS 2009–2016, for example in the way in which the impact of drug supply reduction activities is determined.

Acknowledging the significant increase in drug seizures in recent years, the Steering Group states that during the consultation phase 'the impact of those seizures on reducing the overall supply of drugs was questioned' (para. 2.22). It goes on to state, 'Due to the problems associated with estimating the size of the illegal drug market in Ireland, it is difficult to conclude whether increased seizures are actually resulting in a reduction in overall supply – or whether the overall supply of drugs has increased and the percentage of seizures has remained relatively even.' (para. 2.27) The Steering Group further acknowledges that 'the figures often quoted in relation to drugs seizures as a percentage of the total drugs market in Ireland are speculative and currently, have no proven basis' (para. 2.27). Consequently, the Group concludes that there is a need to develop other measurements to determine the effectiveness of supply reduction activities rather than relying on drug seizures.

An issue highlighted during the consultation phase was the possibility of decriminalising or changing the legal status of cases of simple possession of certain drugs, such as cannabis, owing to the Garda resources involved in prosecuting such cases. The Steering Group reports that, according to

the gardaí, 'about 20% of drugs crime relates to supply offences and 80% to possession' (para. 2.29). Despite this, most members of the Group are not in favour of 'legalising, decriminalising, or changing/redefining the legal status of certain illicit drugs (cannabis was the focus of most discussion in this context)' (para. 2.49). The Steering Group notes that the findings of the nationwide drug prevalence surveys conducted in 2002/03 and 2006/07 indicated that approximately 70% of respondents did not think recreational cannabis use should be permitted (support for the medicinal use of cannabis was about 70%). The Group does, however, identify as a priority the ongoing monitoring of legislative and regulatory frameworks with a view to pursuing changes where necessary.

Other priorities identified by the Steering Group include developing local partnership approaches through the joint policing committees and local policing fora provided for in the Garda Síochána Act 2005; tackling underage drinking and drug-related intimidation; the development of an integrated system to track the progression of offenders with drug-related offences through the criminal justice system; the continued implementation of measures to curtail the supply of drugs into Irish prisons; and a renewed focus on addressing the use of precursors in the manufacture of illicit synthetic drugs. The last priority calls for increased collaboration with international bodies such as the EMCDDA and the Pompidou Group of the Council of Europe.

Prevention pillar

In their forewords to the new drugs strategy both the Taoiseach and the Minister for Drugs emphasised the importance of prevention. Minister Curran stated: 'If we could achieve more in regard to prevention, I believe that the impact on the overall problem would be greatly enhanced.'

Having reviewed progress under the previous drugs strategy, the Steering Group concluded that 'a tiered or graduated approach to prevention and education measures in relation to drugs and alcohol should be developed with a view to providing a framework for the future design and development of interventions' (para. 3.56). The Steering Group identifies three levels in this framework, which are outlined in the following table. In naming the three levels, the Group combined the current prevention classification framework – universal, selected and indicative – with the old classificatory framework of primary, secondary and tertiary.

Universal (primary) prevention programmes

Aimed at reaching the general population, such as students in schools, to promote overall health of the population and to prevent the onset of drug and alcohol misuse. Measures often associated with this type of programme include awareness campaigns, school drug/alcohol education programmes and multi-component community initiatives.

Selected (secondary) prevention programmes

Aimed at groups at risk, as well as subsets of the general population including children of drug users, early school leavers and those involved in anti-social behaviour. These programmes aim to reduce the effect of risk factors present in these subgroups by building on strengths and developing resilience and protective factors.

Indicative (tertiary) prevention programmes

Targeted at people who have already started using drugs/alcohol, or who are likely/vulnerable to engage in problematic drug/alcohol use (but may not necessarily be drug/alcohol dependent), or to prevent relapse. These require individual or small group programmes aimed at addressing specific needs.

With regard to specific interventions, the Steering Group identifies the following priorities:

- *improved delivery of SPHE in primary and post-primary schools* – the Steering Group acknowledges that while the focus of prevention measures in the previous strategy had been on the provision of education services in school settings for the school-going population, their application and delivery had limited their effectiveness.

New drugs strategy published *(continued)*

- *the co-ordination of the activities and funding of youth interventions in out-of-school settings to optimise their impacts* – under the previous strategy the provision of education in non-school settings had been fragmented, the provision of alternative recreational facilities for young people had been under-developed, and many young people had not had access to recreational facilities in out-of-school settings.
- *a continued focus on orienting educational and youth services towards early interventions for people and communities most at risk* – the Steering Group recommends that actions be developed to further support the families of drugs users, and it acknowledged community development as an important step in building the capacity of local communities to avoid, or respond to and cope with, drug problems.
- *the development of timely awareness campaigns targeted in a way that takes individual social and environmental conditions into account* – the Steering Group sees a need to further develop and promote prevention strategies in a number of key areas such as third-level institutions, workplaces, sports and other community and voluntary organisations.

Treatment and Rehabilitation pillars

The Steering Group states that this pillar, which combines the treatment and rehabilitation pillars, has a wider focus than in the previous strategy. It aims to develop a more comprehensive treatment service capable of dealing with all problem substances nationally, rather than focusing mainly on opiate misuse in Dublin. The Group identifies a number of priorities, grouped under four main themes.

1. *Development of general problem substance use services – develop an integrated national treatment and rehabilitation service for all substances, using a four-tier model approach, underpinned by an appropriate clinical governance regime.*

The Steering Group supports the HSE's reorientation of addiction services towards polydrug use using a four-tiered model approach. The focus of the strategy will be on the development of addiction services, and of pathways between them and other relevant health and social services.

The treatment of drug users with hepatitis C is specifically mentioned for the first time in the new strategy. The Group notes that there has been a gradual and consistent decrease in the number of HIV cases reported, while the incidence of hepatitis C among injecting drug users (IDUs) remains a cause of concern. The KPI on the monitoring of the incidence of HIV has been dropped and, for the first time, a KPI for the treatment of hepatitis C in drug users has been included.

Data from the National Drug-Related Deaths Index (NDRDI),² set up in line with Action 67 in the NDS 2001–2008, show an increase in drug-related deaths since 1998, and a new action in the NDS 2009–2016 calls for the development of a National Overdose Prevention Strategy, and also for a response to the increasing numbers of indirectly drug-related deaths.

The Steering Group prioritises the expansion of the availability of detox facilities, opiate substitution services, under-18 services and needle-exchange services where required. The KPI relating to provision of services for under-18s remains the same as in the previous strategy, but with a new target of 100% access to treatment within one week (as opposed to one month) of assessment by 2012. While the document states that methadone substitution is the cornerstone of opiate treatment and looks for continued recruitment of Level two GPs, a new action calls for the review of the Methadone Treatment Protocol to maximise the provision of treatment and facilitate appropriate progression pathways. Additionally, the action calls for alternative opiate substitution services.

Noting that there was only a small increase in the number of residential places between 2001 and 2006, the Steering Group calls for the development of residential care in the context of the four-tier model. Along with appropriate aftercare services, the Group sees residential care as central to the provision of alternative, drug-free treatment for problem drug users. The NDS 2009–2016 includes a new KPI relating to residential places, which states that there should be a 25% increase in residential rehabilitation places by 2012 based on 2008 figures.

The Steering Group calls for the establishment of a drugs intervention programme aimed at young people and young adults, incorporating a treatment referral option, for those who come to the attention of the Garda Síochána because of behaviour caused by substance misuse. While many of the services needed for this programme are already in place, the Group notes that interagency co-ordination needs to be developed. A new KPI specifies that this programme should be in place by 2012.

2. *Specific groups – further develop engagement with, and the provision of services for specific groups: prisoners, homeless, Travellers, new communities, the lesbian, gay, bisexual and transgender (LGBT) community and sex workers.*

These specific groups are listed separately in the NDS 2009–2016. Those with a dual diagnosis (both mental health and substance misuse problems) are also mentioned specifically. These groups have been highlighted in order to differentiate their specific needs and to tailor services for them. New issues for prisoners have also been identified. These include the recognition of the high risk of overdose or relapse immediately following release from custody and the need for the development of an effective and co-ordinated interagency approach to ensure a seamless transition from prison back into the community. The Steering Group notes that not all prisons provide substitution treatment, and identifies this issue as a key gap.

3. *Quality and standards framework – develop a clinical and organisational governance framework for all treatment and rehabilitation services.*

The Steering Group states that while progress has been made in introducing standards in treatment and rehabilitation services, further measures are necessary. For example, currently neither counselling nor psychotherapy services are statutorily regulated. New actions are identified in relation to developing a clinical and organisational governance framework for addiction services and developing a regulatory framework on a statutory basis for the provision of counselling.

New drugs strategy published (continued)

4. *Training and skills development – develop national training standards for all those involved in the provision of substance misuse services, and co-ordinate training provision within a single national substance misuse framework.*

The actions relating to training and skills development are more specific in the new strategy, as they are seen as a

key component in the development of a comprehensive addiction service. The new actions call for the development of national training standards, including accreditation, for addiction services (both statutory and voluntary). The need for staff training in the use of naloxone in order to prevent fatal overdose is specifically mentioned.

Research and information pillar

The NDS 2009–2016 intends to collect information and complete research projects in order to inform policy formulation and to develop or enhance responses to the drug situation, while the NDS 2001–2008 intended to

measure the extent of drug use by person, place and time, and describe the characteristics of drug users, but did not state how the new information would be used (Table 1).

Table 1 Research objectives, NDS 2001–2008, and research and information objectives, NDS 2009–2016

2001–2008	2009–2016
Have valid, timely and comparable data on the extent of drug misuse amongst the Irish population and specifically amongst all marginalised groups.	Ensure the availability of data to accurately inform decisions on initiatives to tackle problem substance use.
Gain a greater understanding of the factors which contribute to Irish people, particularly young people, misusing drugs.	Provide appropriate research to fulfil the information needs of the government in formulating policies to address problem substance use.

The NDS 2001–2008 was based on a low level of information and the information that existed was not collated in a single place or easy to access. The NDS 2001–2008 intended to eliminate all research gaps and funded an extensive programme of research on the drug situation and the responses to it (Table 2).

The NACD was established to co-ordinate the programme of research and advise the government on its findings. The information available on the drug situation has increased dramatically since 2001; for example, the NACD published 70 research reports between 2001 and 2008, and the HRB

published 35 reports during the same period. All research publications are located in a single web-based library known as the National Documentation Centre on Drug Use (NDC).

At the time the NDS 2001–2008 was developed, it was not widely understood by those working in the drugs area that the EMCDDA required all countries to complete an annual national report on the current drug situation and responses to it. Since 2004, these national reports to the EMCDDA have been made available on the NDC website and are used by policy makers to keep abreast of progress.

Table 2 Research KPIs, NDS 2001–2008, and research and information KPIs, NDS 2009–2016

2001–2008	2009–2016
Eliminate all major research gaps in drug research by end 2003.	EMCDDA indicators developed on the extent and nature of problem drug use in Ireland
Publish an annual report on the nature and extent of the drug problem in Ireland and on progress being made in achieving the objectives set out in the Strategy.	Comprehensive and timely reporting systems in place for: treatment, rehabilitation, and the progression of offenders (with drug-related offences) through the criminal justice system
	Completion of identified research programme each year by the NACD

The challenge now is to sustain this level of knowledge and to identify the most efficient ways of updating our knowledge. With this in mind, the title of the research pillar has been changed to the research and information pillar. In the NDS 2009–2016 the emphasis, and investment, will be on the development of a single information system that will consist of existing data sources (such as the CTL, NDTRS, NDRDI, and HPSC) and these sources will be linked using a unique identifier. This will allow services to document the exact number of known problem drug users, and to trace their treatment and rehabilitation pathways and outcomes. Consent and data-protection procedures will be put in place to protect individuals' identities.

The EMCDDA indicators will guide the continuous and periodic data-collection process. Examples of continuous data-collection processes are the CTL, HPSC drug-related infectious diseases, NDTRS, NDRDI and PULSE. Examples of periodic data collection processes are the survey measuring the prevalence of problem drug use among the general population and the estimation of the numbers of problem drug users.

The Minister of State, the OMD and the NACD will develop and prioritise a research programme, revised on an annual basis. The programme will include projects that could not be achieved through routine data-collection mechanisms, for example exploring new issues, testing new interventions or

New drugs strategy published *(continued)*

measuring long-term impact. The development of an annual rather than an eight-year research programme will allow for sudden changes in the situation and prioritising of projects in line with available resources.

The seven research-related actions of the NDS 2001–2008 were substantially completed. In the NDS 2009–2016 four

priorities have been identified which closely link to the key performance indicators (Table 3). These priorities have been translated into eight associated actions which identify the agency with lead responsibility for implementation, together with all other contributing agencies.

Table 3 Research and information priorities, NDS 2009–2016

Continue to develop indicators and reporting systems on the extent and nature of problem substance use in Ireland (seeking to remove barriers to the development of these reporting systems and indicators).
Develop a prioritised research programme, to be reviewed annually.
Continue the drug prevalence and the ESPAD surveys.
Develop a research management framework and disseminate research findings and models of best practice.

The critical success factors for Ireland in delivering on the new strategic objectives are that capacity to complete drug-related research is developed further, that there is not

duplication of research projects or information systems, and that projects and interventions are planned using the best practice available within Ireland or in other countries.

Co-ordination pillar

Compared to the co-ordination arrangements in place for the previous drugs strategy, those to support the implementation of the NDS 2009–2016 have been significantly simplified and streamlined (see Figure 2). A new Office of the Minister for Drugs (OMD) will incorporate the work and functions of both the Drugs Strategy Unit (DSU) in DCRGA and the National Drugs Strategy Team

(NDST) and will report directly to the Cabinet Committee on Social Inclusion, Children and Integration (CCSICI) (see Table 4). The direct reporting line to the CCSICI and use of a ‘networked organisational’ structure in the OMD will preclude the need for an Interdepartmental Group on Drugs (IDG), which will be reconstituted as an Oversight Forum on Drugs (OFD).

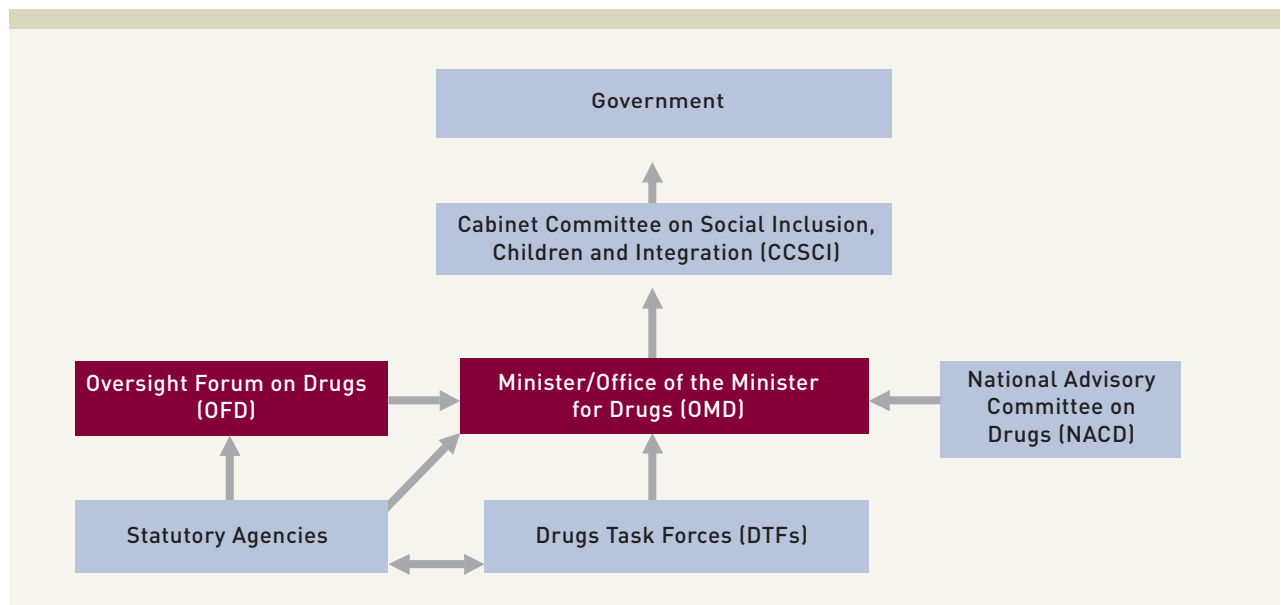


Figure 2 Co-ordination arrangements for the NDS 2009–2016 (after NDS 2009–2016, Table 6.4)

Assessing progress under the NDS 2001–2008, the Steering Group that drafted the new NDS found that 20 out of 22 actions to support co-ordination had been implemented, the key performance indicators relating to co-ordination reached, and that the co-ordination arrangements had ‘stimulated and promoted inter-agency working in a difficult cross-cutting policy and service area’ (para. 6.7). However, the Steering Group also found that there were ‘capacity and structural limitations’, which were limiting ability to meet the new challenges, including:

- accounting for expenditure;
- governance;
- mainstreaming;
- capacity of services to meet client needs; and
- monitoring/evaluation.

New drugs strategy published *(continued)*

The need was identified to establish a structure which would:

- support and drive the ongoing implementation of the NDS, while respecting the various lead roles and statutory responsibilities of the Departments/agencies involved;
- provide a more cohesive and integrated framework that promotes closer co-operation and accountability between the different players, as well as greater transparency for expenditure;
- provide a clear hierarchy and a greater transparency of the roles from the government and the Cabinet Committee on Social Inclusion, Children and Integration to the local project level.

Table 4 Key features of the new Office of the Minister for Drugs (OMD)

Responsibilities	Operating principles	Resourcing
<ul style="list-style-type: none"> ■ national co-ordination ■ policy development ■ supporting the work of drugs task forces ■ supporting the work of the NACD ■ supporting the community and voluntary sectors ■ co-ordinating Ireland's input to the EU, UN and other international for a regarding the drugs issue 	<ul style="list-style-type: none"> ■ local responses to local need, based on local planning and decision making ■ community representation and involvement ■ partnership between community, voluntary and statutory sectors ■ direct linkages between local and national structures ■ direct linkages between local and national policy 	<p>The OMD will be staffed by the current staff of the DSU and NDST. Some 12 officers at Assistant Principal level from the various government departments and state agencies with responsibilities under the NDS will also be assigned on a half-time basis for a minimum of three years. These staff will work with the OMD, and protocols to reflect their ongoing roles will be drawn up. These staff will also continue to work within their parent departments and agencies to seek to positively influence policy, programme activity and resource allocation in regard to drug issues.</p>

The design of the OMD resembles the networking model promoted in a recent OECD review of the Irish public sector.³ The OECD review described the Office of the Minister for Children and Youth Affairs (OMCYA), established in 2005, where staff from different government departments (including Health, Education and Justice) had been brought together in one location (the Department of Health and Children) to work in a networked way on issues of strategic national importance with regard to children. The review's observations on the OMCYA may be applied equally to the new OMD:

Policies that cut across the function responsibility of a number of departments can lead to difficulties in determining who is the overarching 'owner' accountable for the service provided. The work to date by the OMC has demonstrated that there is value in ensuring that units, such as the Irish Youth Justice Services, remain connected to their parent department (Department of Justice, Equality and Law Reform). This ensures that they have ongoing interaction with, and input to the development of policies targeted at children while also ensuring that accountability for the services they deliver remains within the remit of their Minister. This guarantees that historical mismatches between children's policy and youth justice policy can be addressed. (pp. 241–242)

To support integration, the Steering Group recommends an Oversight Forum on Drugs (OFD) to replace the Interdepartmental Group on Drugs (IDG). Comprising the same membership, its primary role will be the high-level monitoring of progress being achieved across the strategy and agreeing appropriate ways forward where issues are blocked or progress is being impeded. It will also provide a forum for discussion and feedback on issues relating to problem drug use that arise in EU and international arenas. The Group proposes two additional mechanisms to support the new integrative role of the OMD: (1) an Advisory Group

of the OMD, comprising representatives of the statutory, voluntary and community sectors, to advise the Minister on operational and policy matters relating to the NDS; and (2) twice-yearly bilateral meetings between the Minister for Drugs and the ministers for Justice, Education and Health; the Minister and the Director of the OMD and the heads of various departments and state agencies involved in implementing the NDS; the Minister and the Director of the OMD and the chairs and co-ordinators of the DTFs; the Minister and the Director of the OMD and the NACD and the Family Support Network. The Steering Group believes these meetings would help to keep a focus on drug-related issues and the broader implementation of the NDS.

This multiplicity of mechanisms raises the question as to whether there is a more efficient and effective means of integrating effort across the statutory, voluntary and community sectors and engaging all stakeholders in the deliberation over and choice of policy options. For example, a study of whole-of-government approaches to cross-cutting policy issues in Ireland in the 21st century⁴ described how social partnership can perform such an integrating function. Advisory groups such as the National Economic and Social Council (NESC) or the National Economic and Social Forum (NESF), with broad-based representation of all the social partners and reporting to the Department of the Taoiseach, have played and continue to play a critical role in supporting the development and implementation of key national policies.⁵

The National Advisory Committee on Drugs (NACD) is to be co-located with the OMD and the Director of the NACD is to become a member of the senior management team in the OMD. While acknowledging the need for the NACD to be 'independent' in regard to research, the Steering Group states that the closer alignment with the OMD will 'better address the issue of linkages between policy development and research'.

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Local and regional drugs task forces (DTFs) will now report to the OMD for all activities, outputs and expenditures. Priorities for the new OMD with regard to the DTFs will include:

- considering reporting and accountability arrangements for DTF projects with a view to simplifying the system;
- examining the feasibility of achieving the optimum structure for the employment arrangements of DTF personnel;

- reviewing and renewing the commitment and participation of all members of DTFs, including the position of chairperson;
- updating the handbook for the operation of DTFs to take account of the new structural arrangements and include guidelines on mainstreaming.

The NDS notes that the National Drugs Rehabilitation Implementation Committee will also be 'closely linked' to the OMD.

Steering Group's assessment of the National Drugs Strategy 2001–2008

The Steering Group that managed the preparation of the NDS 2009–2016 assessed the progress that had been made against the key performance indicators (KPIs) under each of the pillars of the 2001–2008 strategy: supply reduction, prevention, treatment, rehabilitation and research.⁶ The Group's assessment, as reported in the new strategy document, is summarised below.

Supply reduction

All KPIs under this pillar were achieved. The targets of a 50% increase in volume of drugs seized based on 2000 figures and a 20% increase in the number of seizures based on 2004 figures were both exceeded. The 125% increase in supply detections between 2004 and 2008 significantly exceeded the target of 20%. While acknowledging the operational success which this represented for law enforcement, the Steering Group notes that, without a reliable estimate of the size of the illegal drug market in Ireland, the impact of increased seizures on the overall supply could not be measured.

Other areas of progress included increases in the Garda Síochána resources in LDTF areas and various initiatives aimed at reducing the supply of drugs, such as the 'Dial to Stop Drug Dealing' scheme, undertaken by local and regional DTFs. Less progress was achieved in expanding community policing fora (CPFs) and reducing the availability of drugs in prisons.

Prevention

The KPIs under this pillar related to levels of problem drug use, prevalence, substance use policies in schools and rates of early school leaving. Heroin use stabilised in the Dublin area, with a significant drop in new entrants, but rose substantially outside Dublin. Drug prevalence targets were not achieved and the 2006/07 drug prevalence survey reported increases in recent and current use. The target of having substance use policies in all schools was near completion at the time of a Department of Education and Science survey in 2005. A number of data sources were used to estimate the levels of early school leaving and, while precise figures were not available, it appeared that early school leaving had decreased during the period of the NDS 2001–2008.

While many of the actions relating to the implementation of prevention programmes were completed or near completion, the Steering Group questions the effectiveness of a number of the programmes. Despite the high number of schools which reported that they had implemented substance misuse policies, the quality of these policies had not been assessed and there was a need to determine how actively they were being implemented. The Social Personal

Health Education (SPHE) programme, the foundation for developing awareness of drugs and alcohol issues in schools, is a mandatory part of the curriculum but its effectiveness as a drug prevention measure was consistently questioned during the consultation process.

Treatment and rehabilitation

Three of the KPIs under this pillar specified increased availability of treatment and harm reduction services, and one sought a reduction in the incidence of HIV. The target of a maximum waiting period of one month for treatment for problem drug use was achieved for almost all non-opiate addiction cases. However, there were still difficulties in many areas in providing access to methadone treatment within one month of assessment. No under-18s had had to wait longer than one month to initiate treatment following assessment, but there were still not enough residential places or community supports. There was limited progress in providing harm-reduction services, but the incidence of HIV among injecting drug users had seen a consistent reduction. The incidence of hepatitis C continued to cause concern.

While rehabilitation was covered under the treatment pillar in the NDS 2001–2008, the mid-term review (MTR) of the strategy recommended that a separate pillar be established.⁷ Following a recommendation in the report of the Working Group on drugs rehabilitation,⁸ a National Drug Rehabilitation Implementation Committee (NDRIC), chaired by the HSE, was set up. The Steering Group notes that there was progress in several areas related to the MTR's recommendation to strengthen support for families, and that the HSE had significantly developed its family support services.

Research

The KPIs under this pillar dealt with information on prevalence in the general population, problem drug use, demand for drug treatment, drug-related deaths and drug-related infectious diseases. In 2005 the NACD published the findings of a drug prevalence survey carried out in Ireland and Northern Ireland in 2002/03. This survey was repeated in 2006/07 and the results published in 2008. The NACD also commissioned studies on drug prevalence among vulnerable groups, including the homeless, new communities in Ireland and Travellers. Other studies give some insight into alcohol and cannabis use among the youth and school-going populations. While work on the second 3-source capture-recapture study to estimate the prevalence of problematic opiate use has yet to be completed, the Research Outcome Study in Ireland (ROSIE) and the information reported by the NDTRS provide significant insights into the patterns of problem drug use.

New drugs strategy published *(continued)*

Improvements in the reporting of problem drug use to the Drug Misuse Research Division (renamed Alcohol and Drug Research Unit (ADRU) in 2007) increased the efficiency of the flow of this data and the quality of the information. The ADRU manages the National Drug Treatment Reporting System (NDTRS). This system collects data on episodes of treatment, rather than on the individual person treated; neither does it provide outcome/exit data for all areas. In 2005 the Health Research Board (HRB) developed a National

Drug-Related Deaths Index (NDRDI), which subsequently published data for the period 1998–2005.² The Health Protection Surveillance Centre (HPSC) introduced an extended surveillance system for hepatitis B in 2004 and for hepatitis C in 2007. The Steering Group notes that there has been no concerted effort to monitor the incidence and prevalence of hepatitis B, hepatitis C or HIV among drug users since the NDS 2001–2008 was launched.

Inclusion of alcohol in new substance misuse strategy

Announcing the decision to develop a ‘substance misuse’ strategy, including both illicit drugs and alcohol, Minister of State with responsibility for drugs strategy, John Curran TD, said: ‘A combined strategy will facilitate a more coherent approach to the issues and consequences of alcohol and illicit drug use including addictive behaviours. We cannot continue to look at these problems in isolation.’⁹ A new steering group will be established in autumn 2009 to develop proposals for a strategy that will incorporate the already-agreed drugs policy element. Membership of the new steering group will reflect the appropriate statutory, community/voluntary and other relevant interests. The group will be jointly chaired by officials from the Department of Health and Children and the Office of the Minister for Drugs and will be asked to report by the end of 2010.

The interim drugs strategy contains a number of proposals relating to alcohol. These are summarised below.

Supply reduction

During the public consultation process, the issue of underage drinking was consistently raised, both as a problem in its own right and as a gateway to the use of illicit drugs. However, owing to the fundamental legal difference involved in their supply, the focus in the interim drugs strategy is on illicit drugs rather than on alcohol, with the exception of underage drinking.

Prevention

Alcohol is referenced under this pillar with regard to developing a prevention strategy to tackle substance misuse, particularly in relation to under-18s. One of the key themes to emerge from the consultation process was the perception that drug and alcohol use are becoming more widespread and that the age profile of those involved is getting younger. Measures to prevent and/or delay drug and alcohol use – especially among young people – are, therefore, particularly important and urgent.

The Steering Group is of the view that renewed efforts need to be made to address the issue of underage drinking, which is often perceived as the direct, or underlying, cause of many of the problems encountered by individuals and communities. The Group acknowledges the benefits of the enactment of the Intoxicating Liquor Act 2008. However, it also feels that the impact of the legislative measures, and the situation generally, should be monitored to ensure that alcohol is not being supplied to under-18-year-olds in an illegal or irresponsible way.

Alcohol advertising and sponsorship (especially in the sporting context) are seen as particular problems, especially as the messages often target the young and impressionable. The Department of Health and Children established a working group to engage with relevant stakeholders and

sporting bodies to examine the extent of sports sponsorship by alcohol companies and to consider how the health-related concerns might be addressed. The working group is expected to report in autumn 2009. The Steering Group welcomes these developments.

Provision of recreational and other facilities for young people is considered to be important in preventing misuse of drugs and alcohol, and the Steering Group identifies the lack of such facilities and appropriate supporting structures across the country as a key gap. The Group believes that access to school facilities outside school hours should be progressed as a matter of urgency.

The Steering Group is of the view that there is a need to further develop and promote prevention strategies in a number of other key areas – third-level institutions, workplaces, sports and other community and voluntary organisations – using brief interventions where appropriate.

The development of a tiered or graduated approach to prevention and education measures in relation to drugs and alcohol is recommended. This approach would provide a framework for the future design of targeted prevention and education interventions.

Treatment and rehabilitation

The Steering Group endorses the view of the Working Group on Alcohol and Drug Synergies that greater coherence and co-ordination of alcohol and drug issues at policy, planning and operational levels are needed. With respect to treatment and rehabilitation, the Steering Group sees the re-orientation of all addiction services towards dealing with problem substance use as a key feature of the new strategy.

The Steering Group acknowledges that it is not possible to quantify the number of problem alcohol users requiring treatment. However, the significant difference between the number of alcohol-related hospital discharges and the number of reported cases receiving treatment for alcohol addiction indicates that there is a considerable cohort of problem alcohol users who could benefit from engagement with addiction treatment services.

The Steering Group believes that training in brief interventions needs to be rolled out across the healthcare service to maximise the impact of this cost-effective approach. Early interventions, targeted at hazardous and harmful users of alcohol, are designed to reduce alcohol consumption before dependence develops. There is strong evidence to suggest that brief interventions provided within various healthcare settings, including primary care, general hospital wards, mental health services and emergency departments, are effective in reducing hazardous and harmful alcohol use.

New drugs strategy published *(continued)*

Research and information

The Steering Group recommends the development of a research management framework in relation to problem substance use in Ireland. In relation to alcohol, it specifically recommends:

- the development of appropriate epidemiological indicators of problem alcohol use, and building on existing monitoring systems and prevalence surveys;
- measuring the impact of alcohol and drugs on the Irish health and justice systems; and
- monitoring problem substance use (including alcohol) among those presenting to hospital emergency departments.

(Johnny Connolly, Brian Galvin, Martin Keane, Jean Long, Suzi Lyons, Deirdre Mongan and Brigid Pike)

1. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016*. Dublin: Stationery Office.
2. Lyons S, Lynn E, Walsh S and Long J (2008) *Trends in drug-related deaths and deaths among drug users in Ireland, 1998–2005*. HRB Trends Series 4. Dublin: Health Research Board.

3. Organisation for Economic Co-operation and Development (2008) *Ireland: towards an integrated public service*. Paris: OECD.
4. Whelan P, Arnold T, Aylward A, Doyle M, Lacey B, Loftus C, McLoughlin N, Molloy E, Payne J and Pine M (2003) *Cross-departmental challenges: a whole-of-government approach for the twenty-first century*. Dublin: Institute of Public Administration.
5. Pike B (2008) *Development of Ireland's drug strategy 2000–2007*. HRB Overview Series 8. Dublin: Health Research Board.
6. The KPIs used to measure progress under the pillars in the NDS 2001–2008 were revised by the Steering Group that undertook the mid-term review of the drugs strategy.
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. Working group on drugs rehabilitation (2007) *National Drugs Strategy 2001–2008: rehabilitation*. Dublin: Department of Community, Rural and Gaeltacht Affairs.
9. Curran J (2009) Alcohol and drugs to be joined in a National Substance Misuse Strategy. Press release issued 31 March 2009 by the Department of Community, Rural and Gaeltacht Affairs.

Treated problem cocaine and opiate use, 2002–2007



Authors Delphine Bellerose and Anne Marie Carew at the launch of the HRB Trends Series papers on cocaine and opiate use

In the summer of 2009 the Health Research Board published two papers in its Trends Series, one on problem cocaine use¹ and one on problem opiate use.² The papers are based on data reported to the National Drug Treatment Reporting System (NDTRS). It is important to note that the NDTRS collects data on episodes of treatment, rather than the number of individual people treated each year. This means that individuals may appear more than once if they attend more than one treatment service in a year, and may reappear in subsequent years.

The main findings of the paper on treated problem cocaine use are:

- One-fifth (10,764) of all cases treated for problem drug use between 2002 and 2007, reported cocaine as a problem substance. The annual number of cocaine cases increased by 177%, from 954 in 2002 to 2,643 in 2007. This increase was in line with increases in cocaine seizures, cocaine use among the general population and cocaine-related deaths during the same time period.

- The number of cases who reported cocaine as their main problem drug increased by 502%, from 128 in 2002 to 770 in 2007. The number of cases who reported cocaine as an additional problem drug increased by 128%, from 826 in 2002 to 1,885 in 2007.
- The higher rates of new cases treated for cocaine as their main problem drug were in the north-eastern, south eastern and southern counties. The incidence of treated problem cocaine use was lower than expected in Dublin due to the fact that many problem cocaine users in Dublin also used opiates, and the opiate was categorised as their main problem drug while cocaine was categorised as an additional problem drug.
- Almost four out of five cases who reported cocaine as their main problem drug used more than one drug. Cocaine was used alongside opiates, cannabis, alcohol and ecstasy.
- There appears to be two profiles of cocaine user entering treatment, those who use opiates alongside cocaine and those who use combinations of alcohol, cannabis and/or ecstasy alongside cocaine.
- The majority of cases who reported cocaine as their main problem drug used it on two to six days per week, indicating that cocaine may be used as a week-end drug or during a binge.
- Half of the cases were under 27 years old, 83% were men and 33% were employed. The proportion of treated cocaine cases in employment was higher than the proportion of opiate cases in employment, 35% versus 13%, indicating that treated cocaine users were from a mix of social backgrounds.

Cocaine and opiate use *(continued)*

- The majority (69%) of cases were treated in outpatient services in 2007.
- There is a wide variety of interventions provided to cocaine cases, though until there is national data on treatment outcomes it is difficult to comment on the effectiveness of these interventions.

The main findings of the paper on treated problem opiate use are:

- In total, 11,392 cases were treated for problem opiate (mainly heroin) use in 2007, an increase of 29% on the figure of 8,804 in 2002. This increase in treatment provision is explained by a combination of factors, an increase in the number of treatment places, an increase in opiate use among the population and an increase in reporting to the NDTRS.
- This increase in treated problem opiate use was in line with increases in heroin seizures in 2005 and 2006, problem opiate use among the population and heroin-related deaths during the same time period.
- The rate of increase in new opiate cases was highest outside Dublin, and in particular in the midland, north eastern, and south eastern counties.
- The proportion of cases treated for opiates as a main problem drug who reported use of more than one drug decreased from 69% in 2002 to 63% in 2007. Between 2002 and 2007, cannabis, benzodiazepines and, in more recent years, cocaine were the most common additional problem drugs used alongside opiates. The use of additional drugs alongside opiates makes it more difficult to treat the addiction successfully.

- Of the 3,575 cases who entered treatment and reported opiates as their main problem drug in 2007, 52% smoked it, 40% injected it, and 4% consumed it orally.
- Between 2003 and 2007 decreasing proportions of cases reported that injecting was their primary route of administration, while correspondingly increasing proportions reported smoking opiates. This is a good news story indicating that harm reduction messages are being implemented and the transmission of blood-borne viruses will be reduced among this cohort.
- The majority of cases who reported an opiate as their main problem drug used it daily, indicating the addictive nature of the drug.
- In 2007, the vast majority (75%) of opiate cases entering treatment were cared for in outpatient services.
- There is a wide variety of interventions provided to opiate cases, including counselling, methadone maintenance, brief intervention, and medically assisted opiate detoxification.

(Anne Marie Carew and Jean Long)

These Trends Series papers are available online at www.hrb.ie/health-information-in-house-research/alcohol-drugs/publications/

1. Bellerose D, Carew AM, Lyons S and Long J (2009) *Trends in treated problem cocaine use in Ireland 2002–2007*. HRB Trends Series 6. Dublin: Health Research Board.
2. Carew AM, Bellerose D, Lyons S and Long J (2009) *Trends in treated problem opiate use in Ireland 2002–2007*. HRB Trends Series 7. Dublin: Health Research Board.

Treated problem alcohol use: figures for 2007

Figures from the National Drug Treatment Reporting System (NDTRS) for treated problem alcohol use in Ireland for 2007 by HSE area of residence are currently available on the HRB website.¹

Some of the main results are:

- 7,312 cases were treated for problem alcohol use in 2007, an increase of 1,436 on the 5,876 cases treated in 2006. This may be attributed to an increase in the number of people presenting for treatment, or it may reflect the increase in 2007 in the number of treatment centres participating in the NDTRS.
- The prevalence of treated problem alcohol use among 15–64-year-olds living in Ireland, expressed per 100,000 of the population, increased from 182.9 in 2006 to 222.6 in 2007.
- The incidence of treated problem alcohol use among 15–64-year-olds living in Ireland, expressed per 100,000 of the population, increased from 109.8 in 2006 to 118.3 in 2007.
- These increases in prevalence and incidence may be explained by an increase in problematic alcohol use in the population, an increase in reporting to the NDTRS, or a combination of both.

- One in five of those treated for problem alcohol use in 2007 also reported using at least one other substance, a similar proportion to that observed in 2006. The most commonly used additional drug was cannabis.
- In 2007, the median age at which both new and previously treated cases began drinking was 16 years, the same as in the previous three years.
- The median age of all treated cases was 39 years; for new cases, the median age continued to be slightly younger (37 years). While the overall proportion of cases under the age of 18 remained small, the numbers of previously treated and new cases in that age group continued to rise.
- The majority of those treated for problem alcohol use were male, with low levels of employment.

Significant improvements in the NDTRS data collection processes and procedures mean that the HRB is now able to report on the information collected from alcohol treatment services on a more regular basis.

(Suzi Lyons)

1. Alcohol and Drug Research Unit (2009) *Treated problem alcohol use in Ireland: figures for 2007 from the National Drug Treatment Reporting System*. Dublin: Health Research Board. Available at www.hrb.ie/publications/alcohol-drugs

Treated problem drug use: figures for 2007

Figures from the National Drug Treatment Reporting System (NDTRS) for treated problem drug use in Ireland for 2007 by HSE area of residence are currently available on the HRB website.¹

Some of the main results are:

13,620 cases were treated in 2007, of whom 5,977 entered treatment in that year. The majority of cases attended outpatient services.

The prevalence of treated problem drug use among 15–64-year-olds living in Ireland per 100,000 of the population increased by 4%, from 426 in 2006 to 445 in 2007.

New cases entering treatment are an indirect indicator of recent trends in problem drug use. The incidence of treated problem drug use among 15–64-year-olds living in Ireland per 100,000 of the population increased from 75 in 2006 to 80 in 2007.

An opiate (mainly heroin) was the most common main problem drug reported by cases entering treatment in 2007.

The majority (67.1%) of cases treated in 2007 reported problem use of more than one substance, which was slightly lower than the 2006 figure (71.1%). Alcohol was reported as an additional problem substance in 40% of all treated cases.

Many problem drug users in treatment are young and male, have low levels of education and are unlikely to be employed.

Almost 14% of all new cases treated in 2007 were aged under 18 years, a slight increase on the 2006 figure. Almost 3% of previously treated cases were aged under 18 years, as in 2006.

Significant improvements in the NDTRS data collection processes and procedures mean that the HRB is now able to report on the information collected from treatment centres on a more regular basis.

(Suzi Lyons)

1. Alcohol and Drug Research Unit (2009) *Treated problem drug use in Ireland: figures for 2007 from the National Drug Treatment Reporting System*. Dublin: Health Research Board. Available at www.hrb.ie/publications/alcohol-drugs

New information on polydrug use in Ireland

The fifth bulletin of results from the 2006/7 all-Ireland general population drug prevalence survey¹ (a follow-on from the first such survey in 2002/3²) focuses on polydrug use in the adult population (15–64 years) and patterns of polydrug use. The final achieved sample was 4,967 in Ireland. This represents a response rate of 65%.

For the purpose of Bulletin 5, polydrug use is defined as the use in the last month of two or more of the following substances: alcohol, tobacco, any illegal drug or any other legal drug (sedatives, tranquillisers or anti-depressants).

Just under one-fifth (19.6%) of the 4,967 survey respondents reported that they had not used any substance in the last month. Among those who had used drugs in the last month, the most common substance combinations were:

1. 26.5% had used alcohol and tobacco
2. 3.3% had used alcohol, sedatives or tranquillisers, and anti-depressants
3. 2.6% had used alcohol and at least one illegal drug
4. 2.4% had used tobacco and at least one illegal drug
5. 2.3% had used tobacco, sedatives or tranquillisers, and anti-depressants
6. 2.2% had used alcohol, tobacco and at least one illegal drug
7. 1.9% alcohol and sedatives or tranquillisers
8. 1.9% alcohol and anti-depressants

9. 1.6% had used alcohol, tobacco, sedatives or tranquillisers, and anti-depressants
10. 1.5% had used tobacco and anti-depressants

The combination of alcohol, tobacco and any illegal drug was more commonly reported by men (3.4%) than by women (0.9%). Thirty-one per cent of young adults (15–34 years) reported that they had used alcohol and tobacco, compared to 23% of older adults (35–64 years). The same relationship was observed among users of alcohol, tobacco and at least one illegal drug, with 3.8% of young adults and 0.8% of older adults reporting this combination.

The results of the polydrug use survey reflect substance use in recreational situations, rather than problematic substance use in socially deprived areas or among treated problem drug users.

(Jean Long)

1. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2009) *Drug use in Ireland and Northern Ireland. 2006/2007 drug prevalence survey: polydrug use results*. Bulletin 5. Dublin: NACD.
2. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2007) *Drug use in Ireland and Northern Ireland. 2002/2003 drug prevalence survey: polydrug use results*. Bulletin 5. Dublin: NACD.

Comptroller and Auditor General report on drug treatment

The Comptroller and Auditor General published a report entitled *Drug treatment and rehabilitation* on 6 June 2009.¹ The drug treatment services examined in this report were those caring for people with addiction to illegal drugs (mainly cannabis, cocaine, ecstasy and heroin). The report reviewed:

- the extent to which the demand for drug treatment and rehabilitation services is being met;
- the timeliness of access to drug treatment;
- the extent to which the effectiveness of drug treatment and rehabilitation services are evaluated; and
- the effectiveness of the arrangements for co-ordination of drug treatment and rehabilitation at an individual case level, and nationally.

This article presents the findings with respect to drug treatment.

Treatment for problem opiate use

It has been estimated that there were between 12,884 and 15,883 problem opiate (mainly heroin) users in Ireland in 2001. Up to 2000, opiate use was concentrated in the greater Dublin area, but at the time of this report there was evidence that it had spread throughout the country. Methadone substitution treatment is the main form of treatment for opiate addiction in Ireland. At the end of 2007, just over 8,000 people were receiving methadone treatment. Around one-third of those receiving methadone treatment are cared for by private general practitioners. Needle-exchange services are provided in some areas, with the aim of reducing the risks associated with the sharing of injecting equipment. According to this report, there was some increase in the provision of needle-exchange services between 2001 and 2009, but gaps in service provision remain. The authors report that in the period under review the numbers of opiate users who received detoxification treatment and the numbers who attended follow-on rehabilitation treatment were very low when compared with the numbers who received methadone treatment. They estimate that the extent of detoxification treatment provision was in the region of 100 courses of treatment per year. While the authors acknowledge that long-term methadone maintenance is likely to be the best outcome that can be achieved for a significant proportion of opiate users, they suggest that the HSE set targets for rates of progression through the various forms of treatment.

Treatment for problem drug use (excluding opiates)

The prevalence of cannabis and cocaine use among the general population increased between 2002/3 and 2006/7. The authors assume that the habitual use of a number of other drugs was also on the increase between the two survey time periods. The authors report that, despite this, there did not appear to have been a commensurate increase in the number of cases treated for problem use of cannabis over the life of the National Drugs Strategy. The findings of the review indicate that changes in the pattern of drug misuse (e.g. heroin addiction outside of Dublin and cocaine addiction in Dublin) created a challenge that service providers and planners found difficult to address. The review notes that many clients report multiple addictions. The current pattern of drug use suggests that there are, in effect, two separate client groups for whom drug treatment needs to be provided:

- those with a largely opiate-based addiction problem, with more than three in five reporting multiple drug use, concentrated in certain marginalised and poor sectors of society;
- those with problem use of drugs such as cannabis, cocaine and ecstasy, spread more widely across social groups and geographic areas.

Although the prevalence of illegal drugs such as cannabis and cocaine was higher in Dublin than in the rest of the country, the rate at which users of these drugs entered treatment appeared to be significantly lower in Dublin than elsewhere. The authors note that there is a risk that the uptake of addiction treatment reflects the available services in a geographical area rather than the needs of the people living in the area.

Demand for treatment

Accurate information about the level of demand for treatment for problem drug use is very important for service planning purposes. A database on treated drug and alcohol use in Ireland is compiled and managed by the Health Research Board (HRB). This database, the National Drug Treatment Reporting System (NDTRS), relies on treatment service providers to collect details on each individual who presents for treatment. The information is transmitted to the HRB, without personal identification details (e.g. name or address) of the individuals receiving treatment. The result is that while the number of courses of treatment delivered can be identified, it is not possible to track the progression of an individual from one service provider to another. The review notes that 'the NDTRS has the potential to generate better estimates of demand for treatment, but greater compliance by service providers with the NDTRS data input rules would be required if this is to be achieved.' The review recommends that ways of recording treatments sought and provided on an individual basis and in a manner that ensures security of the information. The authors go on to recommend that this should be tackled by the HRB in liaison with service providers and with the Data Protection Commissioner.

Access to treatment

This review reported that the NDTRS data may underestimate the extent of waiting for assessment. The practice in some areas is that recording of information for NDTRS purposes starts only at the time of assessment, rather than at the time of initial presentation or referral. Some service providers also operate 'informal' waiting lists, and call those on the informal list only when an assessment appointment becomes available. In addition, where drug users are aware of long waiting times for access to local services, they may be deterred from presenting for assessment. The HRB provides a protocol defining the terms *referral*, *assessment* and *treatment*, but needs to put more emphasis on ensuring that all service providers record information completely and accurately so that the true extent of waiting for treatment may be gauged. Subject to these limitations, analysis of NDTRS data indicates that an estimated 82% of those beginning methadone treatment in 2007 commenced treatment within the one-month target following assessment. In almost all cases treated for cannabis, cocaine or other stimulants, treatment was provided within the one-month target.

C & AG report on drug treatment *(continued)*

While a high proportion of individuals commenced treatment within the one-month target, approximately 460 people were recorded as waiting for methadone treatment in April 2008. The average waiting time for those on the lists in some areas was over a year.

A target of carrying out an assessment within three days of presentation (or referral) for treatment has been set. Of the opiate cases recorded by the NDTRS for 2007, an estimated 61% were reported to have been assessed within three days of initial presentation. Almost one in eight of those assessed were reported to have waited more than a month for their assessment. For persons presenting for assessment for problem cocaine use in 2007, 56% were recorded as having been assessed within the three-day target. Of those presenting for assessment for cannabis or stimulant use problems, less than 40% were assessed within the target time.

Effectiveness of treatment

Evaluation of treatment effectiveness is complex. Nonetheless, some sound and informative work has been done in relation to treatment of opiate addiction in Ireland. The ROSIE study² found that there had been reductions among those interviewed in the reported rates of illicit use of drugs and of involvement in crime after one year in treatment, and increased rates of employment and independent living after three years in treatment. No significant improvement in health status was noted.

The effectiveness of treatment for problem use of drugs other than opiates needs to be evaluated.

(Jean Long)

1. Comptroller and Auditor General (2009) *Drug addiction treatment and rehabilitation*. Special report, Value for Money 64. Accessed June 2009 at <http://audgen.gov.ie/viewdoc.aspx?DocID=1142>
2. The Research Outcome Study in Ireland (ROSIE) is a large-scale longitudinal study of outcomes achieved for a sample of over 400 people receiving treatment for opiate addiction or availing of needle exchange in 2003/2004. See www.nacd.ie/publications/ROSIE3-YearReport.pdf

Alcohol use among opiate users in methadone treatment

Ryder and colleagues estimated that 35% (95% CI = 28%–41%) of a sample of current or former heroin users attending general practice for methadone treatment were problem alcohol users, and that 14% of the sample were dependent users.¹ According to data from the National Drug Treatment Reporting System, 24% of opiate users entering opiate treatment reported alcohol as an additional problem drug, which is lower than the estimate presented here.

The authors surveyed 196 patients, which represented 8% of those on the Central Treatment List,² 31% of those sampled and 71% of those invited by their general practitioner to participate. The response rate was lower than desired – an indication of the difficulty than can be associated with doing research among patients attending private general practitioners in Ireland.

The survey questionnaire included the Alcohol Use Disorders Identification Test (AUDIT) to assess participants' alcohol use. The questionnaire also collected data on socio-demographic, medical and substance use characteristics. The median age of the 196 participants was 32 years, 68% were male, 79% said that they had used one or more illicit drugs in the previous month, and 76% had ever injected drugs. Of those who knew their blood-borne viral status, 55% said that they were hepatitis C positive and 5% said that they were HIV positive. Other research indicates that self-reported hepatitis C and HIV status can both over- and under-estimate the prevalence of these infections and should be interpreted with caution.

The cases classified as problem alcohol users were significantly more likely to have attended a local emergency department in the previous year and less likely to have attended a hospital clinic in the previous year compared to those who were not problem alcohol users. Among the 107 respondents who reported that they were hepatitis C positive, those who were problem alcohol users were significantly less likely to have attended a specialist hepatology clinic than their counterparts.

The authors concluded that problem alcohol use has a high prevalence among current or former heroin users attending primary care for methadone treatment, and that interventions that address this issue should be explored as a priority.

(Jean Long)

1. Ryder N, Cullen W, Barry J, Bury G, Keenan E and Smyth BP (2009) Prevalence of problem alcohol use among patients attending primary care for methadone treatment. *BMC Family Practice*, 10(42). Accessed on 14 July 2009 at www.biomedcentral.com/1471-2296/10/42
2. The Central Treatment List is a complete register of all patients in Ireland being prescribed methadone by a registered medical practitioner for the treatment of opiate misuse.

Morbidity among opiate users in methadone treatment

Cullen and colleagues completed a study of problem opiate users attending general practice for methadone treatment to estimate the prevalence of chronic illness and examine patterns of health service utilisation among this group compared with matched controls.¹ The cases and controls were matched for practice, age, gender and general medical service (GMS) status. Data were collected on a sample of 114 patients attending three general practices: 57 cases attending for methadone treatment (19 per practice) and 57 controls attending for primary care (19 per practice).

Illness among methadone cases

The average age of cases was 37.2 years, 42 (74%) were male, 41 (72%) had GMS cover, all were Irish nationals and 56 (98%) lived in stable accommodation. Considerable lifetime contact with the practice was observed: 16 patients (28%) had been attending the practice for less than five years, 21 (37%) for between five and 10 years, and 20 (35%) for more than 10 years. There were three reasons for initial contact with the general practice: registration for general medical care (20 patients), treatment of illicit drug use (20 patients), and referral by specialist addiction treatment services for methadone treatment (17 patients). All patients had been prescribed methadone by specialist addiction services prior to attending the general practice for methadone treatment, and 14 (25%) had been referred back to specialist addiction services since commencing methadone treatment at the

practice (six in the previous year). The average dose of methadone prescribed (based on the last issued prescription) was 66 mg daily.

Figure 1 presents a comparison of the morbidity profile and health service utilisation characteristics of patients on methadone compared to their matched controls. Fifty-two patients (91%) had one or more chronic illnesses (in addition to opiate dependence) documented in their clinical record. Hepatitis C (38, 66%), depression (20, 35%), asthma (14, 25%), HIV/AIDS (8, 14%) and DVT/varicose veins/thrombophlebitis (4, 7%) were the most common chronic illnesses recorded. Thirty-nine patients (68%) were on regular prescribed medication in addition to methadone. Thirty-one patients (54%) had had at least one acute condition during the previous three months, of which the most common were: upper respiratory tract infection (10, 18%), insomnia, anxiety or depression (4, 7%), abdominal pain (4, 7%), urinary tract infection (3, 5%) and ear wax (3, 5%). Tobacco use was noted in the records of 39 patients, of whom 37 were recorded as smokers. Twenty-five patients (44%) had been prescribed at least one time-limited medication (in addition to methadone) for the treatment of an acute illness during the previous three months. In the previous six months, patients had attended their GP for issues other than their addiction care an average of four times, and 27 patients (47%) had either been referred to or attended secondary care.

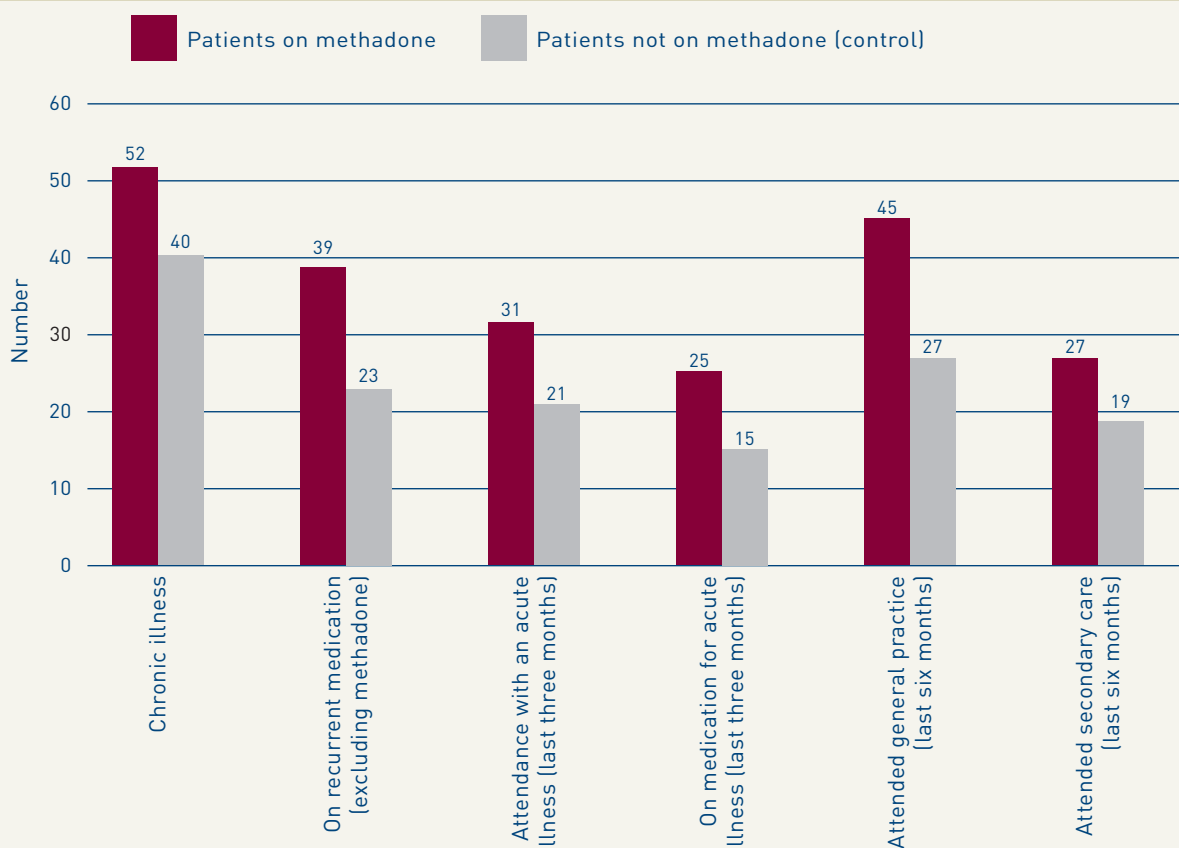


Figure 1 Comparison of morbidity profile and health service utilisation by patients on methadone and matched controls attending inner city general practices in Dublin

Morbidity among opiate users (continued)

Comparison with matched control group

The average age of controls was 37.2 years, 42 (74%) were male, 41 (72%) had GMS cover, all were Irish nationals and 38 (67%) lived in stable accommodation. Morbidity and health service utilisation rates were high among this group also (Figure 1). Patients attending for methadone treatment were significantly more likely to have a chronic illness, to be prescribed recurrent medication and to attend a general practice.

(Jean Long)

1. Cullen W, O'Brien S, O'Carroll A, O'Kelly FD and Bury G (2009) Chronic illness and multimorbidity among problem drug users: a comparative cross sectional pilot study in primary care. *BMC Family Practice*, 10(25). Accessed 14 July 2009 at www.biomedcentral.com/1471-2296/10/25

Alcohol affordability linked to harmful use

The European Commission (EC) commissioned RAND Europe to conduct a study on the affordability of alcohol products across the European Union (EU), and the potential impacts of affordability on harmful use of alcohol. The study's findings are presented in a report published in April 2009.¹

Alcohol is an important economic commodity in Europe, creating jobs, generating revenue in the form of alcohol taxes, and contributing around €9 billion to the EU economy through trade. However, alcohol is the third leading risk factor for death and disability in the EU, after tobacco and hypertension, and in 2003 it was estimated that the costs of alcohol misuse in the EU exceeded €125 billion.

The aims of this study were:

- to examine the link between the affordability of alcohol, alcohol consumption and alcohol-related harms;
- to study the impact of cross-border tax-driven or competition-driven price differentials, which are an important policy concern for the EU; and
- to examine the policy levers that can influence the affordability of alcohol.

In the past decade alcohol has become more affordable in all EU countries examined, apart from Italy. In six countries, including Ireland, affordability of alcohol increased by 50% or more. The analysis in this report indicates that, across the EU, 84% of the increase in alcohol affordability was driven by increases in income, and only 16% was driven by changes in alcohol prices. While incomes went up considerably across the EU, the relative price of alcohol has remained relatively stable, or has fallen at a slower rate than the income increases, in most of the EU countries included in this analysis.

Rates of excise duty on alcohol are not harmonised, and large variations in taxation exist across the EU despite the single European market and the introduction of minimum excise duty rates in 1992. Ireland, along with Sweden and Finland, has set higher rates on alcohol than other countries. However, except in the UK and Italy, the real value of alcohol taxation has decreased in the last decade across the EU.

There is a trend across the EU towards more off-trade alcohol consumption, which tends to be cheaper than alcohol sold on-trade. In the UK, Sweden, Finland, Latvia, Ireland and the Netherlands, off-trade alcohol sales appear to be growing relative to on-trade sales. This is true even in countries in which the market share of the on-trade has traditionally been larger, such as Ireland and the Netherlands. In Ireland, for example, the off-trade share of the alcohol market in

monetary terms grew from 19.1% in 1991 to 27.5% in 2000 and to 35.6% in 2006 (although, according to other estimates provided in the survey, the increase in the share of off-trade alcohol sales has been larger, from around 30% to 50% in the last five years). It is possible that one of the main reasons for the increase in off-trade alcohol consumption is lower prices. In Ireland, alcohol prices in the off-trade appear to be decreasing relative to on-trade prices.

Existing evidence indicates that there is a negative relationship between alcohol price and consumption, and a positive relationship between income and consumption. In accordance with these findings, the analysis presented in this report indicates that there is a statistically significant positive relationship between alcohol affordability (a composite measure looking at the effect of price and income) and consumption across the EU. More specifically, a 1% increase in affordability results in an increase of 0.32% in total consumption. These elasticities are symmetrical, that is, a 1% increase in affordability has the same degree of effect as a 1% decrease in affordability.

The report also noted positive, statistically significant associations between alcohol consumption and related harm. More specifically, it reported that a 1% increase in per capita alcohol consumption was associated with increases of 0.85% in fatal traffic accidents, of 0.61% in traffic injuries, and of 0.37% in the incidence of liver cirrhosis within the same year.

This and many other studies indicate that the price and affordability of alcohol impact on levels of harmful and hazardous alcohol consumption; policy-makers should therefore consider introducing alcohol-pricing policies as effective measures to **curb hazardous and harmful drinking in Europe**. As the problem is multi-factorial, policies aimed at influencing the price/affordability of alcohol should not be the only elements of a country's alcohol strategy. Other policies with a strong evidence base are also effective in reducing hazardous and harmful alcohol consumption, such as reducing alcohol outlet density, increasing minimum legal drinking ages, and enforcing drink-driving counter-measures.

(Deirdre Mongan)

1. Rabinovich L, Brutscher P, de Vries H, Tiessen J, Clift J and Reding A (2009) *The affordability of alcoholic beverages in the European Union: understanding the link between alcohol affordability, consumption and harms*. Cambridge, UK: RAND Europe. Available at www.rand.org/randeurope/publications.

Young people's exposure to alcohol marketing

The National Youth Council of Ireland (NYCI) launched the report *Get 'em young; mapping young people's exposure to alcohol marketing in Ireland*¹ on 9 June 2009. The aim of this project was to map (document, describe and provide examples) young people's exposure to alcohol marketing practices and to examine whether Ireland's stated commitment to protecting young people from the pressure to drink is reflected in the actual experience of young people.

In 2003, the alcohol industry set up a company (Central Copy Clearance Ireland Ltd) to vet and approve all alcohol advertisements to ensure the content was in line with the voluntary code of the Advertising Standards Authority of Ireland (ASAI) and the Broadcasting Commission of Ireland (BCI) code. In 2004, the alcohol and advertising industries introduced a voluntary code of practice regarding alcohol advertising which was endorsed by the Minister for Health and Children. Under this code, no alcohol advertisements would be shown during TV and radio programmes where more than 33% of the audience was under 18 years of age. When applied to outdoor advertising, 33% of all available space could be used for alcohol advertisements, in other words, no 'wrap rounds' are permitted. A revised voluntary code has been in place since mid-2008. The two main changes to the code are that the audience profile cut-off is now 25% instead of 33% and, where advertising is permitted, alcohol advertisements will be limited to 25% of the available space. While some changes have been made to the volume of alcohol marketing (supply side), no evaluation has taken place to assess whether these changes have provided any real protection for children, or what impact they have had on young people's decision to drink and how they drink (demand side).

Sixteen young people were selected from each province through the NYCI network and invited to participate in this research. There were more males than females in the group and the majority were aged 16–17 years. Three were aged 18–19 years to ensure that a full range of venues such as pubs/nightclubs could be included in the study. Data were collected in 2007 by a team of trained young people, supervised and supported by a youth leader and an alcohol researcher. Participants were asked to collect examples of alcohol marketing practices. Full details of the marketing practices observed (place, beverage type, brand name, marketing practice and its appeal) were recorded and, where possible, examples provided.

The main findings of the research project were:

- Sixteen communication channels that exposed young people to alcohol marketing practices were documented – the most commonly mentioned being television, magazines/newspapers, internet, street flyers, billboards and supermarkets/shops.
- Packaging of spirits and alcopops was considered the most attractive, with the shape and colour of the bottles and the colour of the product itself the main attractive features.
- Integrated marketing was common; two-thirds of the young people reported that they had seen the same alcohol products in a number of media channels.
- One in every four of the alcohol marketing practices recorded involved a price promotion, such as special offers, free alcohol, volume sales and deep discounts, with street flyers and supermarkets the main channels of communication.
- Of all the marketing practices recorded, six out of every 10 appealed to young people, with spirits, alcopops and three beer brands (Carlsberg®, Guinness® and Heineken®) having the most appeal.
- Marketing practices that appealed to young people occurred in all communication channels. Within the broadcast media, almost two-thirds of the marketing practices were appealing. In the case of outdoor media, six out of 10 marketing practices were considered appealing by young people.
- The elements of the alcohol marketing practices that particularly appealed to young people were humour, cleverness, cheap/free alcohol and attractiveness.
- Eight of the top 10 most appealing alcohol marketing practices agreed by the youth researchers were television advertisements. In addition a product placement (alcohol portrayal in film) and price promotion (8 beers for €8) made the top ten list.

Alcohol marketing has an impact on youth drinking and it is clear that young people in Ireland are exposed to marketing practices which can be described as pervasive through a variety of channels and on a regular basis. One in every four of the alcohol marketing practices documented involved price promotions which young people considered very attractive. Cheap alcohol, in the form of alcohol price promotions, has been shown to increase binge drinking in young people.

Despite the pre-vetting system for all alcohol advertisements, established by the drinking industry in Ireland in 2003, young people continue to find alcohol advertisements appealing, with humour, cleverness, cheap offers of alcohol and attractiveness the most effective elements. In addition, the introduction of audience profiling for the placement of alcohol advertisements by the drinks industry does not appear to have protected young people, given the range of alcohol advertising and promotion practices that young people documented.

The report concludes that there are over one million young people under 18 years of age in Ireland. These young people need adequate protection from an unnecessary exposure to risk – marketing practices that promote alcohol, a substance that carries serious health and social risks for young people.

(Deirdre Mongan)

1. National Youth Council of Ireland (2009) *Get 'em young: mapping young people's exposure to alcohol marketing in Ireland*. Dublin: NYCI.

Drug tests in Irish prisons

Information on drug testing in prisons in 2008 was obtained from the Irish Prison Service. These data indicate that more than 20,000 voluntary tests were carried out to monitor drug use and responses to treatment. These tests included those carried out on committals (new entries) as well as those carried out on existing inmates. It may be assumed therefore that some of the positive test results relate to drugs or alcohol consumed outside the prison.

Between one-third and one-half of those screened tested positive for at least one drug. The common metabolites detected indicated use of cannabis, benzodiazepines and opiates (Table 1). It is not clear whether the numbers of positive cases exclude prisoners who were prescribed

benzodiazepines; if they do not, these figures overstate the extent of unregulated use of benzodiazepine in prisons. Cocaine and alcohol were detected in a small number of tests. The profile of positive opiate and benzodiazepine tests indicated moderate use of such drugs among prisoners tested in Mountjoy, Wheatfield, Limerick, Midland and Cloverhill prisons. The proportion of positive tests was low in St Patrick's Institution and in Castlerea and Cork prisons. It would be useful if the test results of prisoners who were tested at committal interview could be removed from this analysis as this would provide a more accurate assessment of drug use in Irish prisons.

(Jean Long)

Table 1 Number of tests, by prison, and number (%) of positive tests, by prison and by drug type, 2008

Prison	No. of tests	Cannabis	Benzo diazepines	Methadone	Opiates	Cocaine	Alcohol	Amphetamines
		Number (%)						
Mountjoy Male	3279	1491 (45)	1619 (49)	3075 (94)	1714 (52)	46 (1)	12 (0.4)	22 (0.7)
Dochas Centre	2933	772 (26)	1692 (58)	2433 (83)	816 (28)	179 (6)	58 (2)	8 (0.3)
Training Unit	2849	31 (1)	17 (0.6)	0 (0)	23 (1)	2 (0.1)	14 (0.5)	8 (0.3)
Wheatfield	2552	1026 (40)	782 (31)	1886 (74)	913 (36)	18 (0.7)	15 (0.6)	3 (0.1)
Cloverhill	3191	853 (27)	1265 (40)	2292 (72)	1179 (37)	333 (10)	87 (3)	24 (0.8)
St Patrick's Inst.	2457	133 (5)	71 (3)	300 (12)	27 (1)	0 (0.0)	12 (0.5)	1 (0.04)
Castlerea	164	43 (26)	55 (34)	11 (7)	21 (13)	6 (4)	3 (2)	3 (2)
Loughan House	567	157 (28)	105 (19)	2 (0.4)	21 (4)	2 (0.4)	8 (1)	2 (0.4)
Shelton Abbey	887	214 (24)	118 (13)	7 (0.8)	38 (4)	5 (0.6)	23 (3)	9 (1)
Limerick	496	155 (31)	211 (43)	425 (86)	187 (38)	2 (0.4)	2 (0.4)	1 (0.2)
Cork	153	2 (1)	20 (13)	0 (0.0)	5 (3)	0 (0.0)	0 (0.0)	0 (0.0)
Midland	3452	785 (23)	892 (26)	3063 (89)	1423 (41)	58 (2)	14 (0.4)	11 (0.3)
Portlaoise	18	4 (22)	10 (56)	4 (22)	3 (17)	1 (6)	0 (0.0)	1 (6)
Arbour Hill	46	6 (13)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)

Source: Data provided by the Irish Prison Service

Fall in number of HIV cases associated with drug use

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1985. According to the most recent report of the Health Protection Surveillance Centre (HPSC),¹ at the end of 2008 there were 5,186 diagnosed HIV cases in Ireland, of whom 1,417 (27%) were probably infected through injecting drug use.

Figure 1 presents the number of new cases of HIV among injecting drug users reported in Ireland, by year of diagnosis; data from 1982 to 1985 were excluded from the figure as these four years were combined in the source records. Figure 1 is based on data reported to the Department of Health and Children, the National Disease Surveillance Centre and its successor, the HPSC. There was 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. There was a sharp increase in the number of cases in 1999 (69 new cases), which continued into 2000 (83 new cases). Between 2001 and 2008 there was an overall decline in the number

of new injector cases (38, 50, 49, 71, 66, 57, 54 and 36 respectively) when compared to 2000. It was difficult to interpret the trend owing to the relatively small numbers diagnosed each year, so a smoother curve (red plot line in Figure 1) was calculated using a rolling centred three-year average. This curve presents a new baseline of between 45 and 65 cases each year.

Of the 36 new HIV cases among injecting drug users reported to the HPSC in 2008, 27 were male and nine were female, and the average age was 33 years. Twenty-two of the 34 cases with a known address lived in the HSE Eastern Region (Dublin, Kildare and Wicklow).

(Jean Long)

1. O'Donnell K, Moran J and O'Hora A (2009) *HIV & AIDS in Ireland 2008*. Dublin: Health Protection Surveillance Centre. Available at www.hpsc.ie/hpsc/A-Z/HepatitisHIVAIDSandSTIs/HIVandAIDS/SurveillanceReports/

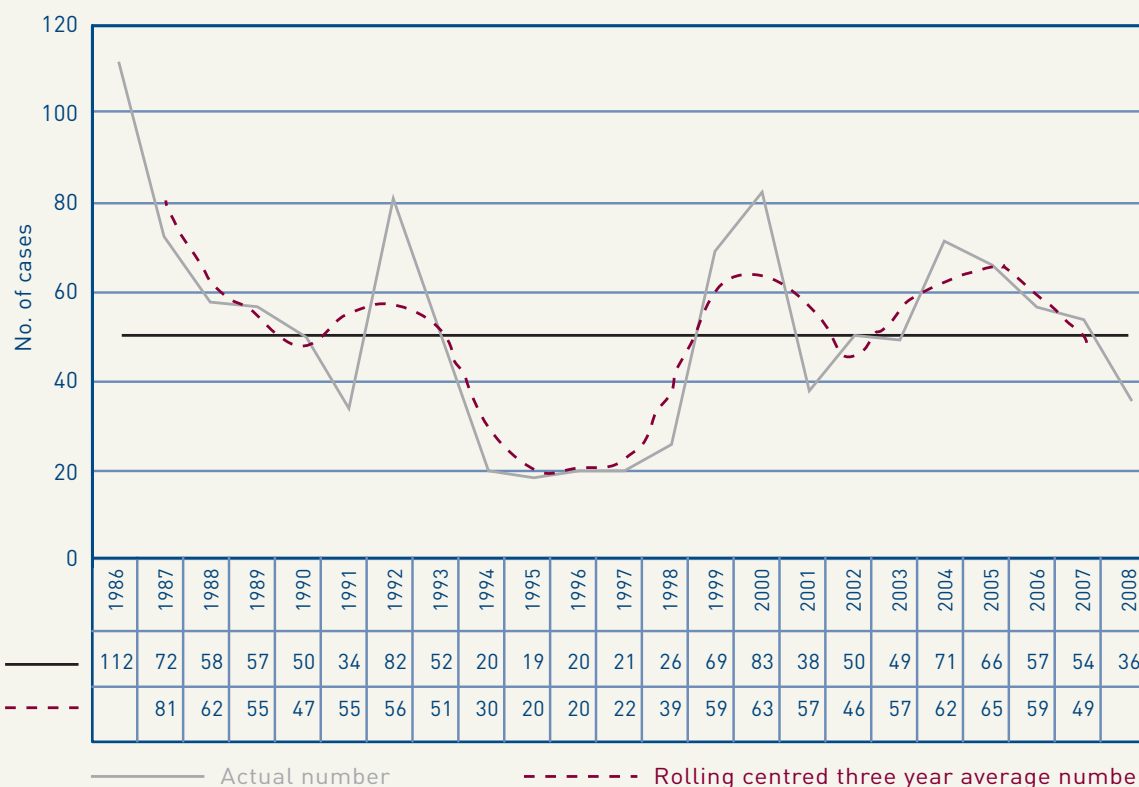


Figure 1 Actual number and rolling average number of new cases of HIV among injecting drug users reported in Ireland, by year of diagnosis, 1986 to 2008



Information leaflet on needle-exchange services

In July 2009, the HSE East Coast Area needle-exchange service launched an information leaflet for people who inject drugs. The aim of the leaflet is to encourage injectors not to share and never to re-use injecting equipment.

The leaflet includes advice about safer injecting practices and provides guidance on how to look after veins and limit vein damage. It stresses the importance of never sharing drug-taking equipment to help prevent the transmission or acquisition of hepatitis and HIV. While the main focus is on injecting drug use, the leaflet states that blood-borne viruses can also be transmitted or acquired by sharing snorting equipment.

Service users are encouraged to seek further advice from needle-exchange services, which are listed in the leaflet, with their opening hours and contact details. Services providing HIV/AIDS prevention strategies in the Dublin 4 area are advertised.

Drug treatment and counselling services in the Dublin South East, East Wicklow and Dun Laoghaire areas also are identified. For people seeking treatment and counselling services in other areas, a helpline number is given. The community addiction teams in the greater Dublin and East Wicklow areas are listed with their contact details.

John Craven, senior outreach worker in the HSE East Coast Area, designed the information leaflet. It was funded by the Dun Laoghaire Rathdown Local Drugs Task Force, and will be distributed to all Irish needle-exchange services. There are plans to evaluate the impact of the leaflet among service users.

(Janet Robinson)

For further information, contact John Craven at (01) 280 3335 or 086 859 0734

The Irish Needle Exchange Forum website was launched earlier this year as the first dedicated online resource for needle exchange services in Ireland. The site aims to provide those working in needle exchanges and related fields with a platform to initiate open, informed discussion and debate, and to identify and promote good practice in the development and delivery of needle exchange services.
www.inef.ie

Drug-using sex workers exposed to multiple risks and harms



A large-scale qualitative study has highlighted the need for adequately resourced support structures to reduce the risk of harm to drug-using sex workers in Ireland. The first of its kind, this study by the National Advisory Committee on Drugs (NACD) explored the local risk environment within which drug-using sex workers in Dublin live and work.¹ The authors conclude that wider social and situational factors, such as poverty, housing, health, educational needs and employment prospects, are as fundamental to reducing risk of harm in this vulnerable group as addressing drug use.

In-depth interviews were conducted with 35 drug users currently or formerly engaged in sex work, and biographical, drug use and offending behaviour data were collected by means of a brief questionnaire. In addition, interviews were held with 40 professionals across community, voluntary and statutory sectors whose work either directly or indirectly impacted on drug-using sex workers. This intensive, qualitative approach revealed that there is a range of behaviours associated with drug use and its accompanying lifestyle which place an individual at particular risk of harm.

For the most part, participants in the study grew up in communities associated with social and economic marginalisation and high levels of unemployment. They moved more or less continually through drug and alcohol services, homeless hostels, the judicial system and other social care agencies. Participants used a range of strategies to reduce danger, yet their perception of risk was relative to their situation, thus leading them to treat some risks as acceptable or necessary. Current harm reduction interventions tend to focus on individual risk behaviour, often overlooking the wider social contexts in which members of this group live and work.

Arising from analysis of the research, the NACD recommends:

- continued and adequate funding of existing services that deal with this client group;
- expansion of outreach services (particularly out of hours) to target existing and developing street sex markets, and development of peer outreach to areas of the city with known networks of drug-using sex workers;

Drug-using sex workers (continued)

- continued funding of programmes (such as specialist CE schemes for drug users) aimed at getting drug users back to work;
- provision of flexible hostel accommodation for drug-using sex workers who are homeless, ranging from low-threshold facilities to accommodation that assists recovery and rehabilitation;
- recognition of the role of drug services in identifying male and female clients involved in sex work and in providing advice on safer sex practices in order to reduce sexual risk in personal intimate relationships and commercial sex transactions.

In terms of policy, the authors recommend that 'harm reduction be explicitly stated as a guiding principle of the new National Drugs Strategy' (p.26), and that the strategy must also outline a continuum of harm reduction activities,

a 'model package' of interventions, minimum standards for services and optimal levels of service coverage.

Speaking at the launch of the report, John Curran TD, Minister with responsibility for drugs strategy, welcomed the research on this key 'at risk group', stating that it would inform developments in the new drugs strategy. He said he was committed to achieving real progress in harm reduction and drug rehabilitation, and acknowledged that significant strides forward were needed across several areas, such as medical support, housing, education, employment and family support.

(Mary Dunne)

1. Cox G and Whitaker T (2009) *Drug use, sex work and the risk environment in Dublin*, Dublin: National Advisory Committee on Drugs.

NACD conference on drug use, sex work and risk

In order to discuss and disseminate the findings of their recent report, *Drug use, sex work and the risk environment in Dublin*, the NACD held a half-day conference in June, chaired by Liam O'Brien, chairman of the NACD Consequences Sub-Committee.

Opening the proceedings, Minister John Curran welcomed the report and the opportunity it gives to make informed decisions using evidence-based research. He promised a varied, inter-agency response to meet the range of issues faced by this vulnerable group.

Following a presentation of key findings from the report by author Dr Teresa Whitaker, Dr Linda Cusick from the University of the West of Scotland spoke about sex-work-related harm. She questioned the narrow definition of harm reduction often used in the drugs field. When emphasis is placed on reducing harm to society, sex workers may feel targeted, and 'that they are the harm to be reduced'. Dr Cusick believes that interventions must start by attempting to identify relevant harms (as in the NACD report), and aim to reduce these not only through conventional methods but by extending human rights to this hidden and stigmatised group. Social, family and education polices all have a role to play.

Dr Kathryn McGarry from Trinity College Dublin presented findings from her research for a PhD thesis on the lived experiences of women in sex work. Risk emerged as a key concept in the course of this research. Dr McGarry highlighted the importance of the social networks of drug-using sex workers. Although not all women wish to collaborate with each other, and networks can expose them to harms such as needle sharing, peers are vital for risk management, working as look-outs to limit exploitation and educating ('telling risks to') each other. Peer-led harm reduction strategies therefore offer a positive and enabling resource for harm reduction efforts.



Dr Teresa Whitaker, Minister John Curran and Dr Kathryn McGarry at the launch (Photo courtesy of NACD)

A range of voluntary and statutory agencies currently works closely with drug-using sex workers and the conference heard from representatives from the Women's Health Project (Linda Latham), the Gay Men's Health Service (Mick Quinlan), Chrysalis (Karen Murphy), and Novas (Mark Vella). These projects offer a range of health and social services that help drug-using sex workers minimise risk. The importance of outreach work to connect with all members of this community, and the challenge to reduce prejudice against this doubly stigmatised group, emerged as key themes.

(Mary Dunne)

The conference proceedings are available on the NACD website at www.nacd.ie.

Review of progress in addressing suicide in Ireland

A Joint Oireachtas sub-committee was established in 2005 to examine in detail the issue of suicide in Irish society; to engage with those who work in suicide prevention; and to hear evidence from those involved in post-suicide counselling and support. According to the World Health Organization, suicide is among the three leading causes of death worldwide among people in the 15–44-year-old age bracket. In 2004, there were 27.1 deaths/100,000 population among men in Ireland, compared to 6.1 in England. For females the rate was 2.9/100,000 population, compared to 1.7 in England. Youth suicide rates in Ireland are the fifth highest in the European Union.

The sub-committee's report, *The high level of suicide in Irish society*, was published in 2006¹ and accepted for implementation. It provided detailed information on the extent of suicide in Ireland and made 33 specific recommendations on how to address the problem. An updated report by a new sub-committee, published in June 2009,² reviewed the extent to which these recommendations have been implemented, and identified the obstacles that have prevented their implementation (Table 1).

Very limited or no substantial progress was reported on implementing those recommendations dealing with the building of evidence around suicide through research and information gathering. These recommendations include agreement on a national programme of research into self-harm, suicide and suicide prevention, the establishment of a technical group to link and exchange data between relevant national information systems, including the National Drug Treatment Reporting System and the National Drug-Related Deaths Index, and the publishing of suicide research guidelines for donors providing funding.

Similarly limited progress was reported regarding recommendations on making more information available to people at risk of suicide, to the general population, to

specific groups such as school children, and to groups and individuals who could play a role in suicide prevention such as teachers, voluntary organizations, primary care teams and mental health staff. However, there was some progress in the organisation of consultation with young people and in the provision of information by primary care services to those bereaved by suicide.

More progress was achieved in the development of services such as a pilot fast-track referral systems from primary care to mental health services for suicidal individuals and the development of a service plan for bereavement services. Other recommended services, including a coordinated response from various voluntary agencies working in the area of suicide bereavement support and a standardized pre-discharge and transfer between mental health services, have not been developed.

It appears that many of the recommendations outlined in 2006 have not been progressed at all. In addition, the few recommendations that have been completed or mostly completed now need financial resources and political drive in order to develop and implement their findings. The report concludes that immediate change is required to properly address the ongoing serious problem of suicide in Ireland. The National Office for Suicide Prevention needs adequate and sustained funding, a higher level of interagency collaboration, and the requisite political support if it is to have any chance of fully implementing the recommendations made in the 2006 Oireachtas report.

(Deirdre Mongan)

1. Joint Committee on Health and Children (7th Report) (2006) *The high level of suicide in Irish society*. Dublin: Houses of the Oireachtas.
2. Joint Committee on Health and Children (2009) *The high level of suicide in Irish society*. First report. Dublin: Houses of the Oireachtas.

National Registry of Deliberate Self Harm annual report 2008

The seventh annual report from the National Registry of Deliberate Self Harm was published in July 2009.¹ The report contains information relating to every presentation of deliberate self-harm to hospital A&E departments in 2008, giving complete national coverage of hospital-treated deliberate self-harm. The Registry defines deliberate self-harm as 'an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or physical consequences'.

According to the report, there were 11,700 presentations of deliberate self-harm, involving 9,218 individuals, to A&E departments in 2008. Reviewing data for the six-year period

2002–2007, the report indicates that the rate of presentation was relatively stable. However, a 6% increase was noted in the national person-based rate per 100,000, which rose from 188 in 2007 to 200 in 2008.

The biggest rise in deliberate self-harm was observed in men, an increase of 11% on the 2007 figure, resulting in the highest rate since the Registry was established in 2002. Men accounted for 45% and women for 55% of deliberate self harm episodes in 2008.

Concordant with previous reports, deliberate self-harm was largely confined to the younger age groups. Almost half of all presentations (46.5%) were by people aged under 30 years. The peak age ranges for females and males presenting were the same as in previous years, at 15–19 years for females and 20–24 years for males. There was an increase in the number of 10–14-year-olds presenting.

National Registry report (continued)

Rates were higher in urban settings, with the highest rate (17%) presented in Dublin North East Hospital Group. The number of presentations was highest on Mondays and Sundays, accounting for one in three of all presentations. Over 40% of all presentations were made between the hours of 8 pm and 3 am.

Repetition of deliberate self-harm accounted for more than one in five (21%) of all presentations in 2008, and the highest proportion of repeated acts was among the 30–40-year age group.

Drug overdose was the most common form of deliberate self-harm, representing 72% of all such episodes reported in 2008. Overdose rates were higher among females (79%) than among males (64%). On average, at least 31 tablets were taken in episodes of drug overdose. The total number of tablets taken was known in 74% of cases. Forty-one per cent of all drug overdoses involved a minor tranquilliser, 23% involved paracetamol-containing medicines and 22% involved anti-depressants/mood stabilisers. The report points out that, despite its withdrawal from the Irish market in January 2005, the analgesia, distalgesic, was involved in 29 cases of deliberate self-harm in 2008, this compared to approximately four hundred cases reported annually between 2002 and 2005.

There was evidence of alcohol consumption in 42% of all episodes of deliberate self-harm, emphasising the strong association between alcohol consumption and suicidal behaviour. Illicit drugs such as cocaine and heroin were involved in 3.8% of all overdose acts.

Attempted hanging was more often used as a method of deliberate self-harm in 2008 than in previous years, accounting for 16% of all self-harm acts in the 10–14-year age group. Self-cutting represented 21% of all episodes of self-harm, and was more common among males (25%) than among females (18%).

The emergency department was the only treatment setting for more than half (57%) of all deliberate self-harm patients, that is, they did not proceed to further treatment.

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

- Provide continued support for the national mental health awareness campaign and evidence-based mental health promotion initiatives and implementing more intensified prevention and intervention programmes at national level.
- Develop and implement initiatives to increase awareness of mental health issues among the general public and service providers supporting the unemployed or people experiencing financial difficulties.
- Develop a system to enable deliberate self-harm data to be linked with suicide mortality data to improve our understanding of risk factors associated with suicide.
- Prioritise evidence-based mental health programmes for children and adolescents, in addition to specialist mental health services.
- Develop more uniform assessment procedures and evidence-based interventions targeting people who repeatedly self-harm.
- Restrict or withdraw highly lethal drugs from the market.
- Verify whether interventions such as cognitive behavioural and problem-solving treatments found to be effective among women can be equally so among men presenting with deliberate self-harm.

(Ena Lynn)

1. National Registry of Deliberate Self Harm Ireland (2009) *Annual report 2008*. Cork: National Suicide Research Foundation.

Poisons Information Centre annual report 2008

The Poisons Information Centre, located in Beaumont Hospital, is the national information service providing advice on the features and management of poisonings. This service is provided 24 hours a day 365 days a year and is offered mainly to health care professionals. Queries are dealt with by poison information officers at the Centre between 8 am and 10 pm; out-of-hours enquiries are re-directed to the UK National Poisons Information Service (NPIS). The 2008 report includes analysis of all enquiries made to the centre, including, for the first time, Irish calls handled by the UK service.¹

In 2008 the centre received 10,494 enquires, a reduction of 4.7% on the 2007 figure. An average of 28 calls a day was received, with a peak call time between 6 pm and 9 pm. There were 9,911 (94.4%) enquires in relation to poisoning in humans, 442 (4.2%) in relation to poisoning in animals, and 141 (1.3%) general enquiries. Enquiries were mainly from hospitals (38%), general practitioners (35%) and members of the public (22.1%).

Of the enquiries relating to poisoning in humans, 4,985 (50.3%) involved children under 10 years old, with a peak age of one to four years [4,087 (41.2%)]. The majority of incidents occurred in the home (89.9%). In the total of 9,911 enquiries involving human poisoning, 16,936 agents were involved. The most common substances taken were paracetamol, ibuprofen and codeine. Ethanol was ingested in 634 cases, often in combination with another substance. The majority of cases, 5,681 (57.3%), were reported as accidents, while a quarter, 2,491 (25.1%), were classed as intentional poisoning or recreational abuse. The remainder were classed as therapeutic error, adverse reaction, other and unknown.

(Simone Walsh)

1. Poisons Information Centre of Ireland (2009) *Annual Report 2008*. Dublin: Poisons Information Centre. www.poisons.ie

A training programme in dual diagnosis

The clinical nurse specialist (CNS) in addictions based in the Central Mental Hospital in Dublin has played a key role in developing a pathway of therapeutic group programmes for people with a dual diagnosis of mental illness and substance abuse.

Dual diagnosis is a very recent concept in the Irish mental health service. The concept was highlighted by MacGabhann and colleagues,¹ who recommended incorporating training for dual diagnosis into undergraduate and continuing education programmes for those working in addiction and mental health services. Because such training is not widely available in Ireland, an innovative five-day training programme was developed by Hanora Byrne, CNS in addictions at the Central Mental Hospital, and Dr Shobha Rani, lecturer in nursing at Trinity College Dublin. The programme has been awarded category 1 approval by An Bord Altranais.

The programme development was based on a six-step approach devised by Kern and colleagues.² The six steps are: problem identification, needs assessment, objectives, implementation, educational strategies and evaluation. Analysis of a needs assessment involving 20 psychiatric nurses and 20 probation officers showed that it was clearly necessary to develop a training programme in dual diagnosis.

The main objectives of the programme were to provide information on dual diagnosis and the treatment programmes that can be applied in service delivery. The programme has four modules delivered through lectures,

group discussions, role play, video recording and feedback, and vignettes. A workbook was developed to accompany the delivery of the training.

The first training programme was run on one day a week for five weeks at the end of 2008. It was delivered by the CNS and members of the multidisciplinary teams within the Central Mental Hospital, including Prof Harry Kennedy, the clinical director, and Paul Braham, the director of nursing. Participants were assessed using formative evaluation tools, such as questions and answers and three short written assignments. The course was evaluated using the following: pre- and post-test evaluation, daily evaluation by the participants, and a focus group carried out 12 weeks after the course completion. The programme co-ordinators envisage running an annual one-day refresher course.

The next training programme is scheduled for early October 2009 in the National Forensic Mental Health Service, Central Mental Hospital, Dundrum, Dublin 14. For more information, contact Hanora Byrne at 01-2157556; email: hanora.byrne@hse.ie

(Hanora Byrne)

1. MacGabhann L, Scheele A, Dunne T et al. (2004) *Mental health and addiction services and the management of dual diagnosis in Ireland*. Dublin: Stationery Office.
2. Kern D, Thomas P and Howard D (1998) *Curriculum development for medical education: a six-step approach*. Baltimore, MD: Johns Hopkins University Press.

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

In July 2009 the European Foundation of Drug Helplines (FESAT) published the results from the 15th and 16th data collections for its monitoring project.^{1,2} Since the beginning of 2001 FESAT has been collecting information every six months on the types of person contacting helplines, the content of these calls and how this has changed compared to the previous six months. According to the author, the main objective of this monitoring is to identify the emergence of new drugs and new drug trends; the data cannot quantify the size of any such changes.

Of the 34 relevant FESAT helplines, 14 helplines in 11 countries, including Ireland, participated in the project in the first half of 2008. This article outlines some of the main changes reported for the first half of 2008 when compared to the second half of 2007, and presents some unpublished information from the Drugs/HIV Helpline in Ireland.

The smallest of the 14 participating helplines in Europe answered less than one call per day, and the largest, more than 60 calls per day. Seven helplines answered 10 calls or fewer per day; six helplines answered 11 to 30 calls; one helpline answered 31 to 60 calls and one helpline answered 61 or more calls. Half of the helplines answered 13 or more calls per day. The Drugs/HIV Helpline in Ireland answered an average of 14 calls per working day, though this figure

included calls about sexual health. There were 1,805 calls between January and June 2008, which represents an 8% decrease when compared to the preceding six-month period. This decrease was expected due to the fact that there was an increase in the number of calls during the pharmacy strike in October 2007 (Aileen Dooley, personal communication, 2009).

The FESAT report notes a decline in the numbers of helplines reporting calls about crack (9 helplines), heroin (6 helplines), ecstasy (6 helplines), cocaine (4 helplines) and hash (4 helplines) across Europe in the first half of 2008 when compared to the second half of 2007, and an increase in the number of helplines reporting calls about alcohol (10 helplines) and medications (other than opiates and benzodiazepines) (7 helplines) and benzodiazepines (4 helplines). There were mixed reports about cocaine and cannabis across Europe, with some helplines reporting increases and some reporting decreases.

In Ireland, there were large decreases in the number of calls to the Drugs/HIV Helpline about hashish and painkillers containing opiates in the first half of 2008 when compared to the second half of 2007. There were large increases in the number of calls about alcohol, cocaine, ecstasy and smoking heroin (Aileen Dooley, personal communication, 2009).

Identifying new drugs *(continued)*

During the first half of 2008, a number of helplines in Europe received calls about drugs that had not been reported to them before. Helplines in Belgium and in Germany reported calls about the 'spice' products which are used to induce the same effect as cannabis. A helpline in Belgium received calls about 'space shuttles', which are in the form of mushrooms or herbs. A helpline in Norway received its first call about mescaline, a hallucinogenic drug.

(Jean Long)

1. Evenepoel T (2009) *FESAT Monitoring Project – Report on the 15th data collection: changes during the second half of 2007*. Brussels: FESAT (The European Foundation of Drug Helplines).

2. Evenepoel T (2009) *FESAT Monitoring Project – Report on the 16th data collection: changes during the first half of 2008*. Brussels: FESAT (The European Foundation of Drug Helplines).

More information about FESAT can be found 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. The freephone number is 1800 459 459. The Helpline manager is Aileen Dooley.

Ana Liffey's SMS service for drug users

On 30 June 2009 the Ana Liffey Drug Project launched the 'Duck, Dive and Survive' SMS service. This service enables Ana Liffey to offer real time information on reducing the risks associated with drug use and provide essential health and service-related information. There is a high rate of mobile telephone use among Ana Liffey's clients and this innovative approach adopts this technology to communicate with people who use drugs.

Ana Liffey used the special bursary it received as winner of the New Initiatives category of the Crystal Clear MSD Health Literacy Award 2009 to establish the service.

Information provided by SMS includes:

- changes to opening times of key services;
- advice on overdose risks and prevention, particularly during festive/holiday periods which Ana Liffey suspects are times when overdoses are more likely;
- new trends and dangers relating to illicit drug use – the North Inner City Drugs Task Force will use the SMS service to get key information to service users;
- information from service users – Ana Liffey works with the service users' 'Peer Support Group' to identify key messages to be sent to their peers.

An example of a group text message sent to people who attended the Ana Liffey project during June 2009 is:

OVERDOSE: Don't panic. Put them in the recovery position, dial 999, ask for an ambulance and stay with them until the ambulance arrives. Ana Liffey: 1800786828

Following feedback from service users, the providers of the service realised that, to be effective, the messages sent must get to the point quickly and should ideally name the issue and the action to be taken. Messages can be no more than 160 characters (including spaces) to allow for the message to be sent in one go. Messages can be personalised by having the person's first name appear at the beginning of the text, but this also uses up text characters.



A total of 2243 text messages were sent during the first 13 weeks after the launch of the service, and by mid-August 73 Ana Liffey service users had signed up.

The Swansea Drugs Project (Wales) has followed the example of the 'Duck, Dive and Survive' SMS service and they are establishing an SMS service of their own.

To date, messages have been developed in a reactive way, addressing issues identified by the Ana Liffey team and external issues affecting the client group. A reactive service is necessary, and is one of the strengths of such a mass communication tool. However, the next phase of SMS delivery will involve the development of targeted health campaigns sent at strategic times. This campaign will build on the success of the texts as developed to date.

(Tony Duffin (ALDP) and Brian Galvin)

New NDC website

The National Documentation Centre on Drug Use (NDC) launched its new website in July. The NDC adapted Eprints, an application used to develop research repositories in universities around the world, to create the new system. It allows the NDC to integrate all its digital collections in one easily searchable database.

The new site www.drugsandalcohol.ie is a repository of Irish research outputs in alcohol and drugs. Any of the repository's 1,000 documents or the 7,000 news items, bibliographical records and reports of parliamentary debates can be retrieved using a simple search function.



Regularly updated news stories and records of new library acquisitions are available on the home page, and various key resources, including the annual national report on the drug situation in Ireland, fact sheets and the NDC newsletter, are made available with just one click on links on the home page.

Visitors can search the entire website using a simple search function on the home page or, for more experienced users, an advanced search can be used for more refined searching. The search result displayed below shows how the repository's records and full text material are presented after a search.

One of the key aims of Ireland's National Drugs Strategy 2001–2008 was to make available 'valid, timely and comparable data on the extent and nature of drug misuse in Ireland'. It is important that high-quality research information is made accessible to, and informs the work of, policy-makers, service planners and service providers. The NDC's new website will help to strengthen its contribution to this process of knowledge transfer during the implementation of the new drugs strategy.

(Brian Galvin)



In brief

On 24 April 2009 *Fear of crime in Ireland and its impact on quality of life* was published by the **Department of Justice, Equality and Law Reform**. The research had been commissioned by the former **National Crime Council**.¹ The authors reported that a relationship was found between illicit drugs and concerns and fear about lawlessness and crime. They also observed a relationship between fear of crime and perceptions regarding the penalties for possession of 'soft' and 'hard' drugs, and between fear of crime and respondents' beliefs regarding how drug abuse and juvenile crime should be dealt with. www.justice.ie

On 13 May 2009 the **Economic and Social Research Institute** published *Investing in education: combating educational disadvantage* (Research Series No 6). The findings show that education is highly predictive of individual life-chances in Ireland: a Leaving Certificate qualification has become the 'minimum' to secure access to further education/training and high quality employment, among other outcomes. www.esri.ie

On 13 May 2009 the **Health Service Executive** published *LGBT health: towards meeting the health care needs of lesbian, gay, bisexual and transgender people*, a report of the findings from a mapping exercise undertaken for the HSE national social inclusion governance group. The report highlighted particular health issues experienced by the LGBT population, including the health impacts of higher levels of smoking, alcohol consumption and recreational drug use. A high incidence of mental health problems, including depression, anxiety, substance misuse, self-harm and suicide, was also reported. www.hse.ie

On 14 May 2009 the **Report of the Inspector of Mental Health Services for 2008** was published, together with the **Annual Report of the Mental Health Commission for 2008**. The Inspector reported that the management of alcohol-related problems was inconsistent: some consultant psychiatrists saw it as the function of the Mental Health Service to provide detoxification, whereas best practice would indicate that this should be carried out either in general hospitals or in primary care. Despite absence of an evidence base that residential alcohol treatment is more successful than outpatient programmes, many centres continued the 'resource-sapping' practice of hospitalisation. With regard to addiction psychiatry, the Inspector wrote that there is a clear need for mental health professionals to become and remain well versed in the problems associated with substance dependence, and identify and refer to the addiction services those patients where this is the primary problem. www.mhcirl.ie

On 21 May 2009 the **National Commission on Restorative Justice** published its Interim Report. The Report examines how restorative justice is applied in Ireland and in other jurisdictions and points to the research-based evidence abroad on the potential of restorative justice to combat crime. The Commission is due to publish its final report, with recommendations, later in 2009. www.justice.ie

On 26 May 2009 **foetal alcohol spectrum disorders** were the subject of an adjournment debate in Dáil Éireann. Deputy Áine Brady stated that, in order to create greater awareness of the risks, the Health Service Executive (HSE) has published a booklet entitled *Women and alcohol*, including advice to women to avoid alcohol in pregnancy, and the Department of Health is devising legislation to provide for mandatory labelling of alcohol containers advising of the

risk of consuming alcohol during pregnancy. The HSE is also developing proposals for a new research project in a large maternity hospital to follow a cohort of women who drink alcohol during pregnancy in order to evaluate the impact on the infant's condition at birth and subsequent development. (www.oireachtas.ie)

On 10 July 2009 the **2008 Annual Report from the Alcohol Marketing Communications Monitoring Body (AMCMB)** was published. The AMCMB was established to monitor the level of adherence by advertisers and media owners to the Codes of Practice on Alcohol Marketing, Communications and Sponsorship. The Codes are intended to limit the exposure of children and young people to alcohol advertising in Ireland. The AMCMB concluded that there had been overall compliance in 2008. However, noting a number of breaches, it considered that the media partners to the Codes should ensure that they have proper procedures in place to prevent breaches occurring. www.dohc.ie

On 14 July 2009 the **Irish Youth Justice Service (IYJS)** published *Designing effective local responses to youth crime: a baseline analysis of the Garda Youth Diversion Projects*. The first part of an improvement programme for Garda Youth Diversion Projects, this baseline analysis provides a qualitative profile of youth crime in each locality and analyses the way that Garda Youth Diversion Projects intend to effectively impact upon youth offending. Currently there are 100 projects located around the country, representing a €13 million investment annually in youth crime prevention. www.iyjs.ie

On 23 July 2009 the **Courts Service annual report for 2008** was released. It reported among other matters that drug offence cases before the District Court had increased by 58% – to 15,658 from 9,870 in 2007 – and that 18% of cases before the Circuit Court were for drug offences. www.courts.ie

In July 2009 three new pieces of criminal justice legislation were enacted targeting organised crime:

- **Criminal Justice (Miscellaneous Provisions) Act 2009** makes provision for a statutory framework for the licensing of firearms, including handguns, which seeks to halt the emergence of a gun culture in Ireland.
- **Criminal Justice (Amendments) Act 2009** provides for additional measures with respect to combating organised crime and, in particular, with respect to countering the increased levels of violence towards, and intimidation of, members of the public perpetrated by criminal organisations and securing conditions in which offences committed by those associated with such organisations can, in due course of law, be investigated and prosecuted, and to amend the law in relation to the investigation of offences, including in relation to the detention of suspects and their re-arrest in certain circumstances, and to otherwise amend criminal law and procedure.
- **Criminal Justice (Surveillance) Act 2009** provides for a statutory framework for evidence obtained using covert surveillance which is to be used in criminal trials. It gives the Garda, Defence Forces and the Revenue a legal basis for surveillance to combat serious criminal, subversive or terrorist activity, and provides for a judicial authorisation procedure for surveillance. www.justice.ie

(Compiled by *Brigid Pike*)

1. The National Crime Council ceased operations in October 2008.

From Drugnet Europe

CLAT 5: Globalisation, harm reduction and human rights

Article by Dagmar Hedrich in Drugnet Europe No. 67, July–September 2009

Over the last two decades, harm reduction has become a recognised component of a comprehensive approach to drugs. Examining its future and taking stock of achievements was the focus of the 5th Latin conference on harm reduction (CLAT 5),¹ held in Oporto from 1–4 July. Organised in association with the EMCDDA, the conference brought together over 600 participants from Europe and the Americas to debate the theme ‘Globalisation, harm reduction and human rights’.

Speakers at the event provided critical analyses of the benefits brought by harm reduction interventions to individuals and society to date. While acknowledging progress, they questioned the current consensus that policies and practice be rooted largely in public health concerns and restricted to local micro-interventions aimed at reducing the health risks of drug use. Central to the debate was the need for harm reduction also to address more global concerns such as discrimination, vulnerability and inequality (North–South, East–West), which are often key factors underlying drug problems. It was argued that the risks associated with drug use were often more linked to social, cultural and historical conditions than to the substances themselves. By setting in the context of human rights our current responses to drug production, trafficking, consumption and harm, the debate was given an important new dimension and its horizons were broadened well beyond Europe.

1. CLAT is the result of collaboration between five countries: Spain, France, Italy, Portugal, Switzerland.
www.clat5.org/en/clat5_objective.php

Annual KBS symposium

Article by Linda Montanari and Margareta Nilson in Drugnet Europe No. 67, July–September 2009

Alcohol-related harm, drinking practices and social and institutional responses were among the issues discussed at the 35th annual alcohol epidemiology symposium of the Kettil Bruun Society (KBS), held in Copenhagen from 1–5 June. KBS is an organisation of scientists which promotes social and epidemiological research on alcohol and fosters a comparative understanding of alcohol use and related problems.

Although alcohol is the main focus of the event, space is also allocated to quantitative and qualitative research on other substances, such as tobacco and illicit drugs, including polydrug use. On the latter, the EMCDDA presented European data on polydrug use among clients in treatment, which confirm that alcohol is most often reported as the secondary substance used in combination with other drugs. The EMCDDA stressed the need to consider the health and social consequences of polydrug use when planning policy and interventions and the importance of improving the quality of polydrug use data at European level.

www.kbs2009.dk/abstracts-kbs2009.pdf

Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). *Drugs in focus* is a series of policy briefings published by the EMCDDA. Both publications are available at www.emcdda.europa.eu.

If you would like a hard copy of the current or future issues of either publication, please contact: Alcohol and Drug Research Unit, Health Research Board, Knockmaun House, 42–47 Lower Mount Street, Dublin 2. Tel: 01 2345 127; Email: adru@hrb.ie.

Drugs in focus – policy briefing

No. 19: Neurobiological research on drugs: ethical and policy implications

Most neurobiological research to date has focused on the fact that addictive drugs increase the release of dopamine, a neurotransmitter which helps individuals memorise signals of pleasure or ‘reward’. New findings suggest that serotonin and noradrenaline (which work as a couple controlling impulsivity and asserting vigilance) are also involved in the addiction process. This briefing describes how chronic drug use disrupts this coupling, making a person more prone to cravings and less capable of controlling consumption.

The briefing concludes with a series of policy considerations:

1. Neuroscience has the potential to improve our understanding of addiction, possibly leading to new forms of treatment. There is a need to continue supporting studies in this area, whilst reviewing how European research can be encouraged and best organised.
2. The assumption that repeated consumption of drugs of abuse induces long-term modifications in cerebral

neurotransmission presents a strong argument for research aimed at characterising these modifications and finding ways to reverse them.

3. New methodologies such as neuroimaging and genetic research may help to better understand variations in vulnerability to addiction, even if social factors are also clearly important. However, the extent to which this can be used in practice remains questionable.
4. The efficacy of novel immunological approaches and neurological techniques will require detailed scrutiny. Some approaches in this area may be used in ways that raise important ethical and social concerns which could offset, or even be greater than potential benefits.
5. Neurobiological research provides support for a ‘medical model’ of addiction. However, many drug issues concern the non-dependent use of illicit substances and the question of which approaches are appropriate to encourage addicted individuals into treatment — particularly those who may not want to be treated — is a critical one.

Drugs in focus (continued)

6. A major challenge for policy will be to find ways to educate the public about the neurobiological basis of addiction, whilst acknowledging that individual and social choices also impact on drug use and addiction.

These issues are addressed in a new EMCDDA monograph: Carter A, Capps B and Hall W (eds) (2009) *Addiction neurobiology: ethical and social implications*. Monograph No. 9. Luxembourg: Office for Official Publications of the European Communities.

Drug use: an overview of general population surveys in Europe

The EMCDDA recently published an overview of general population surveys on the prevalence of drug use in Europe.¹ The authors conducted a meta-analysis of the national surveys in use in 18 countries since 2001 and compared the different survey methods used.

The participating countries provided information about their national surveys under four headings: the intrinsic focus (design of the questionnaire and type of questions asked), the methodology used, financial issues, and the utility and accessibility of the results. The overview identified intrinsic and methodological issues relating to the comparability of the national surveys and the standardisation of definitions used, some of which are outlined below.

The surveys in many countries comply, wholly or in part, with the European Model Questionnaire (EMQ), which allows cross-country comparisons. However, not all countries conduct surveys specifically on drug use. Some include drug-related questions in general health or crime surveys, which limits the number of drug-related questions that can be asked. This means that the surveys conducted in different countries vary in the number of items and the number of questions included.

While most countries want to include in their surveys questions about all the psychoactive drugs that are known to be used, it is recognised that estimates obtained in this way actually underestimate the use of some drugs in the general population.

Most national surveys include three prevalence indicators for each drug included: lifetime use, last year use and last month use. However, some countries feel that these prevalence rates must be interpreted with caution because of the low number of users among the general population. Measuring the prevalence of misuse of licit drugs tends to be limited.

The authors report that countries are divided on the inclusion of an item on intravenous drug use in their surveys. The argument against including such an item is, again, linked to the low prevalence in the general population and the belief that such users, if reached, would not be willing to reply to the questionnaire.

The authors found no consensus about the measurement of the frequency of use of either licit or illicit drugs. Several countries, including Ireland, measure frequency of use in the last month only as they feel that is the most useful recall period; other countries are of the opinion that the sample size for last-month frequency tends to be too small, and therefore also measure lifetime and last-year frequency.

A high response rate is generally seen as a mark of quality in a survey. The rates reported in this overview ranged from 21% in Austria to 91% in Hungary. Information on how non-response rates are calculated is often not reported. The authors suggest that standardised definitions and formulas for calculating response rates be provided so that better cross-survey comparisons can be made.

Securing funding to repeat surveys is a major problem for some countries and leads to restrictions on the length of the questionnaire and the sample size. The authors noted that most national survey reports do not contain any information about the costs of the survey.

In conclusion, the authors suggest that some of the intrinsic and methodological issues should be standardised to improve comparability of general population surveys across Europe.

(Suzi Lyons)

1. Decorte T, Mortelmans D, Tieberghien J and De Moor S (2009) *Drug use: an overview of general population surveys in Europe*. Luxembourg: Office for Official Publications of the European Communities.

Recent publications

Journal articles

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

Youth alcohol and drug use in rural Ireland - parents' views

Van Hout MC

Rural and Remote Health 2009; 9: 1171

Introduction: Drug availability is increasing throughout Ireland due to a convergence of rural and urban cultures during the last decade of economic growth and prosperity. Rural Irish youth may now have a heightened risk for problematic alcohol and drug use due to increased exposure to drugs, urban contact with peer drug users, unstructured recreation time and poor parental monitoring. Rural parents may perceive their children to be less at risk, and often struggle more than their urban counterparts to identify and respond to their children's alcohol and drug use. The aim of this research was to provide an exploratory account of rural parents' perspectives on alcohol and illicit drug use among youth in Ireland.

Methods: A convenience sample of parents with adolescent children was selected at a parent-teacher evening at three rural schools, with the facilitation of school completion officers (34 mothers and 21 fathers). Semi-structured interviews were conducted, which included questions relating to the parents' perceptions of youth drug and alcohol use, both in terms of recreational and problematic use in their communities, levels of drug availability, risk perceptions, settings of adolescent substance use, service provision and drug information. Following transcription of the interviews, a content and thematic analysis was conducted in order to identify areas of similar and contrasting opinions, and various formulations were compared and contrasted in order to ground the information firmly in the data garnered.

Results: The results suggested parental concern with regard to increased drug exposure for youth in local rural communities. The majority of parents were aware of youth alcohol use but were concerned about all drugs, were not aware of specific differences in drug-related risk, and had difficulty comprehending harm-reduction principles. Most parents recognised the need for greater parental monitoring, awareness of free-time accountability, improved parent-child discourse, and visibility of services.

Conclusion: Life in contemporary rural Ireland is influenced by dominant social changes in terms of the normalisation of alcohol and drug use in youth subcultures, with increased fragmentation of traditional rural family norms and values, emerging acceptability of alcohol and drug use in recreation time and widespread availability of alcohol and drugs. There is a need to target rural parents using a community development approach in order to provide drug education, service visibility and family support for those experiencing problematic substance use.

Is the contribution of alcohol to fatal traumatic brain injuries being underestimated in the acute hospital setting?

O'Toole O, Mahon C, Lynch K and Brett FM

Irish Medical Journal 2009; 102 (7): 207-209

Alcohol consumption in Ireland almost doubled during the period 1989-2001. To evaluate the relationship between alcohol and fatal head injuries in the acute hospital setting, we created a database of all fatal traumatic brain injuries in the Department of Neuropathology at Beaumont Hospital

over a ten-year period (1997-2006 inclusive); 498 cases were identified (351 males and 147 females).

Fatalities were highest in males aged 19-25 years (n =101) and 51-70 years (n =109). Falls (n =210) and road traffic accidents (RTAs) (n =183) were the commonest modes of presentation. Of the cases involving a fall, 36 (17%) had positive blood alcohol testing, 9 (4.3%) had documentation of alcohol in notes but no testing, 35 (16.7%) tested negative for alcohol, and 130 (61.9%) were not tested. The RTA group comprised drivers (n =79), passengers (n =47) and pedestrians (n =57). Of the drivers, 65/ (82.2%) were males aged 19-25 years. Blood alcohol was only available in 27/79 (34.1%) drivers and was positive in 13/27(48.1%). Of the pedestrians, 14 (18.7%) were tested for alcohol, of whom 4 (28.6%) were positive. Overall, 142/183 (77.6%) of the RTA group were not tested. The contribution of alcohol to fatal traumatic brain injuries is probably being underestimated due to omission of blood alcohol concentration testing on admission to hospital. Absence of national guidelines on blood alcohol testing in the emergency department compounds the problem.

Prevalence of problem alcohol use among patients attending primary care for methadone treatment

Ryder N, Cullen W, Barry J, Bury G, Keenan E and Smyth B

BMC Family Practice 2009; 10 (42)

Background: Problem alcohol use is associated with adverse health outcomes among current or former heroin users and primary care is providing methadone treatment for increasing numbers of this population. This study aimed to determine the prevalence of problem alcohol use among current or former heroin users attending primary care for methadone treatment and to describe the socio-demographic characteristics and health service utilisation characteristics associated with problem alcohol use.

Methods: We conducted a cross sectional survey of patients sampled from a national database of patients attending general practice for methadone treatment. Participants were recruited by their general practitioner and data were collected using an interviewer-administered questionnaire, which included the Alcohol Use Disorders Identification Test (AUDIT), with a score of >7 considered abnormal, i.e. 'AUDIT-positive cases' and socio-demographic, medical and substance-use characteristics.

Results: We interviewed 196 patients (71% of those invited, 31% of those sampled, 11% of the national database). The median age was 32 years, 55% were hepatitis C positive, 79% had used illicit drugs in the previous month and 68% were male. Sixty-eight AUDIT-positive cases were identified (prevalence of 35%, 95% CI = 28-41%) and these were more likely to have attended a local emergency department in the previous year (p < 0.05) and less likely to have attended a hospital clinic in the previous year (p < 0.05). Twenty-seven (14%) scored 20 or higher, indicating possible alcohol dependence.

Conclusion: Problem alcohol use has a high prevalence among current or former heroin users attending primary care for methadone treatment and interventions that address this issue should be explored as a priority. Interventions that address problem alcohol use in this population should be considered as a priority, although the complex medical and psychological needs of this population may make this challenging.

(Compiled by Louise Farragher)

Upcoming events

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

September

24–25 September 2009

European Commission Conference: Bridging the Research Gap in the Field of Illicit Drugs in the EU

Venue: Albert Borschette Conference Centre, Brussels
Organised by / Contact: European Commission (Directorate General for Justice, Freedom and Security) www.illicitdrugsresearch.eu

Information: To be opened by Jacques Barrot, vice president of the European Commission, the conference will take stock of research in the field of illicit drugs in the EU, looking at future research needs and at how EU co-ordination and co-operation could be improved to strengthen research capacity in this field. To do this, the conference will bring together some 200 policy makers, researchers, and research funding organisations from across the EU, together with representatives from international organisations and EU institutions.

A number of places are reserved for invited participants; however, we encourage active participation, in particular by researchers in the illicit drugs and related fields; research councils and/or funding agencies already involved in the funding of drug-related (or addiction) research, or interested in doing so in the future; and other stakeholders that play an important role in illicit-drug-related research.

If you would like to participate in this event, please pre-register on-line. Closing date for registration is Friday, 18 September. Your registration will be subject to agreement by the Commission and will be confirmed by our contractor TIPIK. Participation may have to be restricted due to the limited number of places available. Participants are requested to make their own travel and accommodation arrangements.

October

5–7 October 2009

The Fifth European Association of Addiction Therapy Conference

Venue: Cankarjev Dom Cultural and Congress Centre, Ljubljana, Slovenia
Organised by / Contact: Cortex Congress Ltd, 20 Mortlake High Street, London SW14 8JN
Tel: + 44 (0) 20 3287 7571
www.eaat.org/index.html

Information: The European Association of Addiction Therapy (EAAT) has become one of the world's leading conferences focusing on understanding the scientific and social bases of addiction. Each year the conference programme covers an extensive range of topics, including substance and non-substance addictions as well as the clinical, behavioural, social and environmental consequences of addiction. Attend EAAT 2009 to hear the latest research and opinions on a wide range of topics and issues, hear from leading experts, ask questions and debate with your peers.

8–9 October 2009

Getting a Grip 2009

Venue: Hotel Europe, Killarney
Organised by / Contact: Chris Barrow,

Conference organiser
Email: lifed@eircom.net

Information: Further information shortly on www.kerrylifededucation.com

19–21 October 2009

Recovery Careers: the quality of care and life. 12th International EWODOR Symposium

Venue: University of Stirling, Scotland
Organised by / Contact: European Working Group on Drugs Oriented Research / Convenor: Rowdy Yates, Dept of Applied Social Science, University of Stirling
Tel: + 44 (0) 1786 - 467737
Email: p.r.yates@stir.ac.uk
www.dass.stir.ac.uk/old-site/ewodor

Information: In current substance abuse treatment, post-modern concepts such as quality of care and life aftercare are clearly linked to recovery careers. Former and current users of treatment facilities depend for their recovery on the quality of the treatment system and ongoing support in the world around them. The programme of the symposium will not only examine the story of the crisis and rejuvenation of the European therapeutic community movement but will also explore the ideological and methodological background to this remarkable development. More importantly, the symposium will consider the successful life careers of former users and examine what can be learnt from quality of care and life research in other fields. The symposium will contain a mix of plenary presentations, panel discussions and workshop sessions.

November

5 November 2009

Irish Needle Exchange Forum National Conference

Venue: Malton Hotel, Killarney, Co Kerry
Organised by / Contact: Tim Bingham, Irish Needle Exchange Forum
Email: tim@inef.ie
www.inef.ie

Information: Speakers will include:

Jamie Bridge: Programme manager for the International Harm Reduction Association and co-deputy chair of the UK National Needle Exchange Forum

Dave Gordon: Team co-ordinator of a harm-reduction unit in Southampton

Josie Smith: Chairperson of All Wales Needle Exchange and research scientist with National Public Health Service for Wales

Mary O'Neill: Has a background in public health nursing and worked in the HIV /Drug services at the Baggot Street clinic. Currently works in the HSE Midlands as project manager in sexual health.

Tony Duffin: Director of the Ana Liffey Drug Project

Martin Chandler: Manager of the Inter Agency Drug Misuse Database at the Centre for Public Health in Liverpool John Moores University

Upcoming events *(continued)*

11–12 November 2009

Research–Teaching Linkages: Practice and Policy

Venue: Trinity College Dublin

Organised by / Contact: National Academy for Integration of Research & Teaching & Learning (NAIRTL)

www.nairtl.ie/conference

Information: The 3rd annual NAIRTL conference focuses on best practice in the development of research-teaching links, identifying potential policy supports to help shape those links. The programme will feature keynote talks, invited papers, workshops and poster sessions. See website listed above for further details and free online registration.

12–13 November 2009

Society for the Study of Addiction: Annual Symposium 2009

Venue: Park Inn, York, UK

Organised by / Contact: Society for the Study of Addiction / Graham Hunt, Leeds Addiction Unit

Email: graham.hunt@leedspft.nhs.uk

www.addiction-ssa.org

Information: The themes of the symposium include:

Treatment policy

Service-user involvement

Young people and families

Professor Christine Godfrey will give the Society

Lecture – ‘Addiction Treatment - Do economists contribute to the policy debate?’

Alcohol Education & Research Council
Symposium: What does the AERC do?

March 2010

15–16 March 2010

4th Annual Conference of the International Society for the Study of Drug Policy

Venue: Santa Monica, USA

Organised by / Contact: RAND Drug Policy Research Center and UCLA’s Integrated Substance Abuse Program
www.issdp.org/conferences.htm

Information: The theme of the conference is ‘The future of drug policy: trends in policy, research to practice and practices that should be researched’. The conference should be of interest to policy makers, practitioners and academics from a wide array of disciplines who are engaged in drug policy analyses pertaining to drug markets, the harms caused by both the supply of and demand for drugs, and the intended and unintended consequences of policy. Researchers and/or practitioners interested in contributing papers that advance future thinking regarding the development, assessment, or evolution of drug policy nationally or internationally are encouraged to submit abstracts or panel sessions.

Drugnet Ireland is published by:

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The Alcohol and Drug Research Unit (ADRU) of the Health Research Board is a multi-disciplinary team of researchers and information specialists who provide objective, reliable and comparable information on the drug and alcohol situation, its consequences and responses in Ireland.

The ADRU maintains two national drug-related surveillance systems and is the national focal point for the European Monitoring Centre for Drugs and Drug Addiction. The unit also manages the National Documentation Centre on Drug Use.

The ADRU disseminates research findings, information and news through its quarterly newsletter, *Drugnet Ireland*, and the HRB series publications. Through its activities, the ADRU aims to inform policy and practice in relation to drug and alcohol use.